EXPLORING THE IMPACT OF INTERPROFESSIONAL TAUGHT MODULES AND PLACEMENT EXPERIENCE ON THE DEVELOPMENT OF PROFESSIONAL IDENTITY AND UNDERSTANDING OF ROLES IN FIRST YEAR MENTAL HEALTH STUDENTS

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ABSTRACT

Mental health services are under continuous pressure to develop multidisciplinary service models in response to government policy. Mental health professionals, however, continue to be trained in isolation with little preparation for working within a multidisciplinary environment. This thesis explored the development of professional identification amongst nine students in their first year of qualifying training. It focussed on their understanding of their role and the roles of other mental health professionals, specifically nursing, social work and occupational therapy. It also focused on the impact of interprofessional education (IPE) and work-based placements.

The research undertaken in this thesis was framed by a social constructionist approach and utilised semi-structured interview data collection methods, discourse analysis and the analysis of course syllabii to explore student experiences.

The findings indicate that there may be benefits that can be achieved through IPE regarding enabling students to understand their professional roles within the broader context of health and social care. IPE can offer a means of preparing social work, nursing and OT students for the multidisciplinary team environments that they will be required to work within should they choose to work in mental health services. This thesis suggests that the impact of placement experiences within the first year of study on identity and knowledge of own roles and those of other professions, whether in MDTs or uni-disciplinary teams is significant. These findings indicate that consideration should be given by education providers to the weight and significance of the first practice based experiences, as a potent learning and development experience that can shape professional identity and understanding.

DEDICATION

For my husband Martin and our daughters Alexandra and Christina, who arrived during the journey, have inspired me along the way and bring joy and happiness to each and every day.

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CHAPTER 1. LITERATURE REVIEW

1.1 The impact of the multidisciplinary team model on professional roles

This chapter is divided into two parts. The first part provides a context for the research by reviewing selected policies in England that have shaped the current multiprofessional configuration of mental health service delivery models. The literature review focused on the period from the early 1990s to 2004 when the establishment of new Multi-disciplinary Team (MDT) models introduced by the National Service Framework (NSF) for Mental Health (1999) target implementation period had been completed. Literature from before and after the policy implementation time period is included in order to encapsulate the views and perceptions of the perceived impact of the changes before, during and following the introduction of the MDT models. These policies are reviewed alongside selected literature that drew on the impact and experiences of the changes from a professional's perspective. The second part of 1.1 then reviews literature that explored the impact of these developments on the perceptions of roles within multidisciplinary teams in addition to any perceived threats to professional identity.

The second part of the chapter (1.2) reviews literature exploring the impact of socialisation and interprofessional education on professional identity, understanding of role and those of other professions.

Definitions of interprofessional and multiprofessional education and practice

It is widely understood in the literature that the prefixes of inter-and multi-are used interchangeably when referring to professional practice and education (McAllin, 2001). This section seeks to give an overview of the variation in terminology used in reference to the provision of education to more than one group of professionals, and the definitions of teams that consists of more than one professional. Miller (2001) defines interprofessional education

(IPE) as different professions learning about topics of mutual interest, rather than about each others' roles. Clifton et al (2006) define these shared learning opportunities as multiprofessional education. They argue that the term interprofessional education describes where professionals learn from and about each other, with the expressed aim of improving the delivery of care to individuals. Freeth et al (2006) suggest that the interactive nature of IPE goes a step further, in enabling the participants to generate new perspectives and ways of understanding between professions. This lack of clarity in the definition of IPE extends throughout policy and research (Sharland et al, 2007).

Barr et al (2005) define IPE as

'Occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care' (p11)

Barr et al's definition has become the most accepted definition across disciplines. The focus is on the intended outcome of the process, to enhance collaboration between professionals, in contrast to multidisciplinary education which simply brings different professions together in the classroom. In constructing a working definition of IPE in relation to this study, I synthesise the definitions of Barr et al (2005) and Freeth et al (2006). My working definition of IPE is occasions where professionals learn with, from and about each other, and in doing so develop their understanding of how professionals can collaborate in practice.

The confusion relating to IPE terminology translates into the practice setting. The terms multidisciplinary and interdisciplinary are often used interchangeably in the literature reviewed here. However, in discussing professional roles within mental health teams the difference is significant. Within a multidisciplinary team only one person, such as the care co-

ordinator within the Care Programme Approach or the psychiatrist, makes decisions about interventions or treatment. There will be opportunities for each discipline to feed in to the care planning process, through individual consultation or team case discussions. The potential advantages of the multidisciplinary approach of bringing different disciplines together are not maximised in this situation. Finding a workable way of combining the input of the range of disciplines into a common decision-making process produces an interdisciplinary team.

A team functioning in an interdisciplinary model would enable the utilisation of the range of skills held by members to best meet clients' needs and pools knowledge and resources to the best effect. Whilst the literature commonly refers to MDTs as the approach of choice, it can be argued that perhaps MDTs provide a realistic starting point from which interdisciplinary systems and processes can be developed. Individual disciplines can often find that their skills, competencies and approaches are exhausted when presented with clients with extremely complex problems. Working co-operatively in partnership with other members of the team to evaluate client needs and develop a joint plan of action would demonstrate successful interdisciplinary team functioning.

In relation to this study, it is important to recognise that the MDTs referred to in the literature are generic CMHTs. These teams were the first point of referral for the full spectrum of mental health needs and as such operated in a multi disciplinary way. Some of the new teams introduced by the NHS Plan (2001) such as Early Intervention Teams and Assertive Outreach Teams have been designed to function as interdisciplinary teams by virtue of the fact that they have shared team caseloads, as opposed to individual case loads. This has been achieved by introducing staff to client ratios and team caseload approaches.

Mental health policy & the development of the multidisciplinary team approach

In the early 1990s government policies relating to mental health service development focused on a multiagency and multidisciplinary model of delivery with the introduction of Community Mental Health Teams (CMHTs). The policies aimed to encourage and facilitate better working partnerships between professions and agencies (Do H, 1989; 1990a; 1990b; 1996; 1997 a; 1998 a). However, uptake and implementation was variable and the government responded by setting national priorities and ring-fencing budgets in an attempt to accelerate the process towards interagency collaboration, including the shift towards multidisciplinary team models (DoH, 1997b: 1998b, 1998c). A First Class Service (DOH, 1998e) announced a new wave of performance measures across the NHS, including the introduction of National Service Frameworks and implementation guides with related targets.

The National Service Framework (NSF) for Mental Health (DoH 1999b) specified models of treatment and care which people would be entitled to expect in every part of the country in the five following areas: mental health promotion; primary care and access to services; effective services for people with severe mental illness; caring about caregivers and preventing suicide.

The Department of Health stated that the intended outcomes of the NSF were to remove the existing 'post code lottery' system of service provision and widespread variations in mental health provision across England. The document's main focus was on new models of service delivery, with examples of good practice referenced throughout. There were also key messages around interdisciplinary working. Chapters 2 and 3, entitled 'Primary care and access to services', highlighted the need for primary care staff to increase their skills and knowledge and deliver services to people with mental health problems, indicating a shift away from specialist services provision for people experiencing less severe mental health problems. This meant that GPs and practice nurses needed to work more collaboratively with specialist

mental health staff. The requirement for 24-hour access to services also meant that interagency and interdisciplinary communication needed to improve. Chapters 4 and 5, entitled 'Effective services for people with severe mental illness' framed success around effective integrated Care Programme Approach (CPA) systems and interdisciplinary working.

A particular strength of the NSF was that it identified the need to develop the workforce and continue working with professions over longer time periods, effectively recognising that multidisciplinary harmony could not be achieved overnight by a change in policy. The framework suggested that providers should produce a professional development strategy and that the balance of existing skills would need to be adjusted in some areas in order to address a shortage of skills in others. A particular weakness of the NSF was that whilst an emphasis on team, interdisciplinary and interagency working within education and training was suggested, this was aimed at a post- qualifying level with no mention of the professionally unqualified workforce or qualifying training.

The NHS Plan (2000b) strengthened the messages delivered in the NSF, announcing major investment in new models of service: crisis resolution, assertive outreach, and early intervention in psychosis teams. The NHS Plan also announced the introduction of Care Trusts that would enable the establishment of a single organisation to commission health and social care, proposing that the new changes would eliminate some of the difficulties experienced between services and amongst staff. Whilst the NSF made specific references to the perceived challenges for professions, the NHS Plan with its new roles and new team models with a specific multidisciplinary focus did not. Indeed, reference to multidisciplinary working was only made twice throughout the 147-page document, with no mention of interdisciplinary working. The new mental health specific roles announced in the plan (Graduate Primary Mental Health Care Workers, Gateway Workers, Community

Development Workers and Carer Support Workers) were not professionally affiliated. The plan introduced changes across the broad spectrum of NHS services, and as such, the guidance did not provide a sufficient level of detail to enable services to easily implement the new roles. The message was clear, however, not only were professions being asked to work in more prescribed multidisciplinary and interdisciplinary models, but also that government policy was looking beyond professional roles to new roles based on competencies.

The Policy Implementation Guide that followed in 2001 (DOH 2001a) specified in greater detail the professional mix and workforce numbers that were expected to be put in place in order to deliver these new service models. Its foreword stated,

"It is always difficult in any national publication to achieve the correct balance between clarity over what is to be done and local flexibility over how it is to be achieved. This is a guide not a prescription…there is also emphasis placed on tailoring services to meet local needs" (DoH 2001, p. 3).

However, the targets were prescriptive and specified target service user populations, numbers and caseload ratios and a service specification for each team, which effectively allowed for very little local flexibility. Whilst key skills were identified to deliver the service to meet client needs, there was no flexibility in the roles that would deliver them, instead established professional roles were specified in numbers per team.

Context; The role of professions in health and social care

There have been a number of policy changes within health and social care in the last two decades that have had a significant impact on professional roles, identity and education:

- Changes in social care policy & effects on the professional status of social work

- The move to degree qualification in social work
- New ways of working and the shift away from professionally affiliated roles
- Developments in health education commissioning
- A competency based approach to roles

This section considers the professions' responses to these challenges within the broader practice context.

Social care policy

The NHS and Community Care Act 1990 and the subsequent shift towards community provision brought new opportunities for professions to work more autonomously and redefine roles. A decade later, The Care Standards Act (2000) introduced a new regulatory body for social care professions, the General Social Care Council (GSCC) which raised the profile of professional roles within the social care workforce. Both of these policies had a significant impact on the perceived status of social work, but in different ways. The NHS and Community Care Act 1990 clearly defined the remit and raised the awareness of the social work role. However, it also brought the challenge of renewed power struggles between professions at the health and social care interface. What the Care Standards Act (2000) achieved with the introduction of registration was to establish equality for social work status amongst other professions and address a long-standing issue for inter professional working. Within health care, regulation was seen as fundamental to professional status, and the perceived lack of accountability to a regulatory body had until this point led health care professionals to view social work as a profession as 'lower status' (Green, 2006).

Social work education

The changes to social work education in England with the move to degree status in 2003 further enhanced the status of the social work profession. The Requirements for Social Work

Training (DOH, 2002a) heralded this as an opportunity for social work to reinvent its image with the public and establish equal standing with other professions. More recently, the revised framework for post-qualifying education and training set high academic levels of achievement in association with specialist and higher specialist awards. These changes have enhanced the status of these roles within the health and social care arena, particularly amongst nursing colleagues who are yet to move to an all graduate profession. Social Work at its Best (2008) highlighted the positive impact that these changes have had on the perceived status of social workers in the health and social care field. However, these changes occurred at a time of great change within the healthcare arena, where there was a significant move away from professionally affiliated roles.

New ways of working & move away from professionally affiliated roles

2001 heralded a drive for new ways of working within healthcare, with the introduction of the Changing Workforce Programme (DOH, 2001b). The main focus of this programme was to develop new roles and expand and broaden existing roles to encompass competencies and task that were currently being undertaken by specific professional roles. The initiative had a focus on reducing all roles down to their component parts & identifying the competencies required. New ways of working for many meant enhancing the role and undertaking activities that had previously been undertaken by more senior roles; nurses undertaking extended roles that were tasks previously only performed by doctors; the development of the health care assistant, genericising and differentiating from the nursing assistant role, to undertake many of the tasks that were previously within the qualified nurses' domain. Whilst professionals expressed concern regarding the undermining of their professional roles, these competency based roles have continued to develop. The impact on professions has been to move further towards specialisation. Within psychiatry, the focus of the consultant role is moving towards advice and treatment of complex cases, as opposed to leading teams and holding overall

responsibility for entire patient populations, as was previously the case. Whilst many have welcomed this development, psychiatrists have voiced concern regarding the lack of opportunities for post graduate psychiatric trainees to gain generalist knowledge on more common mental health problems, which are now routinely dealt with by other professions. (Dale & Milner, 2009). The strength and influence of the professional bodies may have prevented what they perceive as unwelcome change from taking place in previous decades, but the development of commissioning expertise and power within Primary Care Trusts (PCTs) has introduced a different influence upon healthcare workforce development.

Health care education commissioning

The NHS Plan (2001) and the Changing Workforce Programme (DOH, 2001b) provided opportunities for new roles to be developed in response to policy direction and for education programmes to be commissioned to support these. This aspiration was problematic, however, as PCTs lacked experience and competence in the new role that had been bestowed upon them as commissioners of services. This lack of confidence and experience in workforce planning resulted in PCTs costing and purchasing what they had historically bought; more nurses, more social workers and more occupational therapists, and the opportunity to creatively develop and commission new roles was lost. Expertise and capability within the commissioning role has developed significantly over the last 10 years however, enabling the creation of structures and processes to support flexibility. The centralisation of health care workforce training budgets under the Multi Professional Education and Training Levy (MPET) enables employers to directly influence the education and training programmes that are commissioned on their behalf, through the regional workforce deaneries. The economies of scale that this brings create potential for the introduction of new roles and innovative programmes of education.

Competency based approach in mental health

The Changing Workforce Programme had a significant impact within mental health services, due to the direction of mental health workforce policy between 1998 and 2001 being driven by the new models of service delivery outlined in the NSF (1999) and the NHS Plan (2001). The workforce initiatives that emerged from these policies were prescribed multidisciplinary working models and new roles based on specific competencies, with an invitation for local innovation around traditional roles. The policy literature available within the study timeframe concerning the mapping and compilation of competencies required by mental health professionals mainly takes the form of Government funded research project reports (Sainsbury Centre, 1997 & 2001; NIMHE, 2004)

Pulling Together (Sainsbury Centre, 1997) identified core competencies for specialist staff within mental health services and made recommendations to review the education and training of key professions with an emphasis on shared learning and joint training. The report stressed the value in diversity and suggested that each of the current mental health professions has strengths and skills to offer for the services of the future, arguing that developments in professional training should take place within existing professional frameworks. The Capable Practitioner' (Sainsbury Centre, 2001) outlined the skills and knowledge required by practitioners to provide the new mental health functional service model, and for the first time in health care policy extolling value based practice, reflective practice and social awareness as key aspects of healthcare roles. The '10 Essential Shared Capabilities' (DoH, 2004) attempted to encapsulate the core values, attitudes and approaches that all staff working in mental health services from either health or social care backgrounds should aspire to. The intention was that the 10 ESCs would form the basic framework upon which the curricula of all pre and post qualification training for professional and non-professionally affiliated staff would be based. Whilst this document was received well initially, and embraced within the

nursing curriculum, the widespread adoption did not materialise explicitly across social work and other health care profession programmes of study. These contributions to the literature are significant in identifying the tension that arose in the mid 1990s, and that still exists, between the notion of the need for competency based pre-qualifying training with shared value bases, and a move towards the development of a generic mental health professional.

To some extent, the anxieties that professions expressed around generic worker roles have been highlighted by the development of the mental health practitioner role in Hampshire Partnership Trust. Difficulties in recruiting nurses to work on inpatient wards led to the trust approaching the local university to develop an education programme for a new role, based on specific competency gaps identified within the inpatient workforce in 2003. The mental health practitioner programme was a post graduate 2 year diploma programme aimed at graduates from a wide range of backgrounds. The students were employed as trainees, and spent 1 day a week at university, the other 4 days on placement within the acute ward setting, and related services, such as crisis resolution home treatment teams.

This new role was developed by employers to meet a skills gap, specifically psychological and occupational therapy provision to in patients units. Brown et al (2008) who reviewed the experiences of the early cohorts of students, summarised that the new role was an amalgamation of the disciplines of psychology, nursing and occupational therapy. This role met with resentment and mistrust from nursing staff within the ward environment, in particularly in relation to its lack of registered status. The new role was perceived as a great threat to nursing, drawing on an ever expanding pool of non vocational graduates, and taking only two years to complete. The nurses retreated behind profession specific competencies such as medication prescribing and administration. Surprisingly the role survived, but due to its non- regulated status it is not transferrable outside of the organisation. Although

frustrating for the workers, this is advantageous for the Trust, ensuring a high retention rate of new graduates, if employment cannot be sought in neighbouring Trusts.

The development of entirely new non- professionally affiliated roles has continued within mental health. The Improving Access to Psychological Therapies programme (DOH, 2007a) spent 170 million pounds over a three year period to introduce a new workforce based on two new roles of Psychological Wellbeing Practitioner and High Intensity Worker. These non-professionally affiliated roles are based around specific competencies in evidence based CBT interventions for a defined client group with anxiety and depression only. Whilst welcomed by many as plugging a gap in service, many other professionals already in primary care settings, such as counsellors, have felt disenfranchised (Mace et al, 2009).

More recent policy changes have continued to focus on competency based roles and move away from traditional professions. The decision by the Department of Health to utilise the Yorkshire Care Pathways Model (Self et al 2008) as a basis for developing a charging system for mental health service commissioning has spawned a plethora of projects mapping workforce competencies to required interventions, indicating a direction of travel towards a pathway competence based role, irrespective of profession. Another significant workforce change driver has been the changes introduced by the Mental Health Act (2007) and the widening of the pool of professions entitled to undertake Approved Mental Health Practitioner and Approved Clinician Roles. This change in law aimed to improve access to the most appropriate professional for assessment in the most timely manner, although the changes have been met with scepticism by social workers and psychiatrists. For psychiatry, the broadening of the range of professions eligible to undertake the Approved Clinician role has threatened what they perceive to be one of the few remaining unique elements of the psychiatrist's role. These perceptions are set within the context of new working practices for

psychiatrists, functionalisation and diminishing numbers of psychiatry training places commissioned. For social work, the concern that nurses and occupational therapists will not have the appropriate values based training foundation on which to build the AMHP training are coupled with the potential threat to the independence of the role (Bowl, 2009) .

This change is further compounded by the service reconfigurations taking part at a local level in relation to Section 75 partnership arrangements (DoH, 2000a) which provides a mechanism for budgets between health trusts and local authorities to be pooled, and the perceived threats to traditional working practices. In the West Midlands, this has meant wholesale structural change in some organisations, but incremental in others. Depending on how this has been implemented or communicated, these have been seen as collaborative partnership working or hostile take-overs. A number of specialist Trusts within the region have transferred social care workforce contracts from local authorities into the Trust, which has in turn had an impact on the perceived social care identity and independence. For many, this change in employer status could be seen to challenge their independence from the medical model. What this has also brought into sharp relief is the lack of opportunities for social workers to progress beyond senior practitioner roles without moving into management roles. The emergence of non medical advanced practitioner and consultant roles within health has enabled nurses and allied health professionals to do so. These drivers for workforce change during the period of this study provide a means by which we can understand the practice context in which the students undertook their placements and how they have continued to develop.

The emergence of the MDT

The Community Mental Health Teams developed in the early 1990s were based on a multidisciplinary team (MDT) model and drew on professionals from the nursing, social work, psychiatry, psychology and occupational therapy workforce. These teams took referrals

from GPs, Social Services and hospitals for a range of mental health problems, across the age span from 18 to 65. Much of the literature stimulated by the introduction of MDTs in the early 1990s focussed on professional comment and debate as opposed to empirical studies. Onyett et al (1994) and Onyett et al (1995) presented largely positive debate regarding various approaches to making the Community Mental Health Team (CMHT) model work in practice. Galvin and McCarthy (1994) published a critique of the CMHT model arguing that it was flawed because it failed to utilise interdisciplinary team processes and expected too much from the teams. They argued that teams were ill-equipped to deal with the broad range of mental health problems presented and the large caseloads, which resulted in dysfunctional processes within teams. They also suggested that ideology and not a strong evidence base drove the rapid growth of CMHTs. They argued that the vague generic roles and confusion around accountability and responsibility were key elements of failure in the effectiveness of the CMHT model.

A central focus of Galvin and McCarthy's argument was that government policies assumed teams to be the most effective way of managing the workforce resources in place to provide support for people with a range of mental health problems. As workforce had been split across directorates within trusts and across organisations between health and social care they argued that this may have seemed to be a sensible solution to encourage collaborative working relationships between professions. The authors argued that referrals were not being discussed at allocation meetings to ensure best fit of client needs to practitioner skills or the enablement of interdisciplinary perspectives in case discussions. They referred to research by Searle (1991) of CMHTs who found that only 13% of cases worked with in teams involved more than one professional, arguing that the pressure on CMHTs to keep waiting lists down meant that referrals were allocated to whoever had a space in their diary. This resulted in uni-disciplinary assessments with few of the potential MDT advantages being realised, such as

pooling of interdisciplinary knowledge, the ability to specialise in areas of interest and the reduction in delays and confusion caused by interprofessional referral processes.

Searle's findings may well be an accurate reflection of the pressures on CMHTs who, in the 1990s, were tasked to meet the needs of a diverse population with mental health problems. The functionalised team models in the NHS Plan were intended to protect caseload numbers and introduce systems to tailor services to client groups and avoid using a single team to channel all referrals for the broad range of mental health problems. Undoubtedly, Galvin and McCarthy made relevant points in highlighting the difficulties of day-to-day service provision within MDTs but there were opponents to their argument.

In response to Galvin and McCarthy's criticism of the positive and optimistic approach to CMHTs espoused within earlier publications (Onyett et al 1994; Onyett et al 1995), Onyett and Ford (1996) retorted by suggesting that Galvin and McCarthy's argument focused on practical implementation issues rather than problems with the concept of practitioners working jointly together within a multidisciplinary team framework of operation. The authors went on to argue that targeted care, staff equipped with a wider range of skills and the identification of clear team goals with better focussed operational management would improve CMHT effectiveness and that there was no need for the total abandonment of what Galvin and McCarthy described as a 'manifestly inadequate model' (p157) . Furthermore, whilst Galvin and McCarthy suggested the need to take a closer look at alternative approaches and service models within mental health they fail to identify any such alternatives.

The impact of multidisciplinary teams on perceptions of role & professional identity

Literature concerning the impact that MDTs have had on role perception and professional identity focused on both a mix of professional comment and empirical research. Evidence

suggested that MDTs could have a role blurring impact if professions perceive that generic activities such as assessment and care planning can be done by any profession without the input of others (Brown et al, 2000). This view is supported by Galvin and McCarthy (1994) whose fundamental argument is that MDTs assume that team members from all professional backgrounds can undertake core activities like risk screening and need-based assessments. This assumes that each professional possesses an adequate level of skill and competence required to carry out these tasks that has been assessed throughout their pre-qualifying training for their specific profession. Galvin and McCarthy suggested that this reduces the specialist skills that professionals have into a repository of generic competence. In response, Onyett and Ford (1996) suggested that the most obvious cause of inconsistent team aims and individual responsibilities are self-interested professionals concerned with preserving autonomy at all costs. These positions appear polarised, although both seem to support an argument for the identification of skills that are core to all professions and a better understanding of specialist professional roles, approaches and values of other members of the MDT.

Norman and Peck (1999a, 1999b) conducted two linked research studies which aimed to explore some of the commonly identified flaws regarding multiprofessional working in CMHTs and to formulate a proposal for addressing them. They facilitated a series of discussions between two groups: one including representation from professional organisations at a national level and the other with clinicians from a specific service provider within the London area.

The first of their two papers reported the deliberations of the professional representation group, which comprised clinicians, service managers and academics representing a range of

mental health disciplines and professional organisations. The group met for facilitated group discussion four times in a ten-month period.

Feedback from this group provided a number of examples which demonstrated that effective multidisciplinary working had been achieved in teams by finding various ways to overcome the challenges. The key theme arising from these group discussions was that interprofessional working was developing skill mix and range of competencies within CMHTs. However, the group identified four main reasons as to why many staff in CMHTs remained uncommitted to achieving good interprofessional working;

"Loss of faith by mental health care professionals in the system within which they work; Strong adherence to uni-professional cultures; Absence of a strong and shared philosophy of community mental health services; Mistrust of managerial solutions to the problems of interprofessional working." (Peck & Norman, 1999. P231-232)

Both studies set out to identify key problems of interprofessional working in adult community mental health services and to identify potential solutions. Whilst the study succeeded in identifying a range of factors that impinge on interprofessional working in multidisciplinary teams and reported discussions about the reasons why these obstacles existed, it failed to deliver a comprehensive plan of possible approaches and solutions to the issues raised by the four identified areas of working beyond changes in national policy.

The second paper (Norman & Peck 1999b) reported a series of facilitated group meetings between members of three CMHTs. These collated narratives illustrated how professionals perceived their own role and the role of other professionals. Participants met in their uni-disciplinary groups to develop a consensual account of their role, responsibilities and their

professional identity. They were also asked to define and describe the origins and the means of maintaining that professional identity. The series of bi-monthly workshops included two uni-disciplinary groups and aimed to develop the stories and accounts which would then be circulated to the other professional groups. Two further workshops were held one month later to enable individual professional groups to formulate responses to the other professions' stories, on aspects of the professional identity that they valued and perceived areas for development.

The sample of participating teams was drawn from one geographical area, which cannot represent the professional mix and organisation of others around the country, and as such could not be considered representative of multidisciplinary teams nationally. Nonetheless, the study provided an account of mental health professionals discussing what they think are their values, skills and approaches. The researchers also stated that an aim of the research was to "*delineate the origins and the means of maintenance of that professional identity*" (Peck & Norman, 1999 page 232), but findings relating to this are not reported in the paper.

The paper provided summaries of accounts and responses from each of the disciplines. Each discipline demonstrated unease and fear of losing identity and reported feeling undervalued by the rest of the MDT. Whilst all disciplines attempted to articulate the culture and values of their profession, the clarity of these attempts was variable. The most striking element was the reactions and responses received to professional accounts from other professions within their team. Most responses reported surprise or disagreement as to whom the discipline was aligned with, and reported that the information on skills, values and approaches of that profession were new to them. These findings suggested that it could be useful to engage students in interprofessional education at a pre-registration level when they are forming their own professional identity. This would allow for comparison of the roles and approaches of their

own profession with others in the field, leading to a deeper understanding of their own and other's role.

Concern regarding the perceived threat to professional identity posed by multidisciplinary mental health teams inspired McCrae et al (2004) to explore service managers' views of the potential impact upon the future of the social work profession in mental health. A qualitative approach was utilised to undertake interview with 50 senior mental health service managers with responsibility for social workers, and nine academic staff from social work training providers over a three-month period. The data was analysed using qualitative analysis software, following which a thematic analysis was undertaken.

McCrae et al. found that respondents aligned themselves to one of three perspectives, which enabled them to develop an attitudinal framework. This comprised of traditionalists, eclecticists and genericists. Those allocated to the 'traditionalist' category demonstrated a commitment to retaining distinct boundaries around the social work role that would remain separate from NHS professions. This group also demonstrated a strong allegiance to the broader local authority adult social work practitioner role. A group emerged who were assigned to the 'eclecticists' category who demonstrated a willingness to identify and accept areas of commonality in practice and skills who were positive about potential developments in multidisciplinary teams, but whom were unwilling to sign up to a generic worker role as they felt that clients would lose out if choice and difference in professional approaches were not available. The final group assigned to the category of 'genericists' had no qualms about the dilution of professional roles and identities if it meant the client got better care, even if that meant the evolution of the generic mental health practitioner.

McCrae et al warned that the adoption of the traditionalist approach would not be sustainable in the current service delivery models, but social work would risk being left behind and even more isolated from other professions. In addition, failure to align to multidisciplinary service models could have detrimental impact on the access to and range of service provision available to clients. Genericists on the other hand could be perceived as confident and progressive in their enthusiasm to embrace the generic practitioner role. However, this approach overlooked the importance of distinctive skill sets and approaches of different professions in MDTs.

An eclecticist approach appeared to offer a compromise between both traditionalist and genericist approaches. Whilst positively embracing interprofessional working and identifying common ground where possible, the eclecticist retains an appreciation of the unique skills, values and approaches provided by different professional perspectives and recognises the richness that retaining this mix can bring to the MDT and ultimately, the service user. It is possible that this approach could be further enhanced by IPE at a qualifying level by enabling professionals to understand and appreciate the differences and similarities between other professions alongside their chosen profession. McCrae et al (2004) concluded from their findings that mental health social work faces an uncertain future, suggesting that in a world where evidence base for interventions and approaches is key to ensuring service funding, social work needs to clearly demonstrate its value if it is to retain influence on its own professional future.

Professional and team identity

As several authors suggested (Whittington, 2005; Barr, 2003, Norman & Peck, 1999b) preparation for interprofessional working needs to start at qualifying training level, which requires exposure to other professions, both in the classroom and in placement settings. The

socialisation experiences gained by working alongside other professionals can enhance clarity of understanding of other roles but more importantly, provide opportunities for students to compare and contrast approaches, skills and values of other professions outside of their chosen profession. There is a wealth of literature available that explores the impact of socialisation on professional identity across a wide range of professions, that is not specific to mental health (Brown et al, 2000; Carpenter, 1995; Goodman, 1986; Guile & Griffith, 2001; Kuzmic, 1994; Martin, 2005; Wenger, 2000). However, there is research-based literature pertaining to the impact that MDT working can have on team identification specific to mental health teams, some of which has been selected for review here.

A recurring theme of the literature reviewed here is the contrast between the positive impact that MDTs can have on the development of strong team identification and identified shared values, which leads to increased role clarity, and the negative impact that a perceived threat of genericism can have on professional identity such as role blurring (Carpenter et al, 2003; McCrae et al, 2004; Brown et al, 2000). Role blurring refers to the point at which professionals lose sight of where generic skills end and specialist skills commence and can result in a fight to preserve professional boundaries and identification.

Carpenter et al. (2003) investigated the relationship between the organisation of community mental health services and professional and team identification. They set out to test the hypothesis that teams in well integrated areas (defined by an earlier study (2002), relating to organisational links between health trusts and the local authority) would identify well with their team and less so with their profession. They predicted that well-established teams in well-integrated areas would demonstrate positive attitudes and shared values, more role clarity and less role conflict.

The study's research design and methodology was complex. An earlier study had collated data on team organisation and level of integration with the Local Authority. There was also an added variable of whether the service the team provided was targeted towards people with severe and enduring mental health problems. This information formed the basis of the selection of the sample to ensure representation from teams across the range. The sample was large, 113 participants at the first interview stage, and 77 at the second stage.

A quantitative methodology was used, with seven standardised questionnaires administered to gather data, with allowance for some free text at the end. The sample comprised staff from four districts in the north of England who completed the questionnaires, on two occasions, twelve months apart. Data was collected at workshops and the exercise was repeated in twelve months to address team and professional variables. However, whilst this was intended to allow for changes in team composition, nine social workers were unable to participate in interview two. This had a significant impact on the results as social workers demonstrated the largest difference in scores between professions and made up 27% of the sample at interview one. Only 49 participants were present at both time points.

The data collected was subjected to rigorous statistical analysis. A range of parametric and non-parametric tests were used although extremely small sample sizes for some of the professions skewed the overall picture across the professional groups. Psychiatrists, OTs and psychologist numbers were so small that their results were aggregated to from one group alongside social workers, community psychiatric nurses and support workers.

Carpenter et al discovered that although there were differences in team functions due to the impact of integration between health and local authorities in some places, the multidisciplinary team design and function as an environment in itself did not impact on

professional or team identification. Social workers demonstrated a significantly higher rate of conflict of role compared to the other professions and had poorer perceptions of team functioning. The research also found that the multidisciplinary nature of a team did not affect team or professional identification and this was consistent across all four districts. Participants did identify more strongly with their team than their profession, however. This difference was consistent across all four districts. These findings are important to the concerns of this thesis and its aims to explore the impact of socialisation within placement settings on the development of professional identity amongst students. However, it is worth noting that these participants were not students and many may have had significant experience in a number of environments.

Brown et al (2000) also investigated the implications of an MDT approach on professional identity within three CMHTs in a rural area within the Midlands. The three teams, comprising 29 staff, had recently been reorganised into multidisciplinary teams. Participants were interviewed using a semi-structured questionnaire which focused on the day-to-day work role, the data from which was themed and subjected to discourse analysis.

The participants' responses highlighted the existence of significant boundaries between disciplines within the teams. The study also found that participants felt that roles and responsibilities were being blurred in numerous areas which some saw as a progressive developmental step, but for others raised defensive barriers and prompted a retreat behind disciplinary boundaries.

Lack of organisational processes and clarity of team purpose was an issue within the participating CMHT's, with some participants reporting that they felt that they had been left to fight their own corner which for some felt like defending their own professional role. Some,

however, reported that this lack of clarity encouraged further blurring of roles and responsibilities, as all team members endeavoured to get the job done. Brown et al concluded that the challenges encountered by professionals within multidisciplinary teams served to reinforce boundaries between disciplines.

Professional identity and confidence in multidisciplinary teams

Some authors (Laidler, 1991, Dombeck 1997, Whittington, 2005) suggested that the development and subsequent maintenance of professional identity is important to enable people to provide focused and effective input into interdisciplinary processes. Opinion is divided however, on whether this should take place at qualifying or post-qualifying training level. Dombeck (1997) discusses the notion of 'territoriality' (p 15) with regard to professional identity, illustrating that many professionals differentiate themselves by their professional training background and job role responsibilities within an organisation, or service area. Many people refer to their background discipline as a defining feature of their professional identity even when they have not practised within that role for a number of years. Dombeck asserts that a person needs to have a coherent understanding of their own professional identity and role before they can work effectively in an interdisciplinary team. Laidler (1991) proposed that professionals need to feel secure in their own professional role and skills in order to be able to share this expertise. In contrast, Whittington (2005) argued that IPE at prequalifying level could promote professional identity and develop confidence and awareness of other roles.

These contributions to the literature suggest that it is important to consider the difficulty of forming collaborative ties when an individual is unsure of their own professional identity. Collaboration and successful partnership working can be strengthened by an individual's confidence in their own perception of role and professional identity. If someone is confident

in their own identity, role and boundaries and has knowledge and understanding of others professional roles, the multidisciplinary team environment does not present a threat. However, professional identity is formed in the early stage of training and this needs to be nurtured. Through IPE and socialisation, via multidisciplinary placements, students can gain awareness, knowledge and understanding of other professional roles, which enable them to focus on the unique values and approaches of their own profession, and what that means to them as an individual.

Summary

The key themes that have been identified in this chapter and are relevant to this thesis concern the impact of multidisciplinary working on perceptions of professional identity and the importance of preparing students for MDT working within professional qualifying training courses. The literature reviewed in the first part of this chapter highlights a number of issues relating to the impact that multidisciplinary team models in mental health can have on professional identity. Studies of multidisciplinary team effectiveness indicate that professionals have a poor understanding of each other's roles and skills and this can adversely affect the teams' ability to function effectively. Some of the literature suggests that professionals identify themselves with their professional group rather than fellow mental health professionals, and this often acts as a barrier to effective team functioning.

The second part of the chapter examines literature relating to the development of professional identity, socialisation, interprofessional education at a pre and post-qualifying level, and the challenges these present.

1. 2. Professional Identity, Socialisation and Interprofessional Education

This thesis aimed to explore the impact that socialisation and interprofessional education, both within taught and practice placement settings, can have on the development of professional identity in mental health students. The process began with a thorough review of literature examining professional identity and the subsequent identification of processes that may underpin and support its development. Literature was selected on the basis of relevance for health and social care professional training. The notion of professional identity and the impact that socialisation may have on its development is discussed in the chosen literature at a conceptual level, but empirical investigations in the health and social care arena are sparse. However, there is a significant body of literature in the field of education that covers this well, some of which has been selected for review here. There is a raft of profession specific literature commenting on the impact of multidisciplinary working in mental health on the development of professional identity. These include nursing (Lankshear, 2003; Carpenter 1995; Kenny, 2002), occupational therapy (Hughes et al, 2005; Hughes, 2001.; Craik et al, 1998), social work (Carpenter & Platt, 1997) and psychology (Trepka, & Marsh, 1990; Watts,. 1987). However, this literature does not provide empirical evidence to either support or challenge arguments around professional education and has therefore been excluded.

Literature exploring the impact that interprofessional education can have on the development of professional identity is reviewed, with specific focus on empirical studies. Due to the paucity of such research in the mental health arena, literature relating to studies of training in the health and social care professions more generally is also included.

Professional identity

The notion of identity and what constitutes identity is discussed at length in the literature. Epstein (1978) stated that identity "Represents the process by which the person seeks to integrate his various statuses and roles, as well as his diverse experiences, into a coherent image of self" (p101). Soddy (1961) provided a simpler description, that our identity constitutes our likes and dislikes, what we are good at and what we are not so good at. Identity is the person who we think we are, how we describe ourselves, or how we would like to be seen.

An identity imbues a person's values; how you see yourself makes a statement about the values you think are important. A person can have a number of concurrent identities, for example, a woman may have identities of mother, partner, daughter, sister, employee and employer and function very differently in each of these roles and identities, yet each can coexist. Turner (1999) purported that a person may have a number of social identities that run concurrently, but argued that for many reasons, one identity can be dominant at a given time, depending on the situation and context. To this end, identity is a concept of self and people typically see themselves in relation to other people and judge and compare themselves against others.

The formation of an identity can arise from identifying with people who are similar, or who have similar interests or features. Wenger (2000) stated that

"We define ourselves by what we are not as well as by what we are, by the communities we do not belong to as well as by the ones we do." (p 239).

It follows then that the formation of a professional identity is created by students engaged in, learning about, spending time with and taking part in activities with professional colleagues to enable them to define what their role is and what is not.

The Development of professional identity

Having a professional identity involves a person aligning themselves with the beliefs, attitudes and behaviours of a particular profession. How professional identity develops, or what influences that development, is complex. This thesis aimed to explore the impact of exposure to group interactions within the educational setting and the workplace on mental health students and consider whether the opportunity to compare with and differentiate themselves from within and outside of their professional groups has an impact on their unique professional identity.

Cohen (1981) suggested that professional identity is developed through a process of witnessing and experiencing professionals at work to be able to identify the key skills, competencies, approaches, values and norms that the individual practitioners demonstrate. These then need to be internalised and referenced to enable the individual to seek out or identify similarities with their own behaviour. Dombeck (1997) in her discussions on professional personhood, maintained that having a professional identity places additional expectations and responsibilities upon an individual, as there is an expectation by society that a professional person will already have a high level of social functioning.

Social identity theory (SIT) offers a model for examining the process that enables individuals to make distinctions between us (whatever group or organisation we identify we belong to) and them (people outside of that group). It therefore follows that SIT can enable us to understand the process that underpins the formation of professional identity, and explore how

individuals distinguish the characteristics of different professional groups in the placement setting. However, Whittington (2005) in his review of perspectives on identity compared Social Identity Theory (SIT) with Self Categorisation Theory (SCT). He described SIT as the process by which people make judgements to distinguish themselves from other people, which then enables them to look for people whom they view to be similar, a group they can identify that they belong to. SCT however, goes a step further so that an individual stops looking for comparisons with their own identity and characteristics, but looks for what they might have in common with others, to establish membership of a number of groups.

Whittington also described how

"*Our knowledge of the world is derived from our construction of it in interaction with others, and that the primary medium of construction is language." (p.44).*

This understanding is located in a particular time, and within a specific cultural context with all of the norms, values and expectations that exist within that culture. In relation to this thesis, understanding why students use particular terms and phrases to describe their experiences may help us to understand the cultural context they inhabit both in the classroom and the workplace.

Whittington suggests that we need to adopt a different approach to progressing IPE in practice, that does not pose a threat to the identity of individual professions. He suggests that we do not replace discipline specific discourse with interprofessional or generic discourse, rather that interprofessional collaboration will become the dominant theme within health and social care discourse.

Self Categorisation Theory (SCT) as described by Whittington (2005) was utilised by Hind et al (2003) who undertook a study to measure attitudes towards students' own profession and other health and social care professions. In line with SIT and SCT theories, they set out to explore possible relationships between strength of professional identity and attitudes towards in and out groups. Participants were drawn from students on pre qualifying health care courses within their first year, and data was collected using the survey method, and analysed using a quantitative statistical analysis package. What they found was that those who had a positive attitude towards their own profession also had a positive attitude towards other health and social care professions, and vice versa for negative attitudes. The inter-group differentiation predicted by the SIT and SCT theories did not occur. They concluded that the social contexts and perceived membership of the broader group of healthcare students may have been a mediating factor in the results, but more importantly that a lack of IPE opportunities for the students may have influenced the lack of inter-group differentiation.

Factors that may influence the development of professional identity; professional socialisation

The concept of professional socialisation articulated within this thesis is the process by which an individual gains a sense of occupational identity and the common characteristics and values of that particular profession, by observing others in practice as an undergraduate student. McGowen and Hart (1990) suggested that the process of socialisation may or may not be carried out at a conscious level by the student. Adams et al (2006) argue that professional socialisation can develop

"Through critical experiences where procedures and rules experienced by students or novice professionals trigger the construction of a professional identity." (p57)

The passivity of the experience is challenged by Mires et al (1999) who suggested that the process of socialisation requires a conscious effort on behalf of the individual to contrast and compare the norms and values experienced within the setting with their own, emphasising that they are happy to accept them as their own values and norms.

The literature on socialisation in the health and social care field is sparse, particularly in relation to empirical studies examining the impact on professional identity. There is however, a considerable amount of research on the impact socialisation has on professional identity within the field of education (Hanson & Herrington, 1976; Kusmic, 1994; Mealyea, 1989; Mires et al, 1999). Robson (1998) used a single case study approach to examine the role that professional socialisation played within the training programme for a student teacher. She described her approach as the 'reaction approach', which emphasised the investment and reflection a student makes along the journey towards becoming a professional, and developing their professional identity. The key themes that emerged from Robsons' study were identification with colleagues and students and separation from colleague teachers and students. Whilst on her practice placement, the student actively explored her role in relation to her colleagues, but also with her students and university tutors. She was wary of associating closely with any one approach taken by a teaching colleague, but she was also aware that she felt removed from the teaching approaches that had been studied within the university setting. Gradually, she moved away from her fellow students, and towards identification with effective teachers who provided positive role models. She was keen to ensure that she never lost sight of the needs of her students and that she would adapt an approach that was right for her. Robson concluded that that the placement setting heavily influences the development of professional identity as student teachers will be exposed to any number of challenges and choices within the university and practice placement setting, which may have a positive or negative impact upon their identity.

Robsons' findings influenced the design of the current study, as there was a focus on both work place experiences and university-based course elements. It is widely accepted that professional roles may be depicted rather differently within the university environment, than the present day perspectives of current practitioners. (Adams et al, 2006; Melia, 1987). The socialisation process needs to enable the student to ratify the two perspectives presented to them. This comes with recognising their own new identity as a member of that profession, and what that might mean for their own values. This suggests that in order for a student to find an appropriate identity the process depends on the existence of both positive and negative role models.

Typically, role models are placement supervisors and other professionals in the work place. It is highly likely that a number of health and social care students embarking on prequalifying training will have undertaken paid or voluntary work within a health or social care setting, and as a result they have formed a professional identity or at least an opinion or view on other professions. This view was supported by Adams et al (2006) in a study investigating the strength of professional identity held by first year health and social care students. Their aim was to identify factors that effectively predicted variation in the initial levels of professional identification, and compared the different baseline levels of professional identity across various professional groups.

The research surveyed 1,254 first year health and social care students in two cohorts (one an experimental and one a comparison) taking part in an IPE pre-qualifying programme in two universities in the south of England. Levels of professional identity were measured using a rating scale adapted from that created by Brown et al (1986) to measure group identification, and the students understanding of team working was measured using the team understanding

scale (Rentsch, 1993). A number of statistical analyses were utilised to test for associations between professional identity and independent variables.

It was found that a significant number of students had formed a professional identity by the time they commenced a pre-qualifying programme, although this varied by profession. Prior work experience in the health and social care sector, understanding of team working and knowledge of the profession all influenced levels of professional identity. The weakest professional identities were demonstrated by social work participants and physiotherapy students had the strongest. Adams et al concluded that additional research was required to examine longitudinal effects of IPE throughout the prequalifying course duration, and the strength of affect in comparison to control groups.

The potential influence that prior work experience can have on students professional identity was highlighted by Martin (2005), who suggested that the socialisation experience within the workplace can not only offer insight into the competencies, skills and knowledge required , but can also expose the student to situations that reveal the values and culture of the profession. Martin suggests that as a result of these experiences, students are

"Encultured in the community's embodied knowledge; for example, they learn to speak its language, which enables them to become socialised as members of their own profession."(p56)

Dombeck (1997) in her description of 'professional personhood' (p 10), points out that professional training involves passing on specialist knowledge, approaches and standards of practice, but it is the ways in which the profession are expected to behave that an individual will learn in the workplace. She explains that these behavioural expectations for the

profession are not formally and explicitly included in a programme of training, the experienced through socialisation practices in the workplace. It is because of this additional facet which is required to be learnt, the accepted behavioural norms and accepted ways of seeing things that she argues that socialisation has to form an integral part of the educational experience.

Caley (2001) supported this view, arguing that the academic learning context is very different to the work context. Rather than being taught how to do something by experts, professional students need to learn how to do the job required of them in the practice setting surrounded by people currently doing that job.

The findings of Brown et al (2000) reviewed in the first part of this chapter suggested that multidisciplinary team working reinforced adherence and allegiance to professional identity. However, the literature reviewed here would suggest that interprofessional education, interprofessional practice placements and the development of a professional identity early on in professional training would support and enrich multidisciplinary team working. This evidence suggested that the development of a professional identity early on within prequalifying training could positively influence the success of interprofessional learning. Today, IPE forms part of an array of educational and developmental programmes across organisations, but there is no consensus on the extent to which it may influence the development of professional identity, and whether participants should be exposed to IPE at a pre-or post qualifying level.

Interprofessional Education

The working definition of IPE in this thesis is occasions where professionals learn with, from and about each other, and in doing so develop their understanding of how professionals can collaborate in practice.

This definition incorporates any setting where opportunities for IPE might arise, including taught and informal practice based experiences. Sharland et al (2007) undertook a review of IPE relating to qualifying social work programmes which aimed to provide a systematic evaluation of research and knowledge around IPE. They found that for over half of the 42 studies included in the review, the drivers behind the development of the IPE opportunities were policy-based, in response to changing models of service rather than being based on any specific theoretical standpoint on IPE.

There is also a lack of consensus within the literature available as to what stage of education IPE should be introduced. Adams et al (2006) summarise that the spectrum of opinion ranges from introducing IPE early in the first year of training to encourage positive attitudes to other professionals, to leaving it until postgraduate level when it is assumed that an individual will have formed a clear professional identity.

Barr (2000, p177) noted that

"To rationalise that (issues of curriculum redesign) interprofessional learning is best held over until the post qualifying when curricula are less constrained by profession specific requirements"

However, he goes on to stress that newly qualified professionals will be required to work in a multidisciplinary setting as soon as they are qualified. This challenge is further complicated by the fact that postgraduate study opportunities may not be available to many.

IPE at post-qualifying level; challenging stereotypes.

IPE at the postgraduate level has been in the UK since 1985 when the University College Salford developed a multidisciplinary post-qualifying degree in health and welfare. Since then, there have been a number of postgraduate courses and formal and informal learning opportunities where professionals have been brought together, particularly in the mental health field, to learn about specific topics of interest across groups. Wood (2001) suggests that IPE at a post-qualifying level is more likely to be successful due to be confidence, maturity and knowledge of the world of work that participants will bring, alongside experience of reflection on own practice. At post-qualifying levels, it is perceived by some that individuals have the confidence in their identity and professional insecurity is minimised (Hall & Weaver, 2001; Mathias, 1997).

However, those that have already undergone qualifying training programs and may well have a number of years experience in the practice setting, will have well-developed professional identities, and addressing the stereotypes and prejudices that they may hold towards other professions is a challenge for IPE. Dickenson & Carpenter (2005) warn that educators should be cautious about the expectations of the impact that IPE can bring to bear on attitudes and stereotypes in postgraduate study. They draw upon the work of Allport (1954) whose ‘contact hypothesis’ proposed that to address negative attitudes and stereotyping, participants from different professions need to be brought together in an environment where power and status are perceived to be equivalent, and goals are shared.

Carpenter et al (2006) published findings of a longitudinal study of the impact of a post qualifying IPE programme for mental health professionals on stereotypes of professional behaviour. Unsurprisingly, they found substantial evidence of stereotyping amongst the disciplines taking part on the courses, but what is surprising is that the study did not find any evidence that these stereotypes were challenged, altered or reduced in any way as a result of taking part in the programme. Carpenter et al (2006) suggests that this may be due to the fact that participants were forward thinking, experienced professionals who were willing to undertake an IPE programme, and they viewed colleagues as being of a similar mindset. As a result, they did not transfer any negative or positive experiences of fellow students to colleagues of similar professions within their own workplace.

One possible explanation for this is that the course programme did not provide the right conditions to bring about change to counteract everyday experiences the students encountered in the workplace. Most importantly, Carpenter et al concluded that attendance on an interprofessional course appeared to have only a marginal effect on students' professional identities, with evidence of respect of and need for different professions. These findings supported Carpenters' (1995) view that if IPE is to have a positive impact on professional identity and positive views of other professionals, it has to take place before negative stereotypes have been formulated via uni-disciplinary training or socialisation in the workplace.

The impact of IPE and socialisation at a pre-qualifying level on the development of professional identity

This thesis aimed to explore the impact that IPE may have on the development of professional identity if experienced at a qualifying level. The literature indicated that IPE is often resisted or undermined by professionals who are determined to ensure the maintenance of the cultural

identity, authority of their profession. Ovreitveit et al (1997) suggested that the introduction of interprofessional pre-qualifying programmes may be a bridge too far for professionals concerned about the maintenance of the professional culture. However, the responsibility to prepare professionals for practice within a multidisciplinary service lies here, and evidence needs to be sought to determine whether IPE at the pre-qualifying level achieves the level of preparation and interprofessional understanding required, and how this affects individual professional identity.

Despite many mental health professional roles overlapping, professional training courses rarely cover roles and skills of other mental health professions. Peck & Norman (1999) suggested that professionals are not effective in establishing relationships with other professions to develop collaborative approaches within multiprofessional teams because cultural and value differences are held by group members. They concluded that the qualifying training cultivates these differences early on, which are maintained and reinforced by professional socialisation. This view was supported by a review undertaken by the Workforce Action Team, following the introduction of the NSF (DoH, 1999; DOH, 2001b). This national review of the mental health workforce concluded, in specific reference to psychiatry and psychology training, that the doctoral level programmes which required a minimum of five years training from entry did not equip staff with the skills to work in multidisciplinary teams outside of a hospital setting. It concluded that professions undertaking pre-qualifying education in isolation from each other resulted in confusion about roles and expectations, which in turn created problems for communication in interprofessional situations. The introduction of IPE into a broad range of health and social care qualifying and post-qualifying programmes would have significant financial and labour implications, so to this end the development of a body of evidence to support its effectiveness is required.

Barrett et al (2003) reported the complexities and challenges faced by a Faculty of Health and Social Care when designing and providing IPE at a pre-qualifying level. The project involved the development of an IPE element across 10 pre-qualifying training programmes at the West of England University. A core aim of the programme was to preserve and possibly enhance the identity of individual professions whilst extending the skills of interprofessional and interagency collaboration. Therefore, professional skills including professional confidence and competence were seen as a key priority. This project, which involved a longitudinal study of comparison (commencing in 2002) and intervention groups (commencing in 2003), has become known as the New Generation Project (Hean et al, 2006). A number of papers have been published detailing the processes involved (Meirs et al, 2003; Adams, 2006; Hean et al, 2006), but the results, regarding the overall impact and success of the programme on enhancing interprofessional collaboration, are yet to be published.

Local NHS and social service departments were consulted to ensure that the full range of skills and competencies required within the practice settings were addressed within the module development. Where possible students from professional courses with similar knowledge bases were enabled to access shared learning modules. The study involved 700 students taking three interprofessional modules, one in each year of study throughout the 3-year programme, and students were taking a range of health and social care qualifying awards, including nursing social work and operational therapy. IPE was introduced as early as week six in year one, with a further IPE module in year two and three. The project team decided to use an enquiry based learning approach as it was felt that this would best replicate the MDT working environment. There was also a specific focus on reflection in action and relation of IPE module content to real-time cases on placement or from experience.

The main problems encountered by Barrett et al in the development of the curriculum were around timetabling and arguments within the team regarding which scenarios would be prioritised. Faculty staff also attended workshops facilitated by external consultants in order to provide a degree of independence. The pitfalls identified were similar to interprofessional working; the use of different language, professional protectionism and lack of understanding of professional role were all obstacles that had to be overcome. Barrett et al concluded that IPE experiences fuelled interest in the roles of other professions students and engendered collaboration both within the university and placement context.

Barrett et al utilised an enquiry-based learning approach to positive effect across the professions. Lindqvist et al (2005) utilised a case based learning approach in a project aimed at measuring the impact of the training on interprofessional attitudes. The project involved 96 students from five prequalifying health programmes, 46 undertaking IPE modules and the remainder forming the control group against which the effects of IPE on attitude towards other professions could be measured. An interprofessional attitude rating scale devised by Parsell & Bligh (1997) was used at the beginning and end of the study. In addition, group members were asked to share their views about the learning experience after the 9-week long intervention. Their approach drew on the work of Hewstone & Brown (1986) and their ‘contact hypothesis' which suggests that attitudes towards other professions can be improved significantly by professionals interacting with each other in different situations, including learning environments.

The students were allocated to mixed groups and at the first meeting were given the main learning objectives for IPE participants;

“Identify key principles that facilitate successful interprofessional team working; reflect on why effective interprofessional practice (IPP) is important to patients; reflect on their own

role as health professionals and begin to learn about the role of other health care professions; and begin to understand the benefits of and constraints to good interprofessional team working". (Lindqvist et al, 2005. p 513.)

Weekly meetings across an eight-week period would take place in which their group would discuss case scenarios which would enable exploration of professional roles and multi disciplinary team issues relating to professional roles. A repeated measures analysis of variance (ANOVA), multivariate ANOVA (MANOVA) and Tukey's test were used to compare the data.

The study found that case-based learning between the five professions did have significant effects on participants' attitudes towards other health care professionals. The attitudinal scale administered at the beginning and end of the intervention highlighted specific changes in how students perceived other professions in relation to 'caring ' and 'subservient' roles.

At the beginning of the study participants rated nurses as the most caring and subservient, whereas doctors were seen as the least caring and the least subservient. The final rating scale at the end of the study revealed an increase in perception of 'caring' across all professions. This was also consistent across the control group. The repeated measures analysis of variance indicated there was an attitude change overtime for all students which indicates that merely by partaking in the student programme attitude towards other professionals was improved. The intervention group saw an increase in the rating of other professions as more caring across the board, in comparison to the control group who did not. There was also a change with regard to the rating of occupational therapists' subservience, which was lower in the intervention group and the control group at the final questionnaire. The findings of this study indicated that IPE could influence change in perception of and attitudes towards other health care professionals in pre-qualifying training.

Whilst this study provided evidence for the usefulness of case-based approaches in interprofessional education, the over reliance on quantitative methodology and statistical analysis gives a narrow measure of outcomes, i.e. only rating of the degree to which they agreed or disagreed with the researchers' statements is evidenced. Whilst the aim of utilising an attitude scale, multivariate analysis and post hoc tests is to provide robust evidence in support of the intervention, the realism feel that a qualitative approach would have given is lost. There are no examples of the terminology or language used to describe the students' experiences. Additionally, in relying on quantitative methods, the disproportionate numbers in intervention and control groups weaken the result, although this is not explained fully within the report. (Control group was half the size of the intervention group: 24/ 46 first questionnaire; 13/39 in second questionnaire)

These findings supported the research questions that form the basis of the current study exploring the potential impact that IPE within taught and multiprofessional placement environments can have on the development of professional identity. Whilst Lindqvist et al's (2005) study provides evidential value of the case-based approach within interdisciplinary training programmes, it is limited to the formal teaching input and does not address the informal, practice situation-based learning. The practice educator is a key role in linking formal taught training programme elements to the experiences encountered within the practice placement setting. Mulholland et al (2005) assert that the practice educator role is to enable students to reflect upon and analyse the experiences in practice, in relation to the underpinning theoretical frameworks taught at university.

Supporting practitioners in delivering IPE on placement

An important factor in the delivery and planning of effective IPE programmes is the need to prepare the socialisers, the clinical practice teachers and supervisors for interprofessional

attitudes and training students from different professions. Ovreitveit et al (1997) analysed the effects of an innovative project, conducted between 1990 – 1995, that encouraged the joint training of practice teachers and clinical supervisors in nursing, occupational therapy and social work. Known as the Joint Practice Teaching Initiative (JPTI) and established by CCETSW, it recognised that practice teachers and supervisors had a key role to play as trainers and socialisers of the next generation of professionals within the work context. The project involved negotiations between professional bodies about validation for statutory requirements and was influenced by the national controversy about taking National Vocational Qualifications to level five (professional level). Over the five year project, JPTI was piloted at 12 sites across the UK and five jointly validated programmes were run and evaluated in England. The project entailed the formulation of core curriculum modules of practice teacher training which could be shared by all professions. The projects success was limited. A number of pilot courses were successfully completed but a fully accredited mainstream course did not emerge from the project. The authors felt that the main contributing factor to the lack of success was 'mistrust and scepticism' on the part of professionals. Ovreitveit et al stated that 'there were underlying concerns interprofessional training was an alternative respectable language for de-skilling'. (p 144) Following the pilot courses, Ovreitveit held a workshop for project leaders and asked participants to list the positive and negative features of the joint training from their experiences (p 137). Amongst the positive features were an improved understanding of each other's roles, enabling creative thinking across organisations and professions, maximising a range of skills available to provide better services for consumers. Some of the negative features were a threat of weakening or dilution of professional status, tribalistic behaviour as a defence mechanism, and incompatible language and terminology.

Ovreitveit et al concluded that professions would justifiably fight to maintain separate identities and the development of profession specific skills and knowledge. They did not feel that there was a case for general or generic approaches to education and training. However, they identified a need to create new opportunities for understanding and for the prevention of fragmentation and separation between professions.

Mulholland et al (2005) assert that effective interprofessional learning depends on clinicians, practice supervisors and educators being able to help a student apply theory learned in the classroom to the day-to-day experiences within the work environment. They need to be able to encourage and enable a student to reflect on their experiences in a way that draws upon the interprofessional context in which it occurs.

Martin (2005) supports this view, asserting that the practice environment should be the central focus in IPE curriculum development, drawing on the formal planned taught elements within the university setting, formal opportunities to learn alongside others, and informal learning opportunities across all contexts, including the placement setting.

Martin (2005) develops this argument further, by suggesting that a curriculum that offers opportunities across a range of multidisciplinary environments will equip students with a broad understanding of the core generic skills, values and competencies held by health and social care professionals. She argues that this will be in addition to an in-depth understanding of skills, values and competencies of their own profession.

Martin suggests that as a result of practice educators providing good role models for students through effective interprofessional practice, students will

"Acquire the codes of behaviour, belief systems, language, customs, and rituals of their chosen profession but they will also acquire those of a health care professional who values interprofessional working." (p56)

Bowden & Marton (1998) suggest that we need to equip students with the skills and competencies to deal with any eventuality or predicament they may find themselves in. Work based learning situations are unplanned and to a certain extent cannot be dictated or controlled by the placement supervisor/ assessor or the educationalist. They suggest that to gain the skill and ability to deal with unplanned situations in different settings we need to help students identify the significant factors that arise in the scenario that are challenging or new, and to be able to utilise a framework that amalgamates professional and disciplinary approaches. They argue that this essentially would be equipping them with a toolbox of the range of approaches that can be altered or adapted to deal with any situation, rather than a limited range of specific approaches or tools that they have been encouraged to become expert in.

Wenger (2000) presents the notion of communities of practice, suggesting that they are

"Building blocks of the social learning system because they are the social containers of the competencies that make up such a system". (p229).

The communities of practice model argues that members of the professional community decide and agree amongst themselves what constitutes good practice, competence and expected standards of behaviour, and that by being a member of that community individual professionals undertake to uphold and protect those standards. A key point that he makes relates to the '*shared repertoire'* that members of the community will have, which may include ritual practices and processes, a unique vocabulary with a shared understanding of

meanings, which will all form part of the culture of that community. Within this framework, students will develop a professional identity that fits within that particular community of practice, which within multidisciplinary mental health teams will constitute many disciplines. What is unclear is how confusing this may be for prequalifying students who experience this socialisation process within a number of communities of practice across the three years of professional training, and whether these provide complimentary or conflicting messages for their professional identity development.

Summary

The literature reviewed in this chapter examined the concept of professional identity, and explored the impact of socialisation and interprofessional education in both taught and practice based environments at a pre and post-qualifying level on the development of professional identity.

The selection and presentation of literature supports the study of the development of professional identity at a prequalifying level; comparing students who have experienced taught interprofessional training opportunities and placements to those who have not, and examining subsequent changes or development in professional identity.

Chapter two, entitled ‘Metholodolgy’, presents a rationale for selecting Social Constructionism as the theoretical perspective underpinning the design of the study and discusses reasons for selecting discourse analysis as the main method of data analysis.

Table 1; Literature Review Flow Chart

Government policy

NSF 1999 called for better interprofessional working & consistency in service delivery. **CPA 1990b** introduced generic care coordinator role across professions. **NHS Plan 2000**. Introduced functional specialist teams, new non-professionally affiliated roles. Policy Implementation **Guide 2001** .Prescribed workforce focussed on established professional roles.

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Views on the MDT model

Onyett et al 1994 & 1995 & Onyett & Ford 1996. Advocated MDTs are successful approach that utilises broader general skills within professions. **Galvin & McCarthy 1994 & Searle 1991**. Interdisciplinary working rather than MDT working to make use of broad range of professional skills.

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Impact of MDTs on professional identity

Onyett et al 1994 & 1995. Onyett & Ford 1996. MDTs can have a positive impact on professional identity, better management could resolve problems encountered. **Carpenter et al 2003**. MDT design and function as an environment in itself did not impact on professional or team identification.	**Brown et al 2000. Galvin & McCarthy 1994.** Role blurring a result of genericism in MDTs which can engender rivalry and a desire to protect professional boundaries. **Norman & Peck 1999.** Professionals do not understand each other's roles & skills. This is a result of uni-disciplinary training experiences **McCrae et al 2004.** Developed a 'typology' that describes different positions taken on generic versus professions argument.

↓

Identity

Epstein 1978, Soddy, 1961, Turner 1999. What is an identity & how is it developed.

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Professional identity – where & how it is developed

Wenger 2000. Professional identity formation through community membership. **Cohen 1981.** Professional identity is developed in the practice setting. **Whittington 2005 & Hind et al 2003.** SCT- group identification theory. **Laidler 1991, Dombeck 1997.** Professionals need to feel secure in their own role & professional identity before they can share expertise in the MDT environment. Territoriality – individuals develop professional identity by differentiation between disciplines.

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Factors that can influence the development of professional identity

Whittington 2005. IPE at pre registration training can promote professional identity, increase confidence and raise awareness of others. **Wenger 2000.** Communities of practice and social learning. **Cohen 1981.** Involves gaining insight into professional practices and the values of that profession. **Dombeck 1997.** Societal expectations of professional role. **Wittington 2005 & Hind et al 2003.** SIT & Self Categorisation Theory ; Shift from individual identity formation to group identification and associated group identities.

↓

Professional socialisation and work placements

Adams et al 2006. Pre- existing professional identity in experienced students professional socialisation through critical experience	**Melia 1987. Adams 2006. Caley 2001.** Socialisation provides an opportunity to test out theoretical perspectives in the real world.	Professional socialisation can develop through Informal and work based-learning experiences **Hall & Weaver, 2001, McGowen & Hart 1990, Bandura, Kaiser & Muscari 1999, Cohen 1981 & Mires et al, 1999.** Students through exposure to practices and values of the profession construct their professional identity. **Martin 2005**- students become encultured into the community body of knowledge. **Dombeck 1997.** Professional personhood developed in the workplace. **Robson 1998** the practice placement setting heavily influences the development of professional identity

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IPE; Pre or post qualifying

Carpenter 1995. IPE should be in first year of training, to inhibit the formation of negative attitudes towards other professions. **Barr 2003.** IPE should involve pre-qualifying students learning together to prepare them to work collaboratively. **Whittington 2005.** IPE at pre registration training can promote professional identity, increase confidence and raise awareness of others.

Adams 2006. Spectrum of opinion on when IPE is best placed that ranges from pre qualifying to post graduate training level.

Hall & Weaver 2001, Barr 2002. IPE may be better introduced late in training once professional identities have been developed and they have the confidence to share & challenge others. **Wood 2001**. IPE post graduate more successful due to maturity & experience of participants.

↓

IPE at post qualifying level; Challenging stereotypes

Allport 1954. Dickenson & Carpenter, 2005. Contact hypothesis; putting people together in training situations is not enough to bring about attitude change. **Carpenter et al 2006.** Found that professional identity and stereotyping behaviour was not affected by attendance on a Post Graduate IPE course.

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The impact of IPE and socialisation in pre-qualifying training on development of professional identity

Lindqvist et al 2005. Found that IPE had a positive impact on students' attitudes to other health care professions. **Barrett et al 2003** found that IPE fostered a positive attitude towards working together in both the learning and practice environment. **Peck & Norman 1999, WAT 2001.** Interprofessional collaboration within MDTs can be enabled if the values and cultures of other professions are understood at pre qualifying level. **Hewstone & Brown 1986.** Attitudes can be improved via a multi disciplinary learning environment. **Sharland et al 2007.** Studies on IPE are focussed on method rather than outcomes.

Ovreitveit 1997. Uni - professional pre qualifying programmes may be 'a bridge too far' for many and be perceived as a threat to professions.

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Supporting practitioners in delivering IPE on placement

Ovreitveit et al 1997. Professionals are threatened by IPE and will want to ensure that profession specific knowledge and skills are maintained.

Wenger 2000. Social practice theory- placement settings are 'communities of practice' where students can develop a shared language and common understanding amongst professions. **Bowden & Marton 1998.** Educators need to equip students with a toolkit that amalgamates disciplinary approaches that can be utilised in a range of situations. **Mulholland et al 2005.** The key role of practice educators is to enable students to apply the theory they have been taught in the classroom setting in the day to day environment. **Martin 2005.** The practice placement environment is central to IPE curriculum development, as students will get generic & specialist skills.

CHAPTER 2. METHODOLOGY

This chapter outlines the aims of the thesis, its theoretical perspective, the research design, the methods used to conduct the research, and a rationale for the choices made.

Inspiration for the research design was drawn from a study exploring professional socialisation. Conducted by Robson (1998), it used a single case study to track the journey of one further education teaching student throughout the course. Based on reflexive interviews, participant observation and secondary data analysis in the form of coursework, Robson collated data that gave an insight into the planned and unplanned elements of her training programme, including relationships and interactions with students and colleagues in the workplace, and fellow students at university. The analysis addressed a number of key themes including how her learning and development was facilitated, and the various ways that the knowledge and experience of qualified teachers was assimilated and processed. It also focused on the student's identification with and separation from colleagues in the workplace and other students on the course.

Since my thesis aimed to explore the potential impact of socialisation in the form of practice placement based experience on the development of professional identity, I felt that Robson's longitudinal case study approach would work well with a larger sample. I did not replicate her study however, since observation would have been extremely time consuming, and as a part-time doctoral student in full-time employment, this option was not feasible. I did however choose to use semi-structured interviews to gather data on the impact of IPE within taught and practice placement environments. Secondary data was also utilised in the form of analysis of course syllabii to identify relevant features relating to professional identity, understanding of one's own role and that of others within course design.

2.1 Aim of the thesis

The aim of this thesis was to explore the development of professional identity and understanding of role and those of others in mental health student nurses/ OTs/ social workers throughout their first year of training, with specific focus on interprofessional learning experiences within taught and practice placement environments.

The thesis focussed on the following questions;

- **To what extent do taught interprofessional education opportunities in the first year of training impact on the students' development of professional identity, understanding of role and the understanding of other professions?**

The thesis explored whether the students perceived that they had a professional identity at the start of their training, the perception and articulation of which was revisited at each interview stage. The students understanding of the common approaches and underpinning values of the profession and their understanding and knowledge of the roles and values underpinning other professions was also explored at each interview stage.

- **What impact does informal Inter Professional Education in the form of practice placement experience have on the development of students' perceptions of their professional identity, understanding of their role and those of other professions during the first year of their qualifying programmes?**

The thesis explored whether the experiences within the placement setting had an impact on the perception or development of the students' professional identity, understanding of their role, and understanding of roles of other professionals within the team.

2.2 Theoretical perspective

Seabold (2006) defined methodology as the theoretical underpinning knowledge of how research should be undertaken which informs the methods chosen to gather and analyse data. Methodology refers to the underlying assumptions and philosophy that form the basis of a study, drawing on the epistemological perspectives of the researcher. The thesis sought to develop a full description of the elements of the student nurse/ OT/ social work training experience that may have an impact on the development of their professional identity. Specific focus was placed on interprofessional learning experiences and multidisciplinary work- based placements.

This thesis intended to explore the attitudes, opinions, beliefs, feelings and experiences of a small student population in relation to professional identity. This required an approach that could explore participants' perceptions of reality from their own viewpoint, and enable the researcher to explore factors that might influence the construction and maintenance of those perceptions.

Qualitative research is an attempt to gain participants' perspectives on a particular subject, including beliefs, concepts, experiences and perceptions. Qualitative methodology is inductive; data is gathered using various methods, then the researcher works with the data to develop theories. Brymon (1988) and Marsh (1982) suggested that the distinction frequently drawn between quantitative and qualitative research is that the former tends to be oriented to the specific concerns of the investigator and the latter to the participants' perspectives.

However, the social constructionist framework can help us to examine constructs of meaning in relation to professional development and identity by examining the discourses presented. As

such, a qualitative approach was identified as the most appropriate method to explore participants' own perspectives of their development throughout their first year of training.

The Social Constructionist perspective

Social Constructionism is a way to describe how individuals and groups actively contribute to the construction of their own day-to-day reality. In this thesis, the ways in which students interpret their experiences and use them to develop their concept of professional identity have been identified and explored in terms of constructs to explore factors that may have influenced development. The social constructionist perspective holds that there are many perspectives on perceived reality, and the media is that is used to convey these perspectives, such as texts or discourses may vary immensely but are all equally legitimate as they represent the world as the constructor or group of constructors see it.

Burr (1995) described a 'family resemblance' or shared characteristics that most social constructionists have in common, which include a critical perspective on assumed knowledge, a belief that knowledge is historically and culturally specific, and a focus on the role of social processes in sustaining knowledge. Berger and Luckmann (1966) identify three key elements that they feel contribute to the social creation and sustenance of social phenomena. The first is 'externalisation', where an individual will create or produce something such as a written text, which can then be read and re-read, told and re-told so that it becomes lodged within the society's consciousness. They describe this as 'objectivation', as it is something real that exists out there in the social world. As this becomes embedded within the socially agreed knowledge, newcomers to the social group or future generations accept this truth or construct as part of the known world, which Berger and Luckmann refer to as 'internalisation'.

A social construction, or construct, is a view or perspective held by individuals which to them will be completely normal, although it will be one that has been developed and accepted

within their particular culture at that particular time. Ernest (1999) described social constructs as representations of human choices rather than laws resulting from divine will or nature. In the context of the present study, the societal view and implied responsibilities of being a nurse have been developed by and maintained through the specific culture of that society, which can vary greatly across cultures throughout the world, and across time.

Expanding on this example, the social constructionist framework allows us to see the continually changing environment in which mental health students' work and learn as a dynamic, continually evolving curriculum. This view contrasts with the more 'obvious' one, where the first-year curriculum for students provides external pre-determined events and experiences which in turn, dictate what happens to individuals. The experiences of these students during work placement and inter-professional learning situations are represented by and contained within their discourse. This can demonstrate how each student makes sense of the experience within their own respective perceptions of reality at that time in their professional development and which, after analysis, will reveal a cultural construct particular to that environment.

Professional discourse and intersubjectivity

Rogoff (1990) discussed the notion of 'intersubjectivity', which describes how an agreed language can be constructed between people based on social interactions and common understanding and experiences, which then forms the basis for the development of ideas, rules and practices that are socially agreed-upon. These norms and practices are accepted within the social group and then form the basis from which all new information is processed and understood.

McMahon (1997) suggests that the framework of reference lies within the community, and resides within cultures in the interactions between people and their environments. When the

members of the community accept the same intersubjective meanings, new knowledge and activities can be developed around this framework of meaning.

In this thesis, the context representing 'community' relates to the respective professions of nursing, social work and occupational therapy and the intersubjective agreed meanings residing within those professional groups, which students were exposed to in classroom and placement contexts.

Socialisation and the constructionist view of learning

According to McMahon (1997), learning is not separate from any other social processes within the social constructionist framework. Although individuals may have different learning styles and methods, it is through their interaction with other members of the social group that they will be able to apply meaning to what they have learned, to contextualise the information. For the mental health students in this study, this may take the form of the practice placement, the classroom-learning environment and the associations made therein.

Gredler (1997) suggested that for social constructionists, learning has to be developed and interpreted around the range of contexts and settings students find themselves within. Gredler describes a *situated approach to learning* that centres around the environment of the student, that takes into account relationships with key individuals in those surroundings. Gredler argues that environment is pivotal to the learning process, as individual or relationship change within the environment within which the student is situated can affect the roles and expectations of that student as an individual. Wenger (2000) supports this view in his description of a social learning system, which within the social constructionist view of learning places competence and understanding of role within a particular moment which is culturally and historically situated. He suggests that

"Knowing, therefore, is a matter of displaying competencies defined in social communities".(p 226).

To social constructivists then, knowledge cannot be created and learnt in isolation from the society and culture in which we reside, as the framework of reference we use to interpret knowledge is the environment we reside in, or within the context of this study, the learning and working environment.

These perspectives provide a framework to understand the processes by which professional identity develops and is reinforced through social interaction and relationships within the learning environment. This indicates that the journey towards the development of professional identity involves learning, the acquisition of new knowledge and the placement of both of these within a framework of social meaning.

The challenge for social constructionism is judging between competing discourses. People strive for truth or understanding the right way to do things, and much of our conversation and communication relies on how we perceive the messages in relation to this. People use different filters to decide how to categorise what they are hearing or reading, which can have different perspectives from the deliverer, which may be viewed or perceived in a totally different way by the receiver. These misunderstandings can cause friction and problems in everyday social interaction, but also provide challenges when considering the filters that the researcher may be using when analysing discourse.

Discourse analysis (DA) and its use as a methodology

Discourse Analysis (DA) as both a methodology and a method supports and underpins the social constructionist perspective. Discourse in the present study is held within the texts produced from the language in students' accounts describing change, reflecting the structures

surrounding students' reality and their current view of the world at a given moment in time. DA is a general term for a number of approaches to analysing written and spoken language in relationship to the contexts in which they are used. There are many ways of analysing discourse, but in the present work I based my approach on the Potter and Wetherell (1987) framework which uses discourse as a way of understanding how we construct meaning from human social interaction. Their approach is distinct from the scientific search for fact or truth in that they accept that the creators of the discourse have fabricated or created their reality by drawing upon internal references and experiences. This in turn has enabled them to create new perspectives in the light of exposure to new knowledge and ways of interpreting things within different contexts and environments.

DA enables the exploration of the values, beliefs, routines and customs that are demonstrated by professionals in practice settings. This required however, acceptance as the starting point that the socially agreed and accepted professional practices or 'the way we do things' were empowered and maintained through social interactions which were embodied and reflected within the discourse. In this sense, discourse analysis is an appropriate method within the social constructionist perspective to explore and reveal the processes that enable the creation of particular beliefs and perspectives within social or professional groups.

The power that language can have on maintenance of social belief systems needs also to be recognised. Foucault (1980) suggested that language in discourse can be shaped and controlled by influential or powerful groups, or in the case of health and social care professions those whom the wider society afford the most respect for. Burr (1995) stresses that discourse analysis as an approach to research rather than a particular method, *"As it is not possible to describe it adequately in recipe type terms" (p 163).*

She describes discourse analysis as a broad term which includes a range of research practices and methods that can span very different aims and theoretical backgrounds, but each draw upon language through texts. Burr proposes therefore, that discourse analysis can be both a methodology and the method utilised within research.

2.3 Research design and methods

The approach that informed the research design utilised in this study was Potter & Wetherells' (1987) 10 Step Discourse Analysis Model, which also informed the selection of methods. The following section describes rationale for the decisions made in relation to the current study utilising the 10 step format:

Step 1; Define research questions

Step 2; Sampling

Step 3; Collection of records & documents

Step 4; Interviews

Step 5- Transcription

Step 6; Coding

Step 7; Analysis

Step 8; Validation

Step 9; Write up

Step 10; Application

Step 1: Define research questions

The development of the research questions has been addressed in section 2.1.

Step 2: Sampling

The selection of first year students enrolled on nursing, occupational therapy and social work courses were chosen as these professions are found in the majority of multidisciplinary team workforces within mental health services. Nurses undertake a one-year generic nursing

programme before embarking on their two-year specialist branch programme. To this end, nurses applying to study the mental health branch were invited to take part in the study, although it was understood that they would be undertaking generic nurse training for the duration of the study. Social work and occupational therapy students undertake a generic programme of study without specialising or choosing a particular pathway, although they can request placements with specific client groups.

Psychologists were excluded from the study as their undergraduate degree is not a professional qualification and does not involve assessment in practice situations. By the time psychologists undertake their clinical training, they will have completed at least 3 years study and in most cases have undertaken a number of psychology assistant posts, and have therefore been exposed to 'professional socialisation'. Similarly, psychiatrists were excluded as the first year of their core medical degree does not entail assessment on multidisciplinary placements, and by the time they commence specialist training in psychiatry they will have completed seven years of medical training and will have been exposed to professional socialisation.

The first research question related to whether students perceptions change during the first year of their qualifying programmes. For this reason interviews were scheduled on three occasions; on entry to the training course within the first two months to establish their initial views, feelings and perceptions; at mid point during their first year (between five and seven months into their training) and at the end of their academic year on the completion of their multidisciplinary placement. All nine students would be interviewed three times, totalling 27 interviews in all. This approach enabled changes in students' perceptions over the course of their first year of pre- registration training to effectively be 'tracked'. The final interview was especially significant as it attempted to capture any change in perceptions following their multidisciplinary work placement and any IPE experiences.

As three interviews would be conducted with students throughout their first year, it was felt that a small sample would be preferable to achieve an in-depth analysis of each student's journey. As discourse analysis can reveal a large range of variations in linguistic patterns from a small sample it was felt that a large sample would present challenges to analysis that would outweigh the added value. Three participants were recruited from each profession, totalling nine participants in all. For comparison reasons it was important to get a balance between ranges of experience and to allow for drop out from the study. To avoid amassing more data than could be processed it was decided that nine participants would be selected. I chose to restrict my study to one year, for two reasons. First, to enable the completion of the study within the time constraints, and secondly because the placement arrangements varied greatly between the three courses across the two universities following the first year and it was felt that to enable any comparisons to be made, only the first year of study would be included.

Recruiting strategy

The original recruitment strategy was to access a purposive sample constructed to serve a very specific purpose. Wilmot (2010) suggest that the criteria used to select a purposive sample is more important than the number of participants recruited, although knowledge of the target population is necessary to effectively carrying out purposive sampling. The target group for the current study were first year pre qualifying students from the three courses identified, with an additional criteria of having an interest of working in mental health services. This was a simpler task in relation to the nursing participants, as course students whom had enrolled upon a mental health branch course were targeted. Three nurses were recruited with ease with assistance from the University. Only one OT and one social worker were recruited this way, however. As both social work diploma students and occupational therapy degree courses are generic, identifying students who were likely to experience a mental health practice placement

was problematic, as mental health placements were not guaranteed for all students who expressed a preference. Research study information given to prospective participants made specific reference to participants required who had an interest in working in mental health settings.

Patel et al (2003) suggest alternative strategies that can be implemented to augment recruitment include making presentations to potential referrers or participants through arranged meetings, forums and road-shows. Whilst mental health interest and tutorial groups had been targeted via a course lead for OTs and social workers, there were no further recruits so I opted for the snowball sample method. After interviewing OT B and social worker A, the researcher asked participants for assistance to help identify fellow students with an interest in mental health who may be interested in participating. A further 2 OT's and two social workers were recruited this way.

This approach is a further subtype of purposive sampling, which was achieved by asking recruited participants to suggest or recommend other student colleagues who may be interested in taking part in the study. Atkinson and Flint (2001) suggest that snowball sampling can be of particular use where making contact with potential participants is difficult. They suggest that the process of being referred by someone who belongs to a particular group may infer acceptance or membership of the group, has been trustworthy or acceptable. These approaches are often helpful when research requires participation from hard to reach groups, such as abused women or illicit substance misusers. Whilst I recognise that this study's population were not as difficult to access, willingness to trust in a researcher that was from outside organisation may have been an issue.

However, the potential for sampling bias is increased when using this sampling technique, as the initial subjects I approached would have been likely to nominate people that they know well. Because of this, it is highly possible that the participants could share similar traits, values and opinions. In this case, it is possible that the sample could represent a very small subgroup of the entire population of the student cohort.

Potential participants were given a briefing sheet containing details of the study and what would be expected of them if they chose to participate (Appendix E). Those that agreed to participate were then asked to sign a consent form for the use of their recorded interviews as part of the research. Participants were also given written reassurances of their rights to withdraw, confidentiality, and the responsibilities of the researcher to them (Appendix F). Basic demographic information was taken from the participants (Appendix G) and each was asked to choose a pseudonym for use in the study. These pseudonyms were utilised in the transcripts and demographic information (Appendix G & J) although each participant was referred to by occupational code and letter within this thesis (eg, OT A, SW B). As a practical consideration, with the intent to enhance the subject's feeling of security, the participants were sent some basic information and contact details at an early stage so that they were able to evaluate and verify the identity and legitimacy of the researcher.

Step 3: Collection of documents

Potter and Wetherell (1987) suggest that the use of secondary documents alongside primary data collection is a positive addition to the methodology as the researcher cannot influence this data in comparison with the interview transcripts, regarding linguistic practices.

A review of secondary data, in the form of course syllabuses (Appendix B, C & D), was undertaken. A content analysis approach was used to identify occurrences of reference to the four key areas:

- Professional Identity
- Core skills and values of the profession
- Descriptions of IPE opportunities and
- Practice placement elements.

In addition a comparison of module content throughout the first year was required. Once permission to approach students had been granted, a request was made to the course tutors for copies of the course syllabus for the year 2004/2005 (Appendix B, C & D). Supplied to students on entry to the courses, it was felt that the syllabus would be the most appropriate documentation for two reasons. First, it was anticipated that the institutions would be willing to share this document since it was already in the public domain. Secondly, it was assumed that the syllabuses would provide insight into the perspectives of the educators and their views of the process that they believe would best prepare their students for practice. In all cases, the document provided by course leaders was in the format of a course handbook. Written for students rather than educators, these documents described the aims and outcomes of the course in broad terms, rather than providing specific details of competencies achieved and levels of understanding reached. Incidentally, this was not what I had expected.

A conceptual content analysis approach was used to analysing the texts as the required outcome was to identify the presence of key words and phrases relating to these four areas of interest.

It was important to check how these four key areas were addressed and presented within the literature that prospective students of these courses would have access to. Brown & Dowling (1998) suggest that a particular strength of the content analysis approach is that it looks directly at communication as a vehicle for social interaction via the texts. This is supported by Nevendorf (2002) who describes content analysis as enabling the researcher to look beyond the message and focus on how and why it has been presented in the way that it has. Within the current study it was felt that an analysis of the course syllabuses could give insight into the importance and significance assigned to each of these aspects within the course prospectus as 'important' or 'relevant' for students to read and understand at this early stage of their training.

As a qualitative and interpretive approach, reliability and validity issues are widely debated. Graneheim & Lundman (2004) argue that content analysis can be seen as attempting to draw meaningful inferences from a text that may have multiple meanings which can be interpreted in any number of ways. Krippendorff (2004) argues that choice of concept categories for analysis and logical fit within the context in which they are used can heavily influence validity. Within the current study the analysis of discourse within the interview transcripts was designed to be conducted once the content analysis of course syllabi documents had been completed, to contextualise individual students' experiences.

Step 4: Data collection; Semi-structured interviews

Carpenter et al, (2003), Hind et al, (2003); Adams et al, (2006), Barnes et al (2000); and Linquist et al, (2005) reviewed in chapter two, utilised self-completion survey questionnaires. The advantage to this method is being able to produce data which can then be compared with other sources, i.e.; asking the same question to different groups affords the opportunity of

conveniently assessing perspectives of different cohorts over a variety of issues. Self-completion surveys are characterised by systematic measures, made over a series of cases, and consistent variables are analysed to identify possible patterns.

Brown et al (2000) and Robson (1998) used semi-structured interviews in the study of professional identity. In both of these studies interviews were an effective means of accessing information that can be difficult to observe or gain from a self- completion questionnaire, such as emotions, feelings and responses in the day-to-day spoken language of the participants. The advantage that interviews have over self-completion surveys is that complex questions and issues can be discussed and clarified at the point at which they arise. The interviewer has the opportunity to delve deeper into participants responses, to follow particular lines of argument that have arisen unexpectedly, or to encourage the participant to elucidate on a brief response. This depth of questioning through the use of open-ended questions affords high validity to the method.

However, there are disadvantages with semi-structured interviews. Whilst the method yields a depth of personal information, samples tend to be small and this means losing the opportunity to draw definitive conclusions about the populations from which the sample is drawn. In addition, successful interviews require a certain level of expertise on the part of the interviewer to build rapport and ask questions appropriately, and also on the part of the participant the ability to give detailed responses. Interviews can also be time consuming and thus expensive. Furthermore, the more in-depth an interview is the longer the transcript will be which will provide challenge during analysis to derive relevant themes.

The development of an interview schedule can help the interviewer to keep a focus on the main questions, in an attempt to ensure consistency of order of questioning and nature of

question across the participants. It is likely, however, that the interviewer may not be able to ask the same questions consistently in different situations with different participants, particularly where participants are probed further on responses.

The use of an interview schedule offers a more systematic and comprehensive approach whilst allowing the discussion to remain informal, which in turn enables the interviewer to develop the rapport required with the participant to encourage them to give honest and open answers. This method is especially effective when deployed in areas where underlying attitudes and values need to be teased out. Whilst data from interviews can be much harder to analyse, the richness of the material is required to carry out a discourse analysis. Based on the advantages and disadvantages outlined above, semi-structured interviews were the chosen method of data collection

A semi-structured interview schedule was constructed around the three key research questions (see appendix A). The interview schedule was piloted with a nursing student who was mid-way through her first year of training. As a result of this pilot several modifications were made to the schedule's terminology since the level of understanding had been lower than expected. For example, I had included a question about an understanding of professional identity which she did not know how to answer, and when asked to explain her knowledge of common therapeutic approaches used by nurses she struggled to give a response. On reflection I realised that although I wanted to maintain consistency in my questions over the three interviews for comparison, I would have to refrain from using health and social care profession terminology until the final interview. It would only be then that the student had been extensively exposed to the language and jargon within the educational and work-based establishments.

Participants were invited to interviews on three occasions during their first year of study, during which a semi-structured interview schedule was utilised (Appendix A). Participants were offered a choice as to the location of the interview, and most were conducted within university facilities, although two were conducted in their work placement location. Where space permitted, chairs were arranged so that the subject and the researcher were placed in as close proximity as seemed appropriate while endeavouring to avoid any possibility of the appearance of a confrontation. Subjects were always asked to give their permission for the research to be recorded and an unobtrusive microphone was used; confidentiality and anonymity were assured. Subjects were invariably advised that the digital recorder would be switched off at their request and shown how to do this themselves, if they wished.

My role as research instrument in the current study

The use of the semi-structured interview schedule throughout all interviews enabled greater comparability in responses and assisted with initial coding. Potter and Wetherell (1987) stress that interviews are a conversational encounter and as such the researcher, as a research instrument, introduces a potentially intrusive presence into the data as they are:

> *'Active participants not speaking questionnaires' (p166).*

It is important to recognise that throughout the interview and subsequent analysis process, meaning and understanding were constructed between the participant and myself. As a 'research instrument' in this process I was in a position to potentially influence the pace, nature, tone and direction of the discourse.

Piantanida & Garman (1999) suggest that the researcher's views and assumptions based on personal experiences are as much a part of the study as the stated aims. The challenge is to

control the influence that these personal views may have upon the research process. Piantanida & Garman suggest that these subjective assumptions can inform the choice of literature, a style of writing, how the researcher is depicted or positioned within the discourse in relation to the participant, and the weight and relevant afforded to each in relation to this. The challenges presented by this within the study were that the researchers' professional background was aligned to one of the three participating professions within the study, and I only had experience of working alongside and line managing the other two professions within the work context. This professional experience had a potential to influence bias in perception or understanding, overtly or otherwise. Malterud (2001) suggest that this influence spans the entire research process and choice of topic, methodology, and the way in which findings are filtered, selected and communicated. He argues however that awareness of this influence throughout the process can mitigate the effects on choices made.

"*Preconceptions are not the same as bias, unless the researcher fails to mention them*" (Malterud, 2001p. 484).

This view is supported by Moore (2008) who describes the impact upon the researcher of being an instrument within the research process. She describes the term of 'multiple mes' (p 31) which describes the different stances that the researcher is required to take in processing data and making crucial decisions around how it is used. She argues that the researcher demonstrates their own personal values during the process of establishing and negotiating differing positions whilst processing the data. It is this range of roles undertaken by the researcher throughout the process that can cast doubt on the transparency of data collection, selection and analysis. As a professional with a substantial amount of experience of interviewing individuals within a range of situations, the researcher within the current study perceived that these key skills are transferable to the research interview situation.

Creating and facilitating a safe atmosphere within which participants feel they can divulge views and experiences, putting the participant at ease and encouraging the flow of communication, and using gesticular cues and verbal emphasis to both guide and encourage conversation were skills that the researcher felt that they had from their professional practice experience. I feel that these skills had a positive influence on the semi structured interview process. However, as the sole researcher it was me who interpreted and defined the meaning within the discourse generated between the participant and myself, which presented potential for researcher bias. It is the process of enacting both of these elements of the research process that threatens trustworthiness of the qualitative interview process. There are a number of suggested measures within the literature (Poggenpoel & Myburgh, 2003; Krefting, 1991) to address potential bias: Designing a process that involves multiple interviewers; keeping a reflexive journal throughout the research process in which reflections upon methodological decisions and the impact on research journey upon the researchers' values and beliefs; detailing interview technique to be utilised in advance; and member checking.

In the current study only the member checking measure was utilised, by inviting participants to review typed transcripts of interviews for accuracy checking. However, no changes or amendments were suggested by any of the participants. It is difficult to see how it may have been possible within PhD research to involve more than one interviewer, but this may well have provided an effective check and balance, particularly across professional groups. The keeping of a reflective journal would also have been an effective measure, but one which would have required external review to enable learning. With regard to interview technique, this was formed within the preparation phase although not recorded. I intended to draw upon my skills acquired throughout my clinical experience to establish rapport early within the interview, and enable me to focus upon the flow and order of questions, whilst enabling the participant to retain a sense of control and inclusion throughout the interview. I felt I had a

sense of responsibility towards the participant in honouring their feelings and emotions, which meant that I could not dismiss a digression on to an unrelated topic that was away from my preferred line of enquiry, but had to use paraphrasing and reflection to acknowledge the views of emotions before bringing them back to the line of enquiry.

Step 5: Transcription

The interview questionnaire and schedule of interview periods across the academic year was designed to address the two research questions. A digital recorder and separate microphone were used to record the interviews, which were later transcribed by the author (Appendix J). Each participant received electronic copies of the transcribed interviews to check for accuracy, but no suggestions for amendments were made. Interviews took on average one and a half hours each.

Step 6: Coding

An initial set of codes was developed based upon the theoretical framework and the growing understanding of the interview content. This was an iterative process, which evolved and developed on each reading of the texts. These codes were words and phrases used to identify the occurrence of events or concepts within the interview transcriptions. Categories used in the coding process were solely linked to the research questions. Initially, fourteen codes were created as follows:

Identifying with their profession / belonging

Identifying with student colleagues

Becoming a professional

Knowledge of what they (other professions) do

Attitudes towards other health and social care professionals

Understanding of multidisciplinary working

Culture of learning

Learning by doing

Knowing what I don't know

Knowing what we do

Learning together through working together / socialisation

On power within professional group

In reference to service users

On service users expectations

These initial codes were identified during the immersion phase of analysis. These evolved and changed in focus and priority in line with the research questions to four distinct themes. A separate comparison was made between students across the themes to draw out the impact of shared learning experiences.

1. Professional identity
2. Understanding what other professions do
3. Understanding our role
4. Better understanding of other professional roles through placement

The application of a coding approach facilitated the discovery and identification of themes, patterns, and categories within the data. Subsequently, this highlighted apparent connections and relationships between events, concepts and theories that could then be analysed, compared and contrasted in depth.

Step 7: Analysis

Potter and Wetherell (1987) described two phases to analysis. The first involves reading and re reading the texts searching for patterns in the discourse relating to consistency and variation, and the differences and shared features across the accounts. They stress the importance of researcher self -awareness throughout the process in relation to their own assumptions and presuppositions and how these may potentially impact upon how they read or interpret the text. As described earlier in this chapter, DA as a research method draws on discourse through texts which in the present study was transcribed interview text. The analysis questions and explores the way these texts represent 'ways of understanding', thus providing an appropriate method of analysis within the constructionist framework. The DA approach used by Potter and Wetherell (1987) describes discourse as key to understanding the ways in which individuals construct and formulate identity through verbal interaction, which in turn underpins the discursive psychological approach. The Potter and Wetherell approach to DA was utilised within the study as a method for analysing the interview data to explore the ways in which the participants construct and form knowledge and understanding of their roles and identities, and those of others.

Potter and Wetherell (1987) argued that discourse that projects a social or psychological image of self can be powerful, both in a positive and negative sense in different social contexts. They suggest that the way in which discourse can position an individual can have vital consequences for how they are perceived within their social group. Burr (1995) develops this further, stating that

"(discourses) have their origin not in the person's private experience, but in the discursive culture that those people inhabit" (p50)

The analysis of participant interviews in this thesis paid particular attention to the concepts arising in discourse about the self. In fact, the texts produced from the interviews were subjected to interpretive analysis on several occasions throughout the research process. The interview process itself required analytical interpretation of the participant's discourse, to enable myself as the researcher to check understanding, and make decisions about where further probing was required. The participant themselves also had the opportunity to contribute to the interpretive analysis when they were invited to proof read the transcripts, although no recommendations were made for change or correction by any of the participants.

Each interview transcript was analysed to identify themes and constructs which were then compiled into a data set to describe which discourses supported or challenged themes, with a focus on both the content and context of the discourse. This is not to say that the linguistic structure was overlooked, but that the thematic elements took precedence over linguistic style. This approach is supported by Phillips & Jorgensen (2002) who maintain that

> *" Language is a machine that generates, and as a result constitutes, the social world". (p. 9).*

I anticipated that the particular discourses within the interviews would give a sense of allegiance to particular identities. As a method of analysing the interview data in this study, DA enabled the focus on the content and context of the students' accounts by examining interpretations and understandings to reveal implicit beliefs and core values. Interview data was subjected to DA which resulted in the identification of major themes in the students' stories. Comparisons were made between first, second and third interviews throughout the year to explore changes over time and look for any effects of placement experiences, and across professional groups to identify the impact of IPE. In order for the analysis to be valid and reliable, and the results credible to other researchers, it was vital that the methodology was

systematic and comprehensive to guarantee that all subjects are included and analysed using the same procedures. At the same time, the analysis procedure remained reflexive in so much that it could develop over time while retaining the ability to enable the easy retrieval of data.

The second phase of analysis that Potter and Wetherell refer to entails revisiting the data with a focus on the constructive and functional dimensions of discourse. Potter and Wetherell suggest that this final analysis phase is where the researcher can attempt to form hypotheses about the functions and affects the participants aimed to achieve via their discourse and looking for 'the linguistic evidence to underpin these' (Potter and Wetherell, 1987, p 169). Within the current study the approach taken at this second stage was to identify how understanding of roles and professional identity had been fabricated or created by their experiences within the university and practice settings and demonstrated within their discourses. Social Identity Theory, Self Categorisation Theory and Social Learning Theory were the approaches utilised at this stage to conceptualise the relationship between taught IPE and practice placement experiences and the development of professional identity, understanding of role and those of others for the participants in this study. The outcome of this second phase which is reported within chapter 3.2 and chapter 4, enabled me to form hypotheses about how the different contexts and environments may have influenced the creation of the participants' changes in perspectives in the light of exposure to new knowledge and ways of interpreting things.

Step 8: Validation.

This final stage of the analysis entails consideration of how the themes within the 'discourses' identified are held together in a coherent way, in response to the research questions. Potter and Wetherell (1987) described 4 key themes to validation: coherence, appreciation of participant orientation, identification of new problems that have not been addressed and the

fruitfulness of the findings. This stage informed the selection and orientation of the presentation of the findings in chapter 3.1 and is reflected upon within chapter 4.

Step 9: Write up.

Potter and Wetherell (1987) stress that it is important to be honest within the write-up about the researcher's focus and areas of interest, and that there is and openness regarding researcher interpretations on the discourses and the ways in which these are presented . The semi structured interview schedule offered the opportunity for further discussion around the broader aspects relating to the research questions. The analysis of the discourse that is presented in part two of chapter 3, and that is further explored within chapter 4 of this thesis reflects the elements of the analysis that were seen as fruitful or providing a level of insight into the world of the participants in relation to the key research questions.

Step 10: Application.

This final stage is one that Potter and Wetherell (1987) feel is crucial and often neglected within social research. They articulate that the researcher should be able to demonstrate the potential application of findings and the practical use of the work. This step is addressed within chapter 4 of this thesis.

Selection of educational institutions

Coventry University provide qualifying professional programmes for all three groups in which I was interested, but are the only providers of OT training in the region so a decision was taken to select OT student participants from there. My initial intention was to recruit participants from three different universities, as I thought this may provide the additional advantage of learning something about the impact that the individual institution could have upon the student experience. At this stage it was my intention to recruit nurses from Wolverhampton University,

as I had well established links to the School of Health, and I intended to recruit social work students from Birmingham University, as the institution within which I was studying. However, I encountered a major stumbling block as the introduction of the Social Work degree in the academic year of 2004/5 meant that social work students at Birmingham University would not be undertaking a practice placement within the first year of study.

As links with Wolverhampton University were already established by the researcher enquiries regarding the social work programme within the university revealed that they would be providing first year placements to social work students for the 2004/05 cohort. As I had already been granted permission by the Ethics Committee at Wolverhampton to proceed with recruitment of nursing participants, I sought and was granted permission to recruit both nursing and social work students from this university. The heads of schools within Coventry and Wolverhampton Universities were approached to gain permission to invite their students to take part in the study (Appendix H). Thereafter, contact with potential students was then made through senior lecturers and course tutors on each programme.

Ethical considerations

Meetings were organised with programme heads within each university to discuss the study. An application for ethical approval was submitted to Wolverhampton School of Health ethics committee, who granted permission to proceed in July 2004 (Appendix I). The School of Humanities, Languages and Social Sciences granted access to students on the basis of the School of Health ethical approval, as with the School of Health and Social Care at Coventry University.

This study presented important ethical issues concerning confidentiality and the preservation of anonymity. When relating their experiences and stories, participants were ‘exposing’

themselves to the researcher. This exposure could be perceived by the participant in a variety of ways, including embarrassment, feeling judged, disclosing and discussing feelings that have not been discussed in any other environment thus making the subject feel vulnerable to the researcher.

It was especially important to recognise that any further in-depth probing of interesting responses could be intrusive and that the needs, rights and protection from harm of the individual far outweighed the importance of the interview.

Summary

This chapter has outlined the rationale for approaching the study of the development of professional identity within the social constructionist framework. It has also discussed the relationship between DA analysis as a supporting methodology for the social constructionist approach and the strengths of utilising DA as a method that informs research design. Furthermore, a rationale for the methods employed has been given and a full description of the research design and processes has been presented. Lastly, the rationale for the selection and use of documentation for analysis has also been discussed. The next chapter presented a themed analysis of the findings, organised around the research questions.

CHAPTER 3 FINDINGS

Divided into two sections, this chapter presents the findings of the thesis framed around the research questions. The first part presents the results of the analysis of course syllabi, and the second part presents the analysis of the interview data in the form of discourse analysis.

3.1 Professional course syllabus analysis

Since the experience of interprofessional education (IPE) and multidisciplinary placement was a specific focus of the study, understanding of the form these elements took within the various courses was required. University course syllabii were the document of choice as they were written for students and served as a reference point for students seeking guidance and information on their course aims and content. Alternative documents, such as submissions to university validation panels and regulatory bodies, may have provided greater detail about expected outcomes of different elements of the course, but it was established at the outset that these would be difficult to obtain and would significantly differ between universities and professional bodies. The course syllabii were readily available in the public domain and copies of the academic year 2004/2005 syllabii were obtained for all three courses from both universities. The documents were analysed using a content analysis approach focussing on four categories: professional identity: core skills and values of the profession; descriptions of IPE opportunities and practice placement elements. In addition a comparison of module content within the first year was undertaken.

Understanding of roles, IPE and placement experience

Core skills and values

The first research question aimed to explore the impact of IPE on the students' development of professional identity, understanding of role and the understanding of other professions. Within this each interview stage sought to question their understanding and knowledge of the roles

and values underpinning other professions. It was therefore important to ascertain at what stage, if at all during the syllabus, students received formal input on core skills and values of both their chosen profession and that of others, and whether the understanding of these was an expected outcome.

Social work

The social work course handbook did not detail the core skills and abilities of social workers. Since this material is prescribed by national social work bodies, it must have been available to students in another form of documentation. As course handbooks were the only documents selected for analysis, no further searches for information were made. The students taking part in this study were undertaking DipSW in the academic year 2004/ 2005 when the award was being phased out in favour of the Social Work Degree.

Occupational therapy (OT)

The syllabus described in great detail the unique core skills of occupational therapists. There was a focus on the use of purposeful activity and meaningful occupation as therapeutic tools in the promotion of health and wellbeing and treatment of dysfunction. Skills in assessment, analysis, selection and application of therapeutic media were also described in detail. Values and beliefs were well articulated, focussing on empowerment, inclusion and partnership working with services users and carers to enable them to achieve independence.

Nursing

The core skills of mental health nursing were identified in the course syllabus material as an interpersonal process that seeks to help individuals, families and carers to address needs in daily living, promote autonomy, recovery and independence. Whilst the values of the core first year training were not detailed, the beliefs and values underpinning the Mental Health Branch Programme regarding the nature of mental health nursing were. The syllabus also

stated that these are underpinned by national initiatives related to mental health services and higher education provision, with specific reference to the Ten Essential Capabilities (DoH 2004). The syllabus stated that mental health programme students would need to continually examine and question their values, beliefs and prejudices with a view to respecting and valuing diversity, and develop anti-oppressive approaches to their nursing practice. This was not immediately relevant to the participants in this study, however, as they did not enter branch training during the first year.

Taught IPE opportunities

In the context of this thesis, taught IPE opportunities are described as formal planned opportunities to learn alongside other professions within the university setting. Only the OT degree offered an IPE module that presented students with the opportunity to study alongside other health and social care professionals (this was offered at the start of the course). In 2004/05 the professions studying this module were social workers, nurses, occupational therapists, physiotherapists and speech and language therapists. An enquiry-based learning approach was used to explore the role of social policy and health and wellbeing in context of the broader health and social care services. In addition, the Welfare, Inequalities and Health module was taught across a range of professional courses thus enabling exposure to IPE within classroom based discussion and group work.

Practice placements

The second research question aimed to explore the impact of IPE within the placement setting and the impact upon the development of students' perceptions of their professional identity, understanding of their role and those of other professions. The course syllabii provided only very basic detail of the placement length and where it occurred within the first year of training. There was very little detail on the nature, scope or setting of placements, other than to inform

students that these would take place in a variety of settings and agencies. This is probably due to the complex task of allocating students to placements which is seldom achievable in advance of the course.

OT and social work courses undertook one placement, of 30 days duration, at the end of year one. Nursing students undertook a number of placements, ranging in length from between two weeks to eight weeks, throughout the year starting as early as six weeks into the course. All three nursing students taking part in this study participated in a work placement within the first six weeks of course commencement.

Comparison of module content across courses

Table 2 details the course modules within the syllabuses for the first year of undergraduate training. Each of the courses contained modules addressing core skills, values and approaches that underpin the particular profession. They also included a module addressing professional roles prior to placement and consideration of expected professional behaviour. Only social work and occupational therapy courses dedicated a specific module to inequalities. The OT syllabus also contained a larger number of modules than nursing and social work courses, as the module credits were a mixture of 10 and 20 credits. Nurses completed four 30 credit modules and social workers a mixture of 15 and 30 credit modules.

Table 2. Comparison of module content of first year undergraduate course

	Social work	Occupational Therapy	Nursing
1. Inequalities	**Understanding Inequality and Exclusion** Introduces students to sociological explanations of the material conditions of service users. Examines poverty, unemployment, ill health, poor housing, disablement and lack of education and affect on human development and behaviour and exclusion. It will also look at some of the strategies to counter social inequality.	**Welfare, Health and Inequalities** This module is designed for students on professional and vocationally orientated undergraduate programmes in health, social work and social welfare. Its objectives are to provide students opportunities to: - examine at an introductory level, the impact of key dimensions of social inequalities; - consider how health and social welfare services may contribute to such inequalities but can work to challenge and combat them; - learn to discuss these issues in an interprofessional context.	
2. Values & ethics	**Values and Ethics of Social Work** Offers guidance to students regarding their behaviour with service users and to assist students to identify how their own values, beliefs and prejudices affect their practice. Introduces the historical and philosophical underpinnings of social work values and ethics and implications for practice.	**Foundations of Occupational Therapy** The philosophy, core values and beliefs that provide a foundation for occupational therapy. It examines the relationship between occupation and health and the module introduces the theoretical foundations that provide a framework for occupational therapy practice. **Human Occupational Performance** Module aims to integrate student's knowledge of the components of occupational performance, health and wellbeing The aim is to acquire an understanding of human development and the components that contribute to human occupational performance.	**Holistic Nursing Practice in Context** Enable students to develop an understanding of health; the development of health care services and the delivery of services within a wide social, legal, ethical and professional context and to recognise the impact of the local and national health economy.
3. Professional roles and development	**NO SPECIFIC MODULE BUT IDENTIFIED IN 5 & 2**	I**nteractive Processes** An opportunity for students to explore their personal and professional development. Professional roles and personal skills are identified and considered in preparation for the first professional practice placement. On completion of the module, students will be able to identify personal strengths and areas for development through the ongoing reflective process encouraged throughout the programme.	**Self-awareness and relating to others** Aims to enable the student to explore aspects of self-awareness and how they may relate to 'others' in a variety of settings. The student will explore the contribution of interpersonal and communication theories, identifying skills and attitudes required in order to develop effective therapeutic and inter-professional relationships .The module aims to facilitate personal development and prepare students for a wide range of psychological and interpersonal challenges that arise from working in contemporary health care services.

4. Unique to course	**Law for Social Work Practice** Key elements in social work legislation across different service-user groups. Knowledge and understanding of the legal context of social work practice to ensure they are "fit for practice". **Understanding Social Work Organisations** Develops student's understanding of organisations that commission and deliver social care / social work services and the working of teams within those organisations.	**Interprofessional Module 1** This module aims to examine the historical development and contemporary roles of professional groups in health and social care By the end of the module the student should be able to: - Demonstrate the ability to accommodate diversity in collaborative, interprofessional working - Demonstrate self awareness and an appreciation of power relations within the context of groupwork - Explore the nature, scope and significance of social policy in the field of health and social care -Recognise the implications of social inequalities and social diversity for service users and service provision -Discuss the range of skills required to optimise health and well-being in individuals and communities -Reflect on their own health and well-being, professional role, and contribution to collaborative enquiry-based learning **Introduction to Research** "Introduction to Research" seeks to provide an introduction to developing an understanding of research within a practice context.	
5. Practice placement preparation	**Preparing for Practice: Communication and Intervention** Ensures students are prepared and safe to undertake practice learning in a service delivery setting. Development of basic communication skills in interviewing, writing and recording. Provides an introduction to time-management and task prioritisation techniques, understanding of service user perspectives and to encourage service users to participate fully by working partnership. Students should be able to identify agency policy and procedures and be able to show an awareness of the expectations of professional behaviour. They will be provided with knowledge to be able to use and seek out professional support. They will be able to demonstrate a basic understanding of anti-oppressive practice and how to apply this to practice. This module also covers health and safety policy and team operational procedures.	**The Process of Occupational Therapy** The application of knowledge gained in Foundations of Occupational Therapy to the practice settings. This module seeks to prepare students for both clinical/fieldwork experience and their future role as occupational therapists. Provides the student with an opportunity to practice and begin to evaluate the core skills of assessment, report writing and intervention planning through to closure and discharge.	**Introduction to Nursing** Provides students with a foundation knowledge of sciences to support practice. Students will also be facilitated to develop a range of clinical skills, enabling them to participate safely in care delivery under supervision.
6. Practice placement	*Practice Learning One* Introduces students and enables them to begin to participate in social work practice within a broad based social care agency. 30 days.	**Professional Development in Practice I (Fieldwork Education Placement)**	Practice placements 787.5 hours in various lengths of duration from as early as six weeks into the course.

Summary

The OT course was the only course that provided a taught IPE module, which was described in terms of clearly defined outcomes. This syllabus also included a number of modules running alongside the IPE module that specifically focused on the foundations, core skills values and beliefs underpinning the profession. The syllabus documents described preparation for practice modules within each course but there was a marked difference in emphasis between the nursing syllabus focussing on clinical skills preparation and the social work syllabus which places greater emphasis on knowledge of the placement context, and preparing students for the role they are about to undertake. The occupational therapy practice preparation module fell somewhere between the two.

Overall, the placement duration seemed comparable across the three courses. However, whilst the nursing syllabus provided an hourly total across the first year and alluded to a number of placements throughout the year, the timing and length of these placements was not detailed in relation to the overall programme of study. The syllabus analysis highlighted a number of similarities and differences between courses which may significantly impact the opportunities for interprofessional education in both a planned, formal sense and within the practice placement environment.

3.2 Discourse Analysis

This part of this chapter presents the analysis of the interview data in the form of a discourse analysis based on Potter & Wetherell's (1987) approach. An important part of this thesis is tracking the journey of the student through their experiences over the course of the year in order to explore changes in their perceptions and articulation of professional identity, understanding of their role and that of other professions. For this reason the analysis is presented by individual participant. Each journey is organised around the three key themes that emerged following the various stages of analysis; professional identity, understanding of own role and understanding the role of other professions.

Nurse A

Professional identity

Nurse A entered her training with a substantial amount of experience as a health care worker and, through her mother's role as a district nurse, has a firm idea of the professional image of nurses. She bases her views on a historical trust that society at large holds in nurses.

Fig 1

NAI *You have a more therapeutic relationship, with nursing the history….. when you put on a nurses uniform you become a nurse. With a social worker you are like the scourge of society, they really don't want to know you, but with a nurse historically they have been beneficial, they have been carers, they have been people to confide in. And I think history, because your uniform gives you a status, and I couldn't….mmm what am I trying to say…I think that social workers, where they are almost part of society, they are not held in the same regard as a nurse. It gives you a professional barrier, between your own personal life and your professional life. Its regard and esteem.*

Her reference to nurses being *beneficial* and having *more therapeutic relationships* points to a warm, trustworthy do-good element of the nursing image. Her use of the words *regard* and *esteem* infer the warmth society associates with the professional identity. However, she contradicts this with her reference to *uniform giving you status,* and *professional barrier,*

between personal and professional life, almost inferring that it is a mantle one can use to become powerful. At this early stage in her training, nurse A indicates that she has a professional identity as a nurse.

By her second interview, her discourse suggests recognition of personal responsibility for her professionalism.

Fig 2

NA2 *Well as a professional it is my responsibility to be aware of any shortcomings or development needs and to ensure that I address them. Once a nurse becomes registered, then there are no exams or tutors giving advice, it's up to the individual nurse to ensure that they remain fit to practice.*

She uses the *I* rather than collective *you* to describe professional responsibility. The use of the term *fit to practice* suggests that her exposure to professional jargon has already become part of her vocabulary. Remaining fit to practice also suggests that she has changed her belief of professional status assumed from having responsibility for maintaining professional standards in practice - the professional code. She is quite clear that she has a professional identity at this stage, but relates this only to work-based experience.

Fig 3

Do you feel that you have a professional identity as a nurse yet?

NA2 *Crumbs….err, yes I think I do. That's not related to the university course work or lectures though, it's being on placement, doing the job that I'm comfortable with- that's where I feel like a nurse.*

She implies that she is comfortable and at ease with the practical element of the role. By the third interview her discourse refers back to professional power.

Fig 4

NA 3 *Yes, but having said that, when you put on a nurses uniform, it almost gives you a right. People think, oh she's a nurse, it's ok. Just out of courtesy you should ask if you can carry something out. Even feeding is a very personal invasion. It seems that the general public feel that as you are wearing a uniform, you have a right to carry out whatever procedure you wish to.*

She talks about the public seeming to give power to the role, but suggests that permission should be sought *just out of courtesy*.

Fig 5

Is that really how it feels?

NA3 *Yes. One of the palliative care nurses who don't wear uniforms was putting a syringe driver in, and her (the patient's) daughter turned up and asked us whether she was a nurse, that is how strongly the uniform appears. People will tell you their most intimate details when you are wearing a uniform.*

However, here she seems to be moving from the respect the uniform should have to the trust people place in the uniform, inferring that this trust should be treated carefully and respected. She goes on to describe her perspective on ethical stance, professional accountability and personal conscience.

Fig 6

NA3 *But as a nurse, you have to look at the whole person, and not just within the confines of the NMC code and the ethics but, your own personal sort of conscience that you are doing the best you can, in the patients' best interests, rather than just treating the ulcer on the leg, you are making sure they have good nutrition, and using your experience and your professionalism and your knowledge to treat the whole person, but in doing that you need to involve them in the whole treatment, to empower the patient to gain consent and autonomy.*

She still espouses the maternalistic view of looking after a person's needs, irrespective of whether they ask you to or not, ensuring patients have good nutrition in addition to their treatment, but for the first time she makes reference to empowerment and involvement of patients in their own care.

Over the course of the three interviews there is a development of her perception of professional identity. Her discourse within the first interview suggests that she already has a level of professional identity, but throughout the interviews there is a distinct move from assumed respect, power and automatic permission to do unto others. She demonstrates an appreciation of the accountability and responsibility she has as a nurse to develop and maintain her skills, for her own behaviour, and the need to consult and involve service users.

Understanding of own role

Nurse A has her first placement in a nursing home. Her first responses on being asked about the knowledge required for nursing is precise.

Fig 7

NA1 *Anatomy, drugs, psychology.*

She goes on however, to describe the skills required as being listening and understanding.

Fig 8

NA1 *Someone who will listen, of all the things you need to be a nurse, you need to be a good listener and you need to look as though you are listening. To be empathetic, rather than sympathetic. If you're empathetic you actually do something about it.*

She also talks about enabling patients to feel empowered, although she is clear that this is a university perspective, not her own from experience.

Fig 9

NA1 Promoting the autonomy of the patient is what they keep telling us. If someone feels that they are acting rather than being acted upon, it gives them a feeling of empowerment and makes them feel that they are contributing to their own treatment. I found that in one of the text books and I rather like it.

In her second interview, she still identifies empathy and *being alongside a person* as the key roles of nursing.

Fig 10

Right Susan. Could you tell me what the unique core skills of a nurse are?

NA2 *Um, putting yourself alongside a patient and being able to really empathise with how they feel.*

Do you think that all nurses can truly empathise with how a person feels?

NA2 *No. I think everyone should have a stay in hospital, because when you are on the other end of it, you are acutely aware of the power people have over you, physically and decision wise. I remember when I had my hysterectomy I had an epidural, and I was lying here wandering how on earth do people manage when they can't move, and you need to have an all round awareness of what it feels like to be that person in the bed. You need to be able to pick up on the non-verbal signs that people give you, that give away how they feel.*

She expresses an awareness of the power of the professional over an incapacitated person, although her example is of physical incapacity. Again, the focus is on the physical aspect when discussing the intimacy of nursing tasks.

Fig 11

NA2 *Yes, I'm sure that with social workers and occupational therapists that dignity and respect are important, but there is still the intimacy of nursing tasks that these other roles don't do. Well at least I don't think they do.*

Do you think these skills are unique to nursing?

NA2 *Maybe not empathy, but I do think that nurses undertake very personal tasks that invade people's personal space, and I think this is unique to nursing, so being able to empathise and…understand how that may feel, is key for nurses especially.*

Her responses focus on understanding the patient, or the client experience. However, this is described in the context of nurse autonomy and trust. Nurse A also articulates a clear understanding of the nursing ethic.

Fig 12

NA 2 *I suppose the beliefs are that dignity and respect for a patient, or client is paramount and nursing is about being trusted to provide care and comfort when it is needed.*

NA2 *Philosophy and beliefs. That we should support life, keep patients free of pain where possible, and alleviate stress and distress through care and support. That we should use evidence based treatments to treat identified illnesses within agreed protocols, following care pathways.*

At this early stage, 12 weeks into her training, she seems confident in her knowledge of the role of the nurse. This strong ethical focus is deepened by her placement experience, as is evident in her third interview.

Fig 13

NA3 *You have a more therapeutic relationship… when you put on a nurse's uniform you become a nurse...You're there to look after them, holistically- that sounds like I have swallowed my lecture notes. But as a nurse, you have to look at the whole person, and not just within the confines of the NMC code and the ethics but, your own personal sort of conscience that you are doing the best you can, in the patients best interests, rather than just treating the ulcer on the leg, you are making sure thy have good nutrition, and using your experience and your professionalism and your knowledge to treat the whole person, but in doing that you need to involve them in the whole treatment, to empower the patient to gain consent and autonomy, I have swallowed my lecture notes.*

She talks about putting on the mantle of a nurse to look after people. She infers that you become a nurse by wearing the uniform, and in effect, lose that identity once you remove it. This contradicts her later statements about personal conscience informing decisions. Perhaps by this she means that all nurses use personal and professional ethics to guide their practice, and this is imbued within the uniform. Interestingly, she was not successful in gaining a mental health placement; her final placement was on a urology ward in a general acute hospital. Had she had a mental health placement, she would not have worn a uniform.

Whilst nurse A has a good understanding of the role at the first interview her discourse illustrates a deepening of that understanding throughout the second and third interviews, although the focus on physical tasks remains strong.

Understanding what other professions do

At the first interview, nurse A states that she had little knowledge of social work roles.

Fig 14

NA1 (on social workers) I honestly don't know, I mean along the same ideas of listening I suppose, and drawing on resources, but I've never had any contact with a social worker, I don't know any.

However, she has a number of examples that illustrate what she perceives society's views are of them.

Fig 15

NA1 *No. social work I think is terrifying, because I think… you are vulnerable, from what I've seen. From what you see on television, social workers seem to be the whipping boys, um you know. If something goes wrong it's the social worker's fault, it's not the fact that Mr Jones stabbed his wife, it's the social worker's fault.*

NA1 *You're dammed if you do and you're dammed if you don't with social work.*

NA 1 *With a social worker you are like the scourge of society, they really don't want to know you. I think that social workers, where they are almost part of society, they are not held in the same regard as a nurse.*

In the first interview nurse A states that she knows nothing of the OT role. By the second interview her knowledge of social work and OT roles has not improved, although she is willing to stake that they do not carry out intimate tasks similar to nurses.

Fig 16

NA2 *Yes, I'm sure that with social workers and occupational therapists that dignity and respect are important, but there is still the intimacy of nursing tasks that these other roles don't do. Well at least I don't think they do.*

By the third interview, following her placement on a medical acute ward, she has not encountered an OT and has no further insight into the role. She has encountered social workers, however.

Fig 17

NA3 *Social workers assess and devise care plans very much as the nurses do. They purchase care packages but so do the nurses. Social workers do indepth assessments for residential care, or any ongoing care needs that need to be purchased. Other than that, their roles are similar to nurses. The single assessment process means that we share some of the same assessment process.*

Although she only witnesses the assessment and care planning element of the social work role, she surmises that their role is similar to nurses. Overall, nurse A's knowledge and understanding of other professions roles does not improve significantly as a result of her placement experience, as both placements are in uni-disciplinary teams and physical care settings. Over the course of the first year of training, neither the planned taught element and or the unplanned experiential encounters on placement provide her with the opportunity to develop better insight into, or knowledge of other professional roles.

Nurse B

Nurse B only participated in one interview at the beginning of her training. As a result it is not possible to observe changes in knowledge, understanding and attitude throughout the first year of training. Consideration was given as to whether to include her interview data in the

discourse analysis. However, the first interview provides an understanding of the level of professional identity she has as a student nurse on entry to her training, and details relating to the impact that her brief first placement has on her understanding and perceptions of other professional roles. For this reason, the decision was taken to include her data in the final analysis.

Professional identity and understanding of own role

Nurse B had no previous experience in a care provision role prior to commencing her nurse training. What is interesting about her understanding of the nursing role is her broad expectations, or understanding of the expectations she places on herself and nurses.

Fig 18

NB1 *Yes or depending on what they want. Like if someone wants to be able to cook, you'd help and assist them in whatever way they could be helped, or if they needed help to go to the bathroom you would assist them in any way they need help. Um, it all depends on what they want. You need to know how to do most things to be able to help.*

The overemphasis on providing assistance wherever possible is contradicted by her views on the rules that dictate exactly what a nurse can and can't do.

Fig 19

NB1 *Well you'd need to know all the policies that can affect a nurse. So, what a nurse can and can't do, what a patient can and can't do to a nurse, um all the communication skills.*
Yes.
NB1 *Record keeping, knowledge of the different types of drugs, and knowledge of the different types of procedures that go on. Um, that you can do as a nurse. What happens when you do such and such thing, and what happens when it goes wrong.*

She goes on to describe a more interpersonal, reflexive view of the role.

Fig 20

NB1 *Someone who will listen, who has a good knowledge and understanding of … things that can happen to people. Not someone that people feel they can't talk to or ask about something. Have an understanding of everything as well, and not be too pushy.*

Nurse B appears to indicate a level of belonging to the profession but it is difficult to establish from the first interview her level of professional identity. She demonstrates a broad understanding of the role at this stage, which may have been drawn from her early placement experience as her first placement had commenced before the interview took place.

Understanding what other professions do

Nurse B commenced her first six week placement on a mental health rehabilitation ward in an inpatient unit before the interview. During this time she had exposure to social workers and occupational therapists, but the impact of this early placement in a busy, challenging environment seems to be mixed. Nurse B does not demonstrate any knowledge or understanding of the OT role. She does, however, indicate a basic level of understanding of the social work role.

Fig 21

NB1 *Um from what I've sort of seen so far, the nurses are here to help with their health, and social workers are here to help with their social problems. So once they are better and well enough to go home, they will help find them somewhere to live, make sure they are ok when they are there, phone bills, you know, bills and benefits if they need them, help them to get a job, help them back into the community, and we as nurses help them to get better to be able to do that.*

She identifies the skills and knowledge required by social workers as being very much based on empathy and interpersonal skills.

Fig 22

NB1 *It would depend on what they are doing whether it be child or adults, they would need to have an understanding of what the child's going through and what they are feeling. If they are being abused, either violently or whatever they need to know how they will be feeling and why. They might never have experienced it but at least they will have known a number of people who have and have been through it and will know what to look for, and then they go out and see people.*

This view is interesting as she is providing child focussed examples, although her current experience is in an adult service. She does draw on her placement experience in describing the patience and listening skills required for social work.

Fig 23

NB1 *From the people that I have met that are social workers you need to have a lot of patience, um I don't know about people who haven't got mental health illnesses, but on this ward you need a lot of patience, and they have to sit there and listen to people who keep stopping half way through a sentence and swapping back. Um you need to be able to sort out 10 things at once.*

It is unclear in the latter part of the sentence whether she is referring to all staff in this environment or social work in particular. Her short exposure during the work placement has led her to compare professions by the amount of contact with service users, particularly the 24 hour caring role.

Fig 24

NB 1 *They (nurses) tend to have a higher level of knowledge of medical expertise, what to do if something happens to a person on a ward and such. Also they have to learn to deal with people differently to a social worker. They have to be with a patient all the time every day, where as a social worker comes in once or twice a week to see how they are doing.*

Nurse B demonstrates some understanding of the social work role at this first interview, although it is difficult to judge the impact her short placement may have had on this as she has already commenced it by the time the interview takes place. Her discourse suggests that her brief exposure to professional roles, whilst on placement, has stimulated a consideration of the differences in knowledge required and roles performed.

Nurse C

Professional identity

Nurse C commences his training with a number of years experience as a holistic therapist, and has an understanding of the nursing profession as family members are nurses. In his first interview he alludes to an identity as a mental health professional as opposed to a nurse.

Fig 25

Was there any reason why you decided on nursing as a progression on from your holistic therapies and learning disabilities experience, rather than any of the other health or social care occupations?

NC1 *Um, it was just mainly mental health. I'd done a little bit of reading around it. I'd heard bad reports of social workers and different things and I'd heard a lot of stories about social workers… but nursing runs in the family, there's a family attachment as well, even though it's in a different area.*

So would you say that you had a general understanding of the field of nursing?

NC1 *Yes, also a lot of my friends and colleagues are nurses. It was skills but also that I think I've got time to sit and listen to people and folks have pointed out to me before hand that on general wards you don't have time to sit and listen and offer advice as you are short of time. That was the pathway I wanted to go down.*

He still alludes to mental health skills, as opposed to the nursing professional identity. By the second interview any indication of belonging to the profession or identity as a nurse is still absent.

Fig 26

Would you say Howard that you have a professional identity as a nurse yet?

NC2 *No! Someone made a comment today that we are just monkeys out on the wards, and that hasn't gone down too well. You don't get any feeling of belonging at all.*

By the third interview, however, coming to the end of his placement, his discourse indicates a strong identity with the profession.

Fig 27

Do you believe there are core skills unique to nursing?

NC3 *Yes I do, I think that supporting people day in day out, making them feel comfortable and looked after, whether they can be helped or not, whether they want help or not, nurses need to have the strength of character to stick it out. I don't think it's quite the same for other professions.*

Why is that?

NC3 *Well if clients don't want help or are beyond help, they can do nothing for them. The nurse will work 24 hours a day watching, assisting and caring for someone to keep them fed, safe and warm.*

The 'doing to' message is strong; making people feel comfortable, looked after, whether they want help or not. This is language that was not evident in earlier interviews.

Fig 28

It sounds like quite a powerful position to be in Howard.

NC3 *I suppose it is. You have a responsibility to take decisions for the client when they cannot make choices for themselves, but their best interests must be at heart at all times. It's a big responsibility.*

Here again he talks about taking decisions for people, but this is balanced by an appreciation of the responsibility that goes with this.

Fig 29

Do you think your training has prepared you for that up to now?

NC3 *I suppose so yes. At university we spent a lot of time talking about ethical codes of conduct and legal and moral responsively. You have to take your professional responsibility to society seriously.*

He demonstrates a bold transition from a lack of nursing identity to a strong acceptance of a paternalistic approach to clients and moral responsibility to society to uphold professional values. He uses patient terminology, identifying demarcation between staff and patients.

Fig 30

NC3 *I understand the values of nursing, putting the patient first. …we had one lecture whether the NHS was run for patients or staff, and we voted at the end that we thought it was for staff, and it has to, or else it wouldn't work.*

Wow, was this a debate in uni?

NC3 *Yes, people obviously say you have to run a service for the patients, but its just not feasible, the service, the NHS to run as a massive concern has to be facilitated by staff, so the structures and processes that facilitate the delivery of services are there for the benefit of staff - to help them do their jobs.*

He then proceeds to explain a physical nursing task, moving away from the mental health, listening and supportive skills mentioned in earlier interviews.

Fig 31

NC3 *Yes, I suppose I have covered it already. it's the responsibility for caring for someone 24/7, ensuring they are safe, warm and fed, help them with the activities of daily living that we all take for granted, that we need to survive, but for some people who are ill, they cannot do for themselves.*

Throughout the course of the year, nurse C's professional identity has developed from one of generic mental health worker towards nurse, with a strong allegiance to the profession following placement experience. Both of his placements appear to have had a significant impact on his professional identity.

Understanding of own role

Nurse C has prior experience as a holistic therapist, and had family members who were nurses. However, at the first interview, his understanding of the professional nursing role is vague.

Fig 32

What are the core skills of nursing?
NC1 *I'd be really struggling on those at the moment, what the core skills are.*
So if you were talking to someone on the street and you were trying to describe what a mental health nurse does, would you be able to easily summarise the role for them?
NC1 *I support and care for people with mental health problems, helping them to cope with their illness and providing treatment.*

He talks more confidently about ethics and confidentiality, which is something that he has prior knowledge of from his experience as holistic therapist.

Fig 33

Have they talked at all about values, philosophy, and knowledge base of nursing?
NC1 *They say that we must have a knowledge base and evidence base to use in our practice.*
So they reiterate that it needs to be evidence-based practice?
NC1 *Oh yes. The main discussions we have had are on ethical issues on how you work with different religions, etc. Confidentiality is the main thing that they push all the time.*

His reference to university course lecturers suggests that perhaps nurse C does not own the philosophy at this point, or associate himself with it. This seems to have developed by the second interview, following his nursing home placement.

Fig 34

NC2 *I think the ethics thing has been the strongest, evidence based practice, not operating outside of your competence, always ensuring that you are observed in carrying out procedures that you have not been deemed competent to carry out on your own, that kind of thing, the code of conduct and all.*

There is a distinct development and deepening of his understanding of ethics and how it translates into day-to-day practice. At this second interview, nurse C describes the warm, supportive role of nursing which requires strong interpersonal skills.

Fig 35

NC2 *Listening to people, supporting them, making them feel at ease and comfortable in their environment, supporting people with health problems that are not medical.*

Sorry, do you mean not physical?

NC2 *Yes, mental.*

NC2 *I think that we have talked a lot in lectures about values and ethics, but they are all encompassing.*

What do you mean?

NC2 *Well it's about enabling people, not making judgements about people based on your own latent prejudices, helping people to help themselves, that sort of thing.*

At his third interview, following a placement on an inpatient ward for older people with mental health problems, his understanding of the nursing role has changed dramatically. He confidently asserts his understanding of the philosophy of nursing (fig 31) and affirms that there are core skills required for nursing that differ from other professions.

Fig 36

NC3 *Yes I do, I think that supporting people day in day out, making them feel comfortable and anted, and looked after, whether they can be helped or not, whether they want help or not, nurses need to have the strength of character to stick it out. I don't think it's quite the same for other professions.*

Why is that?

NC3 *Well if clients don't want help or are beyond help, they can do nothing for them. The nurse will work 24 hours a day watching, assisting and caring for someone to keep then fed, safe and warm.*

He appears weary and tired from his experience on the placement. His description of the role of the nurse is of paternalistic care and control, which sometimes needs to be imposed on people, dependent on capacity and will.

Fig 37

How would you describe the approach to client care on the ward?

NC3 *I think it was thorough, with a focus on choice and people being comfortable, but with the difficulty of communicating with very demented and confused patients. Sometimes they don't even understand what you are asking them, and you just have to cajole them along to have a wash or get dressed or eat a meal.*

Nurse C is describing idealistic care provision, which whilst he is keen to defend has been recently challenged by the difficulties encountered when working with service users who have communication or comprehension difficulties.

Fig 38

What were the skills that you required to carry out that role?

NC3 *Lots of patience, trying to find ways of communicating with people, definite unconditional positive regard for people, as sometimes they can be quite rude and hostile towards you, but you have to constantly remind yourself that they don't have the cognitive ability to be aware of what they are doing.*

His reference to *unconditional positive regard* seems out of place in this sentence. It is as if he has drawn on a theory or model of understanding from his theoretical underpinning study and is clinging to it to enable him to make sense of, or survive this challenging experience.

Fig 39

NC3 *Well I have spent 10 weeks bathing, toileting and feeding people, that's what it feels like.*

Hard work.

NC3 *Yes, but I know the experience wouldn't have been the same on the adult wards. I think I may have had more opportunity to get involved in therapeutic interactions, counselling, talking and listening to people talking about their problems. Communication was a problem with the older patients.*

Even though his experience has been difficult, he has not accepted that it is the norm for mental health nursing and returns to descriptions used in his first interview, the role of the counsellor and listener, which he feels he has not been able to use in his placement.

It is evident that Nurse C's understanding of the nursing role has developed over the course of the year. His initial, vague understanding and broader aspects of nursing practice has been replaced by an appreciation of the role, function and skills required to practice as a nurse. His understanding and perception of the nursing role is more orientated to generic roles than mental health specifically, which may have been influenced by the fact that his placement has been in older persons services where the focus is more on physical than psychological care.

Understanding what other professions do

Nurse C does not have a good understanding of the social work role at first interview.

Fig 40

NC1. *I'd heard bad reports of social workers and different things and I'd heard a lot of stories about social workers…**NC1** I'll have a job to answer that I think, as I don't have sufficient knowledge about the other occupations. I'm not sure whether some of the other occupations actually see an end result, I hear of social workers with very large caseloads and files being passed on, which is the same as patients.*

You were talking earlier about the bad press you have heard of social workers. In the same vein, what might their core skills be?

***NC1** I'm not sure that I know. They seem to have a lot of power to interfere.*

Could you tell me what they do, what their role is?

***NC1** Deciding when children can or cannot stay with their families, such as in abuse cases.*

Nurse C makes some very negative comments about social workers but it is not clear where these views originate. It appears to be based on media stereotypes, although he states that *he hears of social workers with very large caseloads* and *deciding when children can or cannot stay with their families*, as if this is an individual social worker decision. His discourse indicates that he has encountered social workers in a previous role.

Fig 41

Ok, what about work with adults?

NC1 *finances, like organising care packages for people with learning disabilities, buying beds in care homes, that sort of thing.*

What do you think might be the values and philosophy of social work?

NC1 *I don't know. Protecting vulnerable people I guess.*

Nurse C has previously worked in a learning disabilities care home, and draws from his experience in that role. From his throwaway comment '*Protecting vulnerable people, I guess'*, he appears to minimise the importance of the role of protecting vulnerable people. His limited knowledge of occupational therapy is mentioned in relation to his learning disability experience. He does not know how they may operate in mental health services.

Fig 42

OK. What about occupational therapists, do you know much about that role?

NC1 *Um, I've come across them on learning disabilities, they help people recovering from illness and accidents, that sort of thing.*

In what way, how do they do that?

NC1 *They help people get the right adaptations to help them around the house, climbing stairs, getting into the bath, that sort of thing.*

So you wouldn't know what they might do for someone experiencing mental health problems?

NC1 *No idea.*

By the second interview his knowledge of social work roles has not developed despite having contact with them on his short placement.

Fig 43

Ok. Since we last met have you had the opportunity to gain more knowledge or insight into the core skills of social work?

NC2 *No, I've been in meetings with social workers in the short placement we just did in the nursing home but no further insight into the skills they need, no.*

However, he proceeds to make a bold statement about social workers being similar to mental health nurses.

Fig 44

NC2 *I'm not really sure what the social workers do, but they do support individuals more within their own homes or care homes than within hospitals. I know they are brought into hospitals to help with individuals. If I looked at it longer I may feel that there is not much difference between them and the mental health nurse because mental health covers the individual, but social workers also cover the extended family and other events that do occur, particularly children of course.*

He seems to be confusing philosophy and approach with role. However, his understanding of the OT role has dramatically improved since placement contact.

Fig 45

What about occupational therapists?

NC2 *Now interestingly I did come across these on the placement, as it was for elderly people, and there was an OT on a local team that used the respite beds, and they spent some time assessing their capabilities, it was quite interesting.*

Any further ideas on the skills they need?

NC2 *Well, this person was a good communicator, and I suppose if they deal with people who have had strokes and other debilitating illnesses, then the communication gets even harder, doesn't it, so they need to be clear communicators, and good listeners I suppose.*

Any other skills?

NC2 *Assessing people's physical ability to carry out tasks...this one lady could not get herself to the toilet or make a cup of tea and this OT put a programme in place for us to try and work towards, well help her to work towards that goal. She told us what aids to use.*

He seems impressed by the OT outcome focussed intervention and identifies the OT role as being similar to that of the nurse.

Fig 46

What about occupational therapy, do you have a better understanding of the core values, philosophy and beliefs that underpin OT at all since we last met?

NC2 *Well, seeing the OT worker at the home, the values are clearly similar to nursing, but more focussed on enabling, putting things in place to help people to regain independence.*

Nurse C's experience of this OT was positive. He describes the individuals' strengths around communication skills, which prompts him to think about the context and purpose of their role and where this competency may be necessary. Nurse C compares the OT values with nursing based on this one encounter with the OT at the home. He describes the values of occupational therapy, with confidence, making assumptions based on this encounter.

By the third interview nurse C has been on placement in an inpatient ward for older people with mental health problems. This is not a multidisciplinary team, only nurses and psychiatrists, but there is input from the wider team. It is evident that as a result of increased contact with social workers his views have softened. Prior to his second placement, nurse C's views on social work had been scathing but his new experience has resulted in exhibiting a more positive attitude to the work social workers undertake. His experience, albeit at a distance on the ward was however, positive.

Fig 47

Any other professionals that were allied to the team on the ward?

NC3 *There was a community team that worked with both of the psychiatrists for that part of the city, and there were CPNs, an OT, and two social workers.*

Oh, and what was their interaction like with the ward?

NC3 *Well they come to ward rounds every week and take part in case discussions and case conferences. the social workers would often pop up to the ward to see the patients and be to -ing and fro-ing from the patients relatives and the ward. I think they do a good job making sure the relatives are coping ok.*

From his first interview statement of *social workers getting bad press* he seems to view them as hard-working, with a positive view of their role in looking out for carers' needs. Nurse C recognises a valuable element of the social work role in supporting relatives and establishing links between the home and hospital.

Fig 48

NC3 *Yes and no, I didn't get a chance to get involved in what they were doing, I did get to speak to some who had sectioned the patients to come in, that must be a very scary part of their job.*

Indeed. What about the value base of social work practice then?

NC3 *Again, I can't remember what I've said before, but I definitely feel that they are focussed on equality and people's rights, and protecting the vulnerable from abuse.*

This is the first time he mentions *equality* and *rights*, and it is done so in a neutral rather than derogatory tone. Nurse Cs insight into the OT role has also progressed as a result of his placement.

Fig 49

Ok. Now onto occupational therapy, do you have further insight into the core skills required?

NC3 *Well I have had more to do with the OT department on the ward, and the OTs and the OT assistants seem to be very upbeat, full of energy and extremely positive. I think that it is more of a disposition than a skill that they would need to do the job well, enthusiasm and infectious motivation.*

That sounds fabulous- infectious motivation.

NC3 *Yes (laugh).*

What about the value base that underpins their work?

NC3 *I would say it's about enabling people towards independent living, helping people to remain independent for as long as possible.*

He does not offer any further insight into their role but seems to identify with the motivation and enthusiasm of the individuals he met. Overall, his experience has left him with a positive view of the OT role.

Fig 50

NC3 *They (OTs) come on to the ward and assess individual patients for independent living skills, like making a cup of tea, cooking a light meal. They run groups, based on reality orientation and memory provocation, that sort of thing, organised physical activities and games that helped the patients keep mobile, such as catching balls or playing skittles.*

Quite a lot of interaction with the clients then?

NC3 *Oh yes. I think they work very hard, but they only work 9 – 5 which I thought was a bit pathetic really.*

His perception of the OT role and his attitude towards them remains positive, but his statement regarding 9 – 5 working hours as *pathetic* gives some indication of the impact that placement shift work has had on him. However, this does not detract from his admiration for the profession. Not only does he talk enthusiastically about their role and approach, but he also refers warmly to their *enthusiastic disposition,* and their *infectious motivation.* Evidently, he is clearly impressed and holds a positive view of occupational therapy as a profession. Nurse C's placement experiences have had a substantial impact on his knowledge, insight and attitude towards occupational therapists and social workers. There has been a significant shift in his understanding and regard for other professions throughout the course of the first year, primarily influenced by his two placement experiences.

OTA

Professional identity

OT A's discourse indicates a good level of understanding of the role of the OT and the skills required at first interview.

Fig 51

OTA1 *Well, the job, I think, requires skills in assessing people's needs, social and daily living skills, employment work and stuff …and enabling people to relearn practical skills and being able to get around and care for themselves when they have experienced illness, injury or accidents.*

He seems to demonstrate a level of identity with the profession.

Fig 52

Ok, so what core skills would enable someone to carry out that role?

OTA1 *Patience, an ability to strike up a relationship fairly quickly and easily with someone. You need to work with people to encourage a positive attitude. I mean some people may need to relearn how to dress themselves or even go to the toilet.*

'You need to work with people' suggests that he already feels part of the profession.

By the second interview there is evidence that IPE has had an impact on his perception of professional identity.

Fig 53

OTA2 *No...I'm not anything yet, I'm just a student. I think I know more about the difference between my chosen profession and the other health and social care roles.*

Really? Why is that?

OTA2 *Well, on the inequalities module I've been doing these last few weeks we have focused on all of the health and social care professions really, on the approaches they all take and the values they are based on. That's not to say that we haven't focused on the role of the OT- I'm also doing a human occupational performance module which really does focus on the foundations of occupational therapy practice.*

In answer to the question regarding professional identity, he states that he has an identity as a student rather than as an OT. This broader view of the health and social care world seems something that he is comfortable to inhabit alongside the world of OT and specialist OT modules. By the time he completes a work placement in an OT team, within an inpatient environment with some multiprofessional working, his identity as an OT has become markedly stronger.

Fig 54

Do you think that this multidisciplinary work environment and the social engagement that you have had with colleagues has had any impact on how you perceive your identity?
OTA3 *(pause) I have liked what I saw with the ways that fellow OTs operated, so I think I am happy to identify myself with the profession. Yes, I suppose I feel like a student OT now, not just a student.*

Now, he refers to *fellow OTs* and *feeling like a student OT* as opposed to *just a student.* He indicates that the opportunity to test out his skills has increased his comfort in the role.

Fig 55

OTA3 *Um, that's an interesting one. Yes, I think I do feel like an OT now. I have had the opportunity to try out my skills and test some of the theory taught in uni.*

He describes being able to *try out his own skills* in the real world environment and to test the theories presented to him within the university environment, and he is content with how both have fared. There is a sense that he is happy to pursue the OT profession.

Fig 56

OTA3 *Right…improving quality of life is the main role. Our focus is on the whole person, the holistic approach. We… enrich the quality of peoples' life, the things that are important to them. Our approach is holistic, seeing every part of their life and experience as equally important to clients. Through occupation and activity, we try to enrich that life... psycho-educational interventions such as anxiety and anger management.*

OT A frequently employs inclusive terminology and references to *our foc*us, and *we enrich* which indicates his sense of belonging to the profession, presenting a pride in the role that he is comfortable to align himself with. For OT A, both his IPE experience and his placement experience appear to have had a positive impact on the development of his professional identity.

Understanding of own role

OT A does not have any prior experience of occupational therapy, although his discourse at first interview indicates a good understanding of the role.

Fig 57

But what do you think makes a good OT?
OTA1 *Um, someone with patience, common sense, um I think you need a practical approach to problem solving, um, thinking things through.*

OT A is able to describe succinctly the broad remit of occupational therapy and the knowledge and value base required.

Fig 58

OTA1 *Umm, values are to promote independence and enable people to live as independently as possible…*
OTA1 *Well, ...occupational therapists help people to overcome difficulties, which may be the result of physical or mental illness, an accident or the ageing process, so I suppose you need to have knowledge about physical illness, mental illness, the types of injury people might have and the affect this may have on their independence, the ageing process, that kind of thing.*

Although this level of knowledge could be gleaned from written material, he seems to demonstrate an understanding of the challenges in practice. He describes [see Fig 52] a number of core skills which are more related to disposition and communication; namely, patience, positive attitude, and the ability to strike up relationships easily.

Fig 59

OTA1 *I mean, I don't think its rocket science, helping someone to prepare a meal for themselves, it's not about having skill in the actual task, but being able to make someone feel comfortable with you helping them to do that.*

He exhibits an awareness of the experience of the person receiving the service, although his examples are based on physical ill health rather than mental health issues. By his second interview, his understanding of the role is still focused on physical health needs.

Fig 60

OTA2 *We might undertake an assessment and offer advice regarding appliances that will enable a person to carry out everyday tasks in their own home, such as washing, cooking.*
What sort of treatments, what would the programmes be?
OTA2 *Well for example, we might teach a patient recovering from a stroke how to dress themselves.*

The role of promoting independence is the focus of his discussion.

Fig 61

OTA2 *Right...we work with clients on a one-to-one basis and adapt treatment programmes to suit each individual's needs and lifestyle. ..... Well, I would say the core values are promoting independence and enabling people to live their lives in the way they wish to, the philosophy...is to help people to lead full and satisfying lives as independently as possible.*

By the second interview, his focus on the importance of building relationships with clients has changed.

Fig 62

OTA2 *Ok (laugh). I think a core skill an OT needs is to have the ability to form effective working relationships with people who may be disillusioned, disappointed, lacking in motivation...that takes patience, determination and a positive attitude.*

So you would say the main skills are around communication and relationship building?

OTA2 *Well yes, but also the ability to understand and accept other people's priorities and lifestyles. What you might think is appropriate and achievable may not be what they think... you shouldn't impose your views on a client.*

Now, there is a distinct focus on self-awareness and working with people's priorities and decisions, as opposed to imposing one's own. By the third interview, following his placement in an OT department in a mental health inpatient unit, OT A describes the role of the OT in broader language (Fig 56).

The language he uses to describe the role is no longer focussed on equipment or physical, daily living tasks but shifted to centre on the individual client's needs. He refers to client experience and enrichment through activity, as opposed to the physical independence referred to in earlier interviews.

Whilst his course input has clearly had a positive impact on his understanding of the OT role, the placement experience appears to foster an appreciation of the breadth and depth of the role of the OT in mental health work.

Understanding what other professions do

At the first interview OT A states that his understanding of the nursing role does not progress beyond TV drama stereotypes. He does articulate some understanding of the skills and values of nursing.

Fig 63

What do you think the core skills may be for nurses?

OTA1 *Listening and communicating well with patients, um practical skills such as lifting and handling... giving injections and those sort of hands-on interactions.*

What would you envisage are the values and philosophy underpinning nursing?

OTA1 *Um...would it be something about caring for people when they cannot look after themselves and helping them in their recovery? I don't know.*

What about their knowledge base?

OTA1 *Well again, that would be about anatomy and physiology, drugs, the nervous system...that kind of thing.*

Although his understanding is based on the acute general nursing role, his descriptions are quite well informed. He demonstrates a little more insight into the social work role at the first interview.

Fig 64

What about social workers – what's your understanding of their role?

OTA1 *Assisting people who are having difficulties, socially deprived people I suppose mainly.*

How would you describe socially deprived people?

OTA1 *Um, with no job and income, perhaps in bad housing...um old people who are struggling with money and bills on their pension, that kind of thing.*

Ok. How do you think they might assist these people then, what would their role be in relation to those you describe?

OTA1 *Um, sorting benefits for them, knowing where they can go for help, day centres, that sort of thing.*

He demonstrates a basic grasp of some of the tasks that social workers may undertake.

Fig 65

What about social work, what do you think may the core skills required for social work?

OTA1*Um, again, listening to people and being able to communicate well. I would think that being able to explain things to people in ways that can be easily understood would be important.*

(on values) ***OTA1****Um...values and philosophy might be....I don't know I'm guessing it would be...helping people to access services that they cannot access themselves.*

What underpinning knowledge may they need for that?

OTA1 *Good knowledge of benefits and the law and peoples' rights.*

He indicates a basic understanding of the skills and knowledge that would best enable a social worker to carry out their role. However, following his IPE experience with nurses and social

workers, OT A demonstrates more sophisticated insight and understanding during his second interview.

Fig 66

Have you developed any views about the social work and nursing profession over the last few weeks? You said in your first interview that you didn't really know much about them. Has that changed at all?

OTA2 *Well I have spent time with social work, physiotherapy and nursing students in lectures, which means that I have got a broader understanding now of what their work is about, but I can't say that I know what they do. Mind you, I don't think I can say that about occupational therapy either.*

He describes a better understanding of the role, the philosophy, in comparison to knowing what they do in comparison to his first interview (Fig 53). He seems confident with the dual approach that covers both a generic awareness of all roles and a more specialist focus on occupational therapy practice. His understanding of the application of the nurses' role also appears to have developed.

Fig 67

(on skills) ***OTA2*** *I think some of them might be similar...but I would see nursing as providing more distinct treatments when someone is acutely ill, so perhaps choice and working at someone's pace isn't an option. I would say they have more practical application skills as core, around treatments and medicines.*

What about philosophy and values?

OTA2 *I think they are more about caring for people, keeping people comfortable, preserving life, although the equal access thing would be the same.*

He appears more comfortable with how the role of the nurse fits within the overall structure. With regards to social work, his deeper understanding has led to identification and drawing similarities with occupational therapy.

Fig 68

And what about social work. What are their core skills required to practice?

OTA2 *I would say a lot more similar to occupational therapy, around relationship building, communication. Perhaps they need to have more confidence and skill in challenging discrimination; working on behalf of others ... I'm not sure. I think there is a lot more that they have to learn around the law, rights and policies- that sort of thing.*

OTA2 *I think they are similar in many ways, but more about challenging society to treat people equally, with regard to access to services, that kind of thing.*

He identifies that anti-discriminatory practice is the fundamental difference between the professions, with the focus on active challenge within society. Things are not so positive following his work placement, however. OT A is placed in an inpatient OT team within a mental health unit. His experience of the nursing role is not a positive one.

Fig 69

What about the purpose and role of a nurse?

OTA3 *Well from what I saw on the wards it was preventing suicide, managing aggressive behaviour and administering medication.*

Goodness, that doesn't sound too attractive a career option.

OTA3 *Well, it's what I saw. They didn't do much with the clients, know what I mean? Talking or therapeutic activities - they sort of looked to the OT department for that.*

The nursing interventions that OT A has witnessed on his placement are not what he had expected.

Fig 70

(on skills required) OTA3 *Mm, from my experience of nurses in the hospital I'd say completing paperwork (laugh).*

Really, is that what you saw them doing most?

OTA3 *Well, the qualified ones seemed to just spend all of their time in the office. I can't remember what I might have said before…something about caring for people when they are unable to do so for themselves I think.*

Is that what you think now?

OTA3 *Well I didn't really see much caring, more keeping safe. There were definitely some challenging clients that were, well really quite abusive, physically and verbally. The nurses were the ones dealing with that.*

OT A's analysis seems contradictory. On one hand, he describes the nurses as engaged in custodian tasks and not caring duties, but then he goes on to justify that the nurses were adopting this approach in order to deal with the abusive clients in their care. His view from the placement experience is that nurses are hard, distant custodians of clients.

Fig 71

What about professional stereotypes- have any of the stereotypes you held of doctors, nurses, social workers and psychologists been challenged or reinforced during this placement?

OTA3 *I think my perception of nurses has changed, they weren't the approachable, hands on nurses that I had imagined, much more distant, tougher, harder in some ways.*

Ok .What made you think that?

OTA3 *Just the way there were with clients, how they kept control of the ward and the way they maintained the routine I suppose.*

Although he only had the opportunity to work alongside nurses in one inpatient team, his experience has marred his overall perception of nursing approaches and values. He seems to accept that their approaches are necessary to control the ward environment.

OT A was quite scathing in his appraisal of nurses in the ward environment. However, he seemed to perceive a difference in the role of nurses based in community teams.

Fig 72

OTA3 *Well the social workers seemed quite happy to take on the doctors but the nurses didn't, well not the ward nurses. I must say that I would have liked to have had a placement in the community mental health team, the attitude with the staff seemed very different.*

In what way?

OTA3 *Well, they seemed to be more willing to take responsibility, take decisions, take risks. The OT on the team seemed to have a very different role to the ones we had in the hospital.*

Like what?

OTA3 *Well they did much the same as the social workers and nurses, acting as care coordinator, developing care plan.*

So their roles were quite similar?

OTA3 *From what I saw in ward rounds and in meetings, yeah.*

As a result of his contact via CPA meetings, OT A appears to identify similar traits and approaches in all of the CMHT staff. He admires the independence that practitioners exercise and compares it with his hospital placement, where he does not witness nurses challenging medical decisions. From his perspective as an observer in a CPA meeting, he perceives that the roles around care coordination are the same for nurses, social workers and OTs. Consequently, he adopts a broad view that this similarity extends to their broader roles within the team.

OT A's experience has resulted in the formation of a narrow and negative view of the nursing role. In contrast, his contact with social workers, albeit less frequent, has resulted in a more positive experience.

Fig 73

Ok what about the purpose and role of a social worker?

OTA3 *I think its about advocacy, working on behalf of clients to enable them to access help such as finances, benefits, housing and services that they cannot access themselves.*

Following his placement contact, his overall impression is that the social work role focuses on practical issues and advocacy, and he seems impressed by their confidence in challenging medical opinions. With OT A, there is evidence of a significant change in his knowledge of others' roles and attitudes towards the nursing and social work professions as a result of his IPE and placement experiences. Whilst his IPE experience appears to have a positive impact on his attitudes towards and understanding of other professions, his placement experience has had a negative impact on his perceptions of nurses. What we see as a result of his placement experience is a strong alignment towards his own profession and a more subjective view of other professions. This contrasts with the perceptions he held prior to placement.

OTB

Professional identity

OT B gives some indication of identifying herself with her profession at the first interview.

Fig 74

Did you find it easy to find information on OT?

OTB1 *No! Definitely not. Not a lot of people know what we do, most people think its basket weaving and making tea! When I got to the open days at uni that's when things started falling into place. That's where I got the accurate information on the OT role from.*

There is some confidence in knowing *what we do,* and belonging. However in her second interview, she aligns herself to her student identity rather than OT.

Fig 75

Ruth, I know its early days, but do you feel that you have developed an identity as an OT yet?

OTB2 *Umm I don't know. I still feel like a student I suppose.*

This is interesting as she moves on to describe an interprofessional rivalry on her IPE module.

Fig 76

You do some with other professionals don't you?

OTB2 *Yes we are currently doing one with social workers, nurses and physios. The physios hate us.*

Who?

OTB2 *OTs, they think they are better than us.*

Why do you say that?

OTB2 *Well, in one recent lecture the OTs were sat on one side and the physios on another, and this physio picked her chair up and turned it away so her back was to us, and the teacher asked her to move when she came in and she said 'why do I have to move?'*

Gosh, why is there this attitude?

OTB2 *Because you need better grades to get onto the physio course and they think most of us are failed physio applicants. It's not just physios. Another time, we were doing a practical dressing session, helping someone to cope at home, and at the end of the session the speech and language students turned around and said, well is that all you do then.*

The *most of us* relates to fellow OT students so throughout this challenging confrontation she is expressing an alliance with fellow student OTs, rather than the profession. By the third interview, following her placement, she demonstrates an identity as an OT.

Fig 77

Ruth, would you say at this point of your training that you are developing a professional identity as an OT?

OTB3 *Yeah, I think so. Initially on the course I was referred to as the student, introduced as the student. Now I'm introduced as the student OT, and yes I am, but I also feel that I have a part to play, something to offer. Like helping in the sessions. I feel more confident in the role. I feel that I know what to do now. As part of the team, we look at treatment scenarios and plan strategies and approaches as a team.*

Her language suggests that she is moving from student identity towards practitioner. She says *I know what to do now* as if this professional identity was absent prior to her placement experience.

Fig 78

That's really positive. So, you have had the opportunity to work alongside professional OTs here as part of the team, but also alongside nursing and teaching staff. Do you think that you have been socialised in the ways of an OT?

OTB3 *Um…I don't know, that's really difficult.*

Have you felt like part of the OT team, picking up tricks of the trade, or learning better ways to do things other than what you learned in uni?

OTB3 *Well I suppose it's a really nice feeling, to be part of a particular staff team with specialist skills, and as I said earlier, being a student OT rather than just a student. I feel that I have a part to play. We have talked about different approaches and methods used by the unit staff (nurses & nursing assistants), and some of the shortcomings of teaching approaches, but on the whole everyone here appreciates the efforts of the other staff teams. And there are a lot of case planning meetings, so everyone is involved.*

She demonstrates an understanding of roles of others, critiquing approaches and methods used by other professional groups, but not disparaging 'professions' as a whole. She portrays a mature, unthreatened confidence in her professional identity. OT B's IPE experience enables her to identify with the role as a student, but it is her placement that enables her to feel confident in carrying out the role.

Understanding of own role

OT B has experience of learning disabilities through her relationship with a cousin. She has also undertaken a school placement at college and her mother worked in the health care field, but she has no prior experience of occupational therapy. At the first interview she does not seem able to describe the role of the OT, nor the skills, values and knowledge required to carry out the role.

Fig 79

Ok, what would you say makes a good OT?

OTB1 *Um, you've got to be friendly, and be good with people.*

Good interpersonal skills then?

OTB1 *Yes.*

What would you say then are the core skills of occupational therapists?

OTB1 *Umm, I think they are the same as the ones I just said, being a friendly person and being able to communicate well with people.*

By the second interview she seems more able to articulate the basics of her role.

Fig 80

OTB2 *Well, my role is to... teach or help someone learn new skills and abilities which they can practice and will help or benefit them for the rest of their lives. Like dressing practice, if I can do that with somebody so that they no longer need someone to come to their home to wash and dress them in a morning, then it's helping them to maintain their independence further. You are giving people the opportunity to help themselves.*

And what are the values that underpin OT work?

OTB2 *To enable people to achieve independence in everyday life.*

Her description of the role focuses on promotion of independence and uses examples related to physical disability. She goes on placement to an independent school for children with mental health and learning disabilities, within an OT team, but with opportunities to work alongside nurses, social workers and psychologists. By the third interview the core theme of promoting independence is still evident in her discourse.

Fig 81

Ok, What about the core values & philosophy of OT?

OTB3 *Well, it's to enable people to live as independently as possible and where you can enable people to make their own decisions about the levels they want to achieve. Promoting autonomy.*

What emerges from her placement experience is a focus on practitioner autonomy and the responsibility of the individual.

Fig 82

OTB3 *You have got to be able to work well as part of a team, whilst at the same time being a safe practitioner able to work on your own. You need to be well organised, and keep your managing skills on a level where you can manage caseload and paperwork, do it all in one go, you need to be able to juggle things. You need to be able to apply theory to practice, so academic skills are generic too. I think all skills are shared; looking for challenge, flexibility, being approachable. But these are skills needed in all professions working with people, they are not unique to occupational therapy.*

Although OTB's confidence in her role as a student OT seems to develop during the course of the first year, specialist knowledge and in-depth understanding of her own role is not demonstrated to any degree. The main message within her discourse following her placement is a general appreciation of other professional roles and the challenges of managing yourself as a professional. However, she fails to demonstrate any evidence of a deeper understanding of the OT approach, or identify what distinguishes it from other professions.

Understanding what other professions do

OT B states at her first interview that she has no knowledge or insight whatsoever into the nursing and social work roles. By her second interview, she has studied on an IPE module with nurses, physios and social workers, and the impact of this is noticeable.

Fig 83

Ok last time I asked about your understanding of the skills required for nursing. Has you knowledge or insight on their role changed at all since we last met?

OTB2 *Um, we are doing a module with nurses, social workers and physios. They help their patients, just in a different way to us. A nurse or physio is medical, we don't do anything medical like treatment.*

Ok, so if you enable clients what do they do?

OTB2 *Umm (laugh) maintain physical health.*

What skills might they need to do that?

OTB2 *Knowledge of medical treatments, teaching skills and helping people to understand how to look after themselves.*

Ok. Do you have any idea what the values and philosophies may be that underpin nursing

OTB2 *Um, maintaining health and life where possible, I think.*

The notion of medical treatment and health promotion is the key message that OT B has taken from the IPE experience. Her language suggests that she is largely guessing the value base; perhaps because the IPE module addresses role and task but fails to address value base and philosophy. It is a similar result for social work. Whilst her description of the social work role and values is incoherent, she demonstrates a general understanding of the difference between the social work role and the others within the group.

Fig 84

Ok. What about social workers?

OTB2 *They maintain the social and environmental level.*

In what way?

OTB2 *Maintaining the family environment and social situation, helping restore the status quo, the um balance.*

If that's the underpinning philosophy and value base, then what might the skills be that they need?

OTB2 *The ability to work with people and their families, good people skills.*

In her final placement, OT B is placed in an unusual setting, an independent special school for children with mental health and learning disabilities. The placement is within an OT team, but working within a small organisation that employs nurses and social workers, alongside teachers and psychologists.

Fig 85

Ok. You have mentioned the other disciplines you have been working alongside on placement. So has your understanding of the nurses' role developed?

OTB3 *Um, I understand that nurses do basic medical procedures like obs, injections, blood testing, the basics before a doctor is involved.*

Do you have any further insight into the skills they may need, or the underpinning values and philosophies?

OTB3 *Um, I haven't had the opportunity to work alongside them, just being in case planning meetings and reviews, and visiting children on their units where I have seen the nursing staff in action. I don't really have a view on them. Um..the nurses seem a little strict, hard at times , but perhaps that's unfair as they work with the children 24/ 7, they would know best how to approach the behavioural aspects. I think their philosophy is about looking after someone's global needs, whether that be diet, sleep, personal care, etc at all times.*

She seems reticent to voice her feelings, referring to some actions as *a little strict* followed with hard at times, which suggests she witnessed this and felt uncomfortable. Then she goes straight into a defence of their actions, justifying that since they work *24/7* this constant contact will give them the insight into the most appropriate approaches to tackling difficult behaviour.

She continues by describing their approach in relation to the activities of daily living, and refers to them *looking after* people *at all times*. She seems to be excusing the hard line described earlier in her description of their global priorities around looking after the individual. Again, her reference to 24 hour working seems to suggest that she perceived this to be a challenge, perhaps difficult.

There is some development in her knowledge of the nursing role from her contact within meetings and on the units, but her perspectives on their approaches and philosophy are shallow and lacking substance. Similarly, her understanding of social work roles is vague.

Fig 86

Ok. What about social work, what about the skills, underpinning values and philosophy?
OTB3 *They don't have to specialise, they work across the client groups. Their role is to help normalise things. Like with children the social worker would concentrate on returning the child to normal life.*
So their philosophy is normalisation?
OTB3 *Well yes, helping people to live day to day with essential requirements such as housing, income, education, employment, well I'm not sure that they focus on employment actually.*
What kind of skills may they need to do this role?
OTB3 *I think counselling skills, negotiating skills, dealing with families.*

OT B describes the approach of social work in the context of her placement as working with children, although when describing the philosophy she draws on her learning from the IPE experience, since she describes work with adults. Her insight into the role has developed, but not as a result of working alongside social workers on placement, more through IPE experience validated and reinforced by placement experience.

OT C

OT C only took part in two interviews, one at the beginning and one 12 weeks into the course. Since she experienced IPE this enables some evaluation of the impact on her professional identity, knowledge of role and understanding of other roles. However, it does mean that placement impact cannot be evaluated.

Professional identity

OT C does not demonstrate identity with the profession within the first interview, although she describes the role and skills with confidence.

Fig 87

OTC1 *Occupational therapists help people to cope with disabilities or problems that can be the result of physical or mental illness, an accident, or just getting older and more frail.*

Ok what knowledge base might be needed?

OTC1 *Um, some very practical knowledge about services and equipment. For instance, if you need to provide specialist equipment such as a shower chair, a hoist to help a carer lift someone, or arranging adaptations such as a stair lift, then you need to know how you access those things, where they come from.*

However, the impact that IPE has on her external perception of professional identity is significant.

Fig 88

Would you say, Claire that you have developed a professional identity yet as an OT?

OTC2 *Um , that's hard to say. When we have been in mixed lectures with other professionals, I suppose you feel that you are representing occupational therapy, that you should defend it somehow if it comes under fire. But I'm not an OT yet, I've got a long way to go.*

Do the other trainees understand occupational therapy then?

OTC2 *No, they have the usual misunderstanding, like we do basket weaving and clay modelling, or that we just help people make cups of tea.*

Oh gosh, really?

OTC2 *Well those of the sort of things they say as jokes but I really don't think they appreciate the breadth of things that we do.*

There seems to be reticence in her phrase *I suppose you feel that you are representing occupational therapy, that you should defend it somehow* almost reluctantly, *I'm not an OT yet, I have a long way to go*. This may indicate that she does not identify herself as an OT yet, or that she does not know enough about the profession to defend it properly. However, her reference to the *usual misunderstanding* demonstrates some allegiance to the profession, in that misunderstanding of role is something to be expected. She also alludes to appreciating a breadth of the OT role and belonging to the profession. Her IPE experience seems to enable further development of her professional identity as an OT.

Understanding of own role

OT C has insight into the role of the OT via the care and support that her grandmother received from an OT in a community team. At the first interview she seems to demonstrate a broad understanding of the role of the OT (Fig 87). Her description of the skills and value base give the impression that they are drawn from her personal experience with her grandmothers' OT.

Fig 89

OTC1 *Um, core skills. Well being an approachable person with a practical approach to problem solving .Um, you've got to have common sense and be able to find workable solutions to problems with everyday living.*

Ok, so very practical skills?

OTC1 *Well yes, but also the ability to motivate people who are not really able or aware of what their limitations are…….. Um, values would be a strong desire to help people.*

Previously OT C describes the problems she encountered whilst caring for her grandmother with Alzheimer's disease and how the OT provided valuable practical assistance. The skills

she outlines seem to describe all that she identified as positive and helpful in her grandmother's OT. She draws on personal experience and refers to finding *workable solutions* and working with people who are unaware of their limitations.

In her second interview, OT C continues to highlight interpersonal skills related to engagement and motivation.

Fig 90

OTC2 *Right. A sense of humour ,with good communication skills . You need patience, determination and a positive attitude to deal with people who may be very unmotivated.*
Why might the people you would deal with be less motivated that other people?
OTC2 *Well, any patients that have a condition that is only going get worse over time, like dementia or multiple sclerosis, which means they gradually become less mobile and more disabled. It's really important to have a positive attitude and helping them to retain independence for as long as is possible, and even then making sure that you enable them to make choices for themselves about how they want to be cared for.*

However, she talks in greater detail about the assessment function of the role.

Fig 91

Could you explain for me what the main professional roles of an OT are then?
OTC2 *Well, assessing people's needs, social and daily living skills, employment and work abilities and opportunities, um carrying out in depth assessments of people's abilities regarding daily living, domestic skills and cognitive functioning.*

Ok.

OTC2 *A large focus is on the physical such as mobility assessments, putting in adaptations in the home. But from the mental health aspect is can be things like encouraging someone suffering with depression to take up a new interest or rekindle something that they were good at in the past.*

She gives an example of the kind of intervention that an OT may carry out with someone who has a mental health problem. This is not evident in the discourse with the other two OT students. Again, this may be OT C drawing on her own experience as a reference for the role. What seems to be a new feature in her discourse regarding the role is reference to promoting and enabling independence.

Fig 92

OTC2 *Um I think the overarching philosophy is enabling a person to live as independently as possible* **...** *we take a holistic approach to the whole person, including their aspirations, interests, and beliefs.*

She also refers to '*we'*, suggesting that she now feels part of this profession and more confident with the role. Her understanding of the OT role has developed over the course of the first 12 weeks, broadening her views from those elements of the role she identified through her personal experiences.

Understanding what other professions do

OT C does not demonstrate any understanding of the role of nurses or social workers at first interview.

Fig 93

OTC1 *I don't know (giggle) I don't know what nurses and social workers do really. I saw a bit of what the nurses did when my Nan was in hospital, but they didn't seem anywhere near as helpful as the OT was to my Nan.*

However, her second interview following IPE yielded different responses.

Fig 94

In that respect Claire, what is different about the core skills nurses may need?

OTC2 *Well I don't think they are doing the same job. They work with the illness, or condition, and administer treatments, so their skills are similar in as much as they need to be good communicators and to be able to build up a good relationship with people, but it's not about helping someone to function to their optimal level in day to day living tasks, it's about treating an illness.*

So any idea about what their required core skills may be, above communication skills and relationship building?

OTC2 *Um, I don't know. It's more about knowledge to me, of being able to feel confident in leading someone's treatment, treatments and approaches to problems relating to illness.*

Ok. What about nursing, the values and philosophy?

OTC2 *Um I have to say I don't really know. But I would say something about helping people who cannot help themselves, saving lives, dignity and respect, something like that.*

In contrast to the lack of knowledge and insight demonstrated in her first interview, OT C now speaks confidently about the focus of the nursing role and the medical model of illness and treatment. She seems to be able to identify common skills with OTs in communication and relationship building, whilst speaking confidently about leading treatment and illness related approaches.

The development of her understanding of the social work role is also dramatic.

Fig 95

Ok, what about the core skills of social workers?

OTC2 *Umn, I'd say the basics as with nurses around relationship building, confidence and um good communication skills, but more specifically being able to challenge people on others behalf, like advocacy.*

Challenge who - people or organisations?

OTC2 *Well, yes, people in organisations, the rent office, benefits agency, housing associations, any one that they need to settle problems with on behalf of the patient.*

Ok. What about social work?(values)

OTC2 *Um, I'd say values are about preserving people's rights and ensuring they have equal access to services…um protecting vulnerable people perhaps.*

Now, she confidently defines similarities and differences between nurses, OTs and social workers. Although referring to patients, she is able to give examples of some of the agencies that social workers would be dealing with on behalf of clients. In both cases she suggests that she is, at best, guessing the values of nurses and social workers. So whilst the different value bases have not been explicitly explored in the IPE module perhaps, her basic knowledge of the roles is markedly increased by the second interview.

SW A

Professional identity

SW A demonstrates identity with the profession at the first interview. She does not use the term social work, but in relating to her previous experience she describes the role of mentor, relationships and strong bonds, as if these are what she identifies as core social work approaches.

Fig 96

Ok. So What do you think makes being a social worker preferable to the other professions?
SWA1 *I suppose the engagement, working directly with people. My experience is in children and families. My experience was working for a voluntary organisation called Re-entry which helps children get back into mainstream education, so my role was to befriend them and act as a mentor. The relationships were strong, the bonds were strong so was something you could work with for months.*

Her language intonates that she is already a member of the social work profession. By the second interview, however, SW A's identity is more aligned to that of a student.

Fig 97

Do you feel Rebecca that you have a professional identity yet– do you feel like a social worker?

SWA2 *I don't feel like a social worker, no. I feel like a university student.*

So you are beginning to feel like a social worker, identifying yourself with the professional role?

SWA2 *I think that we are learning the core skills, well the theory behind the social work role. We have been given information and booklets on professional standards of behaviour, and what will be expected of us out there on placement, that's been really helpful. I don't feel like a social worker yet though.*

She has shifted from the hands-on job role identified in the first interview to describing a learning role, and the theory behind the role, rather than the skills required. At the third interview, following a placement in a social care day centre housing a multidisciplinary CMHT, her identity is not as strong as she indicated that she would like it to be.

Fig 98

Ok, thanks. How confident would you say you are now in your own professional identity and ability to function independently in a multi disciplinary team?

SWA3 *I think I have a good understanding of the role and I feel confident with theoretical underpinning models, but I am a little apprehensive about putting it into practice. Next I will have a caseload on placement, so although a student, I will feel like a social worker…I hope! This placement just wasn't long enough to get my teeth into.*

Her apprehension about putting theory into practice seems to indicate that she does not feel she has had the opportunity to practice as a social worker on her placement. She identifies having a caseload as critical to her [*feeling] like a social worker*, perhaps in reference to responsibility and autonomy. Whilst, she refers to the experience as *comfortable* and *really interesting* she is clear to express that it *wasn't long enough* suggesting that it has only begun to develop the skills required by social workers.

Fig 99

SWA3 *I felt comfortable doing this. I have found it really interesting here, developing the skills I am going to need as a social worker, the people skills, the assessment skills.*

This is further reinforced by her identification with [*development] of a professional manner* rather than professional social work identity.

Fig 100

SWA3 *Through my experience I now feel like a professional, as I have developed a professional manner.*

So you feel confident now in understanding what the role of the social worker is?

SWA3 *Um, I don't know about that. I have been on placement in a mental health day centre, here at xxxxxxxxxx . So , there aren't many social workers, qualified ones on the day support and outreach teams. The CMHT is part of the overall service here at the centre though, and there are social workers, well ASWs in that team.*

It seems that exposure to the social care perspective within a social care team has not been enough to engender and develop her professional identity; there has not been a consistent role model.

Fig 101

Right. Have you had a chance to spend time with those social workers?

SWA3 *Yes, I have shadowed them and been on visits. My placement supervisor thought it would be important to see the job from both angles, really.*

So, are you saying that you feel like a social worker now, or like a mental health professional?

SWA3 *Umm, I don't know, probably a professional mental health worker. I'm not sure how different the roles all are really.*

SW A is reluctant to identify herself as a social worker and the absence of a professional role model has left her in some way confused about clarity between roles. In the first year neither her university or placement experience enables her professional identity to develop. Yet, she

demonstrates her highest level of confidence in her social work identity at her first interview, based on experience prior to starting the course.

Understanding of own role

Prior to starting the course, SW A has been exposed to social workers via experience in a voluntary care provider for children, but her understanding of the role is fairly vague and her discourse describes the requirement to have a general desire to help people (Fig 96).
In her first interview she relates to her social care work experience in terms of developing and maintaining good relationships.

Fig 102

What are the underpinning models and beliefs to social work practice?
SWA1 *You have got to be able to want to help people from all walks of life with whatever their problem is. Wanting to help and befriend people and help them to keep independence wherever they can.*
So, what do you think makes a good social worker?
SWA1 *Um…..Giving time to people, and helping where you can.*

Twelve weeks into the course the taught element is clearly having some impact as she describes the importance of a non-judgemental approach.

Fig 103

How would you describe, then, the philosophy, core values and beliefs that provide a foundation for social work?
SWA2 *Um, respect for choice…….. treating people with respect, and enabling people to make choice.*
Could you tell me what you think the unique core skills of social work are?
SWA2 *Um, to have the knowledge to be able to help people access the help and services they need. To view people as individuals…and to not make judgements about people and their ways of life.*

She identifies that underpinning knowledge is required to enable a social worker to be helpful, but her knowledge of the social work role and related philosophy is not articulated at this stage. SW A goes on to a placement in a social care provider day service. Although there are no social workers in this team, she is based in a resource centre where there is a CMHT and she has the opportunity to spend time with the ASWs in that team. However, it is clear that this placement does not enable her to develop a deeper understanding of the role. In Fig 101 she alludes to the fact that her placement has been in a day centre within a mental health resource centre.

Fig 104

SWA3 *Umm when you say social work, do you mean the social care perspective? The core values are the same, enabling and assisting service users to achieve their potential, maintain independence, that sort of thing.*

Her inability to differentiate between social work and the social care perspective is evidence of a blurring of role perception and a lack of professional modelling on placement. In Fig 99 she states that she has confidence in her knowledge of theory and the role, but is apprehensive about applying the knowledge. Her understanding of the role is not articulated well during the interview, but her apprehension at putting theory into practice is probably based on the fact that she does not feel that she has had a social work placement and has be unable able to practice the social work role. Neither her university or placement experience have significantly developed her understanding of the social work role.

Understanding what other professions do

At the first interview, SW A indicates that she has a very superficial understanding of the nurses' role.

Fig 105

Why did you think social work was more for you?

SWA1 *Because nursing, I liked the CPN area. I know this sounds silly, but I'm not into injections and drugs and stuff. So if that's a no no straight away, like much of the training is hospital based.*

What would make a good nurse, and what would the skills be?

SWA1 *You have to be caring, and have a good all round knowledge of different conditions and treatments.*

She has even less knowledge and awareness of the occupational therapist role.

Fig 106

What about OTs, do you know much about them?

SWA1 *No, I don't.*

Would you have an idea what the role is, and what skills they may need?

SWA1 *Are they mental health workers?*

At her second interview, she describes again the focus on ill health and disease but cannot offer a more informed understanding of the nurses' role.

Fig 107

Ok, and nursing, has your knowledge or insight into the skills a nurse may require changed since we last met?

SWA2 *I don't know I can't remember what I said last time, umm…. Being caring and sensitive …..… and warm and helpful I suppose.*

And how are these (social work values) different to the philosophy and values of other healthcare professionals?

SWA2 *Well, I think that nurses have very wide ranging skills and abilities, mainly focused on ill health and disease. Doctors are more specialised and take on leadership roles. I don't know much about any other healthcare roles, um, nursing assistants maybe.*

Her understanding of the OT role has not developed. Her third interview takes place at the end of her placement, which has been in a social care mental health provider service within a health and social care resource centre. Now, her understanding of the mental health nurse role has developed considerably.

Fig 108

What about nursing. Do you have further insight into the skills required by nurses?
SWA3 *I think so, I've had quite a lot of opportunities to see what they do, and they have to have a lot of skills around treatments, different types, and putting care plans together, trying to bring together other workers who are involved, and sort of organising things really.*
Did the social workers and OTs not take on these roles too with the care programme approach?
SWA3 *Yes, I suppose so.*

She describes encounters with nurses that have been inclusive and informative and notes that she has been able to observe them in practice. She describes the care coordination element of their role and perceives it as something they do well.

Fig 109

Ok, what about the values and philosophy that underpin nursing, have your views changed at all?
SWA3 *Um, I think they focus a lot more on recovery and getting people better and keeping them well, to a level that they are happy functioning at, rather than quick fixes. Does that make sense?*
I think so, are you saying that they don't work towards a cure, but more around management of symptoms and working at the clients pace?
SWA3 *I think so, I thought it would be more short term focussed, you know.*

Her understanding of the nursing role has evolved from one confined within an illness and disease model, focussed on treatment and medication, to a broader view of recovery focussed

work and care coordination. Unfortunately, her placement has not provided opportunities to develop her understanding of the OT role.

Fig 110

Ok. What about OTs, did you get a chance to spend time with them?

SWA3 *Um, they were in the team, I just didn't see much of them. There was an OT, xxxxxxx, but I can't say that I saw what she did.*

Did you come into contact with her in meetings or care programme meetings?

SWA3 *In the weekly CMHT meeting, yes she was there. She seemed very nice, but I can't say I worked out what she did.*

So you wouldn't be able to tell me what skills an OT needs, or the values and philosophies underpinning OT?

SWA3 *NO, not at all.*

Despite attending team meetings with the OT, she has not gleaned any insight into the role. SW A's placement experience has enabled her to understand the relationships between professions and agencies.

Fig 111

Right, so what about how these teams work together?

SWA3 *Um, I think I now understand better how the nurses and doctors in the community teams relate to the wards, and how the social workers in the community teams don't seem to work that closely with other social work team. They are part of the health team, if you know what I mean.*

Yes, they are seconded across aren't they?

SWA3 *I think the social workers work closely with the nurses, outreach workers and doctors, although there are still many hierarchies and games being played.*

Interestingly. SW A's placement is in a health and social care resource centre but not in the CMHT. She is placed in the social care provider arm of the service and this seems to have provided a different perspective. From a distance, she observes the work of social workers in the health team and identifies that they work closely with nurses and doctors. She also notices close working between the social care staff on her team. Interestingly, she observes a lack of relationship between social workers in community mental health teams and their professional colleagues in community Social Services adult teams.

Fig 112

What impact do you think that working in a multi disciplinary team, well indeed the wider multi disciplinary service that you have been working in, has had on your perceptions of other professions, maybe any stereotypes that you may have held?

SWA3 *Umm, I have spent my time trying to find who does what, what the processes are, what service are available, and I don't think that it has felt like different profession to me, just different processes and systems.*

Here she seems to describe a blurring of roles, not differentiating skills, roles and approaches, but focussing on processes and systems that differentiate services and teams. However, she goes on to demonstrate clarity in perception of differences between the roles and approaches. Her description of the nursing and social work roles seems balanced and something she is at ease with. She appears to understand the medical and social models and how they work together. She does display a lack of identity with her profession, and talks about social workers as another profession. This disembodied perspective may have been influenced by her placement in a team which does not have a strong professional focus; she has problems describing the staff identity in her team.

Fig 113

SWA3 *I suppose when in the CMHT allocation meetings the nurses came across as I expected them to, focussing on medication and diagnosis.*

Really, was it that obvious?

SWA3 *Yes, and I sat in a couple of CPA reviews and outpatient appointments, and the doctors were definitely in charge, controlling and running things.*

Right, so within your own team, the day support and outreach team, you didn't see these roles?

SWA3 *No, the staff weren't social workers, well, some of them were, but most were…um counsellors I think, day centre officers they were called.*

So has this placement given you an insight into the roles of other health and social care professionals within multi-disciplinary mental health teams.

SWA3 *I think so. I mean…..nurses follow the medical model and social workers follow the social model. Nurses need to have a good understanding of illness and medication, to work with the doctors, whereas social workers look at all aspects of a person's life, day time activities, employment, housing etc. The two roles to work together hand in hand. Social workers need to know the law, although nurses working in mental health would need to have some understanding.*

For SW A, the placement within the provider arm of a mental health service has not enabled her to develop a deeper level of professional identity, nor does it appear to offer a better understanding of the social work role. What her placement experience does offer is the opportunity to develop her understanding of other roles within the mental health care system but this appears to be at the expense of a deeper understanding of her own.

SW B

Professional identity

SW B identifies the role of social workers with those who cared for her when she was in care. This identity is strong.

Fig 114

SWB1 *The people who looked after me in care were, well mostly really great to me. I feel that I want to repay them…the system for looking after me so well. I want to be a social worker and make a difference to peoples' lives.*

So would you say that you choose this career, or has it chosen you?

SWB1 *I think social work has chosen me, and I know I will work in children services at some point, to repay my debt, but I am really interested in mental health.*

By the second interview her identity has shifted to a less confident alignment with the student identity.

Fig 115

Would you say that you have a professional identity, as a social worker?

SWB2 *I think that I am a student social worker, and I have a long way to go before I can say I'm confident as a social worker- I have a lot to learn.*

SW B is comfortable to identify herself as a student but she is not confident in the social worker role. However, her confidence in both role and identity as a social worker develop markedly by her final interview, following her placement.

Fig 116

Ok. What approaches are used in social work, in mental health?

SWB3 *Approaches used in social work…um we provide a mixture of practical interventions and well, counselling really, coming from a humanistic approach rather than a treatment or illness approach.*

The use of *we* indicates a sense of belonging to the profession. She proceeds to explain how she views her profession as possessing an approach preferable to other professions.

Fig 117

SWB3 *Well I think that some of the other professions have very specific interventions, treatments, models, that I think they slot people into very easily. We as social workers don't have diagnostic tools, specific questionnaires and measures like the psychologists, or medication to prescribe. I think it's harder to stand back and take the time to get to know a person and the world that they inhabit, before establishing how you can best help them, on their terms.*

Whilst demonstrating professional identity as a social worker, she also demonstrates an understanding of the overlapping roles within MDTs in mental health.

Fig 118

Well, do you feel that you belong to that profession, that you are now part if it?

SWB3 *Well yes, I am still a student social worker, but I feel that the role is much broader in the mental health setting, all of the roles are.*

This language may indicate a blurring of the boundaries between the approaches she articulated earlier, or it may be indicative of the comfort and confidence she feels working in mental health settings. SW B's placement experience definitely enables further development of her professional social work identity.

Understanding of own role

SW B has insight into the social worker role as a result of being in care as a child. She has also worked in a voluntary capacity in a community Asian women's service. At first interview, she describes the holistic element of the social work role.

Fig 119

What do you think makes social work different, or even preferable to the other professions?

SWB1 *Well I think it's about seeing people as a whole person, you know, all of their needs; love, housing, money, education, the things that all of us need.*

What would you say makes a good social worker?

SWB1 *Someone who is non-judgmental, who does not impose their values and views on other people, but who really wants to enable people to improve their lives.*

The non-judgmental value base is key for SW B, but she also emphasises the importance of the knowledge that is required to be useful to people.

Fig 120

SWB1 *Um, the values are around being non- judgemental, enabling people to realise their own potential, empowering people, preserving rights.*

Ok so what are the core skills needed to be a good social worker?

SWB1 *Um, well, knowing the law, knowing people's rights, what they are entitled to, knowing what services people can access.*

So you would say its knowledge rather than skills?

SWB1 *Well you need the knowledge along with a non-judgemental approach - it's an approach, an open way of thinking.*

Do you think this approach or way of thinking is unique to SW or is it shared amongst other health and social care professionals?

SWB1 *Um, I think anyone working with people should understand people's rights, but I think people look to social workers to know what people are entitled to, especially in the way of benefits and housing and such.*

SW B talks about society's expectations of a social worker as the holder of knowledge about access to services. In interview two she describes this element as unique to the social work role.

Fig 121

OK. Could you start by describing for me what the unique core skills of a social worker are?

SWB2 *Having a non-judgemental approach to individuals, knowing people's entitlement to support and help and services and being able to help them to access it.*

However, she also talks about the choice navigator element of the social work role and the fundamental anti-discriminatory practice values.

Fig 122

Could you tell me ....., what your understanding is of the philosophy and core values that provide a foundation for social work?

SWB2 *The belief that someone has the right to live the lifestyle of their choice, and should be enabled to make choices that enable them to do that.*

Ok. What about the values that underpin social work?

SWB2*…um core values are non-judgemental approach, unconditional positive regard for people, and equal opportunities for all irrespective of race, gender, culture, religion, etc.*

SW B demonstrates a good understanding of the social work role prior to her placement experience. Following her placement in a CMHT, anti-discriminatory practice is still a key element, but it is mediated by the responsibility of protection.

Fig 123

Ok. What is the value base that underpins this work and what are the approaches used?

SWB3 *Values…well, the code of practice for social workers spells out the underpinning values. I can't remember all of them, but for me the main focus is on promoting independence and respecting the rights of service users, whilst protecting them and other people from harm. Ummm…empowerment of individuals and anti-oppressive practice are key.*

Her choice of words shifts from *preserving rights* and *entitlement* to the use of words like *respecting rights* whilst *protecting them and others*. This slight change in emphasis may be a result of some of the difficult decisions she would have faced on her placement, regarding the balance of rights and risks. Another new aspect on her understanding of the role is an appreciation of a person's distress as a result of their environment.

Fig 124

Right. Would you be able to explain the philosophy and beliefs that provide a foundation for social work?

SWB3 *Philosophy….um...we see the individual as social beings which are a product of their environment - including family, friends, income and housing, employment and health. I think the fundamental belief is that we should respect the service users' views and it's not our place to be judgemental.*

Do you believe there are core skills unique to social work?

SWB3 *Erm, I think it's a skill to be able to reflect on your values and be aware of your prejudices, being open and honest with yourself and constantly being aware of how these may impact on your practice.*

What is evident from this discourse is an acceptance of the responsibility for practitioner reflection in action. She also identifies herself as a member of the social work profession and articulates well some differences between social workers and other mental health professions (Fig 120). SW B describes the challenge of contextualising distress on an individual basis and how the approaches used by other professions do not address this. This mature and reflective appraisal of the social work approach demonstrates the impact of the placement experience and her deepening understanding of the social work role in practice.

Understanding what other professions do

At her first interview, SW B gives a brief description of what she understands to be the role of the nurse.

Fig 125

What skills do you think a nurse might need?

SWB1 *I would say people skills, putting people at ease, not being squeamish or tickle stomached when dealing with vomit and blood.*

Would you be able to describe what the value base and philosophy might be that underpins nursing?

SWB1 *I dunno, looking after people, keeping them free from pain, making sure they have access to treatments.*

She describes a role focussed on physical care, in effect a general nursing role. She knows nothing of the occupational therapist role at this stage. However, she does make a broad comparison between health care and social work approaches.

Fig 126

How is (sw) that different to the other professions?

SWB1 *Well, they focus on illness and specific problems that need treatment, not the whole person.*

Although she has not had contact with other professions by placement or IPE, her dichotomous view of the approaches of social work and nursing has altered by the second interview.

Fig 127

Have your views about the skills required for nursing changed at all since we last met?

SWB2 *No, I haven't learned anything about the nursing roles.*

What about the values and philosophies that underpin nursing?

SWB2 *I suppose when talking about social work values and philosophies you start to think that they probably apply across all of the helping professions, you know? They are probably the same as social work in nursing.*

Her reflection on her personal learning around values and philosophy relating to social work prompts her to think in broader terms about the values and philosophies of the other helping professions. At her third interview, following a placement within a multidisciplinary CMHT, her understanding of nursing and OT roles is unclear. On one hand, she takes a strong stance in defence of social work values whilst suggesting that health care workers impose treatment on unwilling clients (Fig 120).

There is a clear expression of '*them*' and '*us*' in her discourse. She emphasises that social workers get to know the person and involve them in the planning approach, rather than

operating independently of the client. This is reinforced in her views on the skills required for nursing.

Fig 128

You discussed nurses. What are the skills you think they may need to carry out their role?
SWB3 *I think the confidence to apply treatments and approaches without really knowing someone, without having had the time to build up a relationship and know that it is something you have chosen, it's like the medication. Thing is, they are happy to give it whether a client wants it or not, just because it's been prescribed by a doctor.*
So this is more of a value base or underpinning philosophy issue, isn't it?
SWB3 *Um I suppose so, it's a we know best philosophy. Not client knows best.*
Do you think most nurses would be willing to enforce treatments that clients are unhappy to receive?
SWB3 *I think so yes, if they are satisfied that it is in the overall best interests of the client's health, but I think most of the time they do not have that foresight.*

SW B seems to suggest that the nurses' approach to administering treatment is wrong. She implies that they lack insight, rather than purposeful disregard for clients' wishes. However, she then explains that approach is dependent on the individual and not specific to the professional role.

Fig 129

You refer to some of the other professions within the team. Do you think that the experience that you have had working alongside them has had an impact on your attitude towards them or any stereotypes you may have held?
SWB3 *Um, I think working alongside people helps to dispel stereotypes as you get to know the people and realise that it's the person, the individual that matters, not the profession they trained in. You know, there are good nurses and bad nurses, the same goes for social workers.*

This response contradicts her previous views. Until her placement, SW B had no insight into the OT role. On the placement she had the opportunity to work alongside an OT.

Fig 130

Was there an OT on the team?

SWB3 *Yes, xxxx*

Did you have the opportunity to find out about their role?

SWB3 *Um, I shadowed her doing a couple of assessments, and sat in on a couple of CPA meetings she ran. Um she seemed to be a very capable worker, but I would struggle to say she did anything different to the social workers.*

Would you be able to say what skills an OT needs?

SWB3 *I think the people skills required to enable you to carry out an assessment of someone's mental health problems and their abilities and needs.*

Ok. What about the values and philosophies that underpin occupational therapy?

SWB3 *Oh I don't know about that, no I would be presuming.*

From this discourse, SW B demonstrates understanding of core elements of the OT role that are similar to social work, such as carrying out assessments and the care coordinator role. She does not differentiate between the OT's role and her own, and she does not identify any specific roles, approaches or philosophies that are unique to OT. Apart from describing strong feelings of discontent with medical approaches to treatment, the overall impact of the placement on her understanding of other professional roles is unclear. Across the course of the year, however, there is a definite development in SW B's perspective on, and understanding of the roles of others, which seems to be largely influenced by her placement experience in a multidisciplinary team.

SW C

Professional identity

At the first interview, SW C imparts a passionate view of the identity of the profession.

Fig 131

Have you considered nursing as a profession, or any of the other health roles such as occupational therapy?

SWC1 *Um, not really. I feel that social work addresses all people from all sections of society and empowers and enables people to make choices. A lot of the health care professions are very hierarchical, and the medical model does not empower people to make decision for themselves.*

Right. Is it the enabling, non hierarchical approach that makes a social worker different, or even preferable to the other professions?

SWC1 *Well, the medical profession specifically I think, yes. It's not imposing a treatment or making a judgment, its enabling people to make decisions for themselves.*

By the second interview this confidence is held in check by her perceived lack of practice.

Fig 132

How about yourself? Do you see yourself as a social worker?

SWC2 *No not yet, I'm a student social worker. I don't mean I haven't got the skills to be one, I just haven't practised as one yet.*

Do you feel that you have started to develop a professional identity yet?

SWC2 *Well if you were to ask whether I see myself as a social worker in comparison to other jobs like nurses, then I would say yes, I have an identity - as a social worker.*

However, by the third interview, following her MDT placement, she conveys confused messages.

Fig 133

How confident do you feel now in your own professional identity as a social worker, would you know your role and function within a multi disciplinary team?

SWC3 *Um…I think I would know what I am supposed to do, but I would not have the confidence to challenge other professionals regarding their role, as I don't understand it enough. I would challenge unethical or bad practice, of course.*

She is not confident of her role as a social worker in the team and she does not feel that she understands other professionals' roles well enough. There is an element of role blurring.

Fig 134

So do you feel that your professional identity as a social worker has developed as a result of being on placement?

SWC3 *Well I think I have a good idea what social workers do in a CMHT, but I think the roles of the team are pretty similar, apart from the very specialist social work responsibilities.*

What were these?

SWC3 *Um, mental health act assessments, vulnerable adult assessments and some other things relating to the Mental Health Act processes.*

SW C identifies similarities between MDT roles and is able to articulate the specialist elements of the ASW role. Over the year, SW C's perceptions of professional identity do develop but the impact of the placement experience on this is not conclusive.

Understanding of own role

SW C has previous experience of working with people with learning disabilities in local authority and independent care provision. At her first interview, she is able to proficiently articulate why she has chosen the social work role over health care roles (Fig 131). She describes the medical profession as '*judgmental'* and '*imposing'*, as opposed to the '*empowerment'* and '*promotion of independence'* within social work. She also focuses on the choice navigator element of the role.

Fig 135

Can I ask you then, what you think the core skills are that are needed for social work?

SWC1 *Core skills…empathy, being able to help someone to make a decision or choice about the direction they want to go in, and I think like I said before, knowledge of the services and options available.*

SWC1 *I think the medical professions and the skills they need focus more on giving a treatment and working with illness, rather than enabling people to choose how they want to be helped. I think the skills of enabling people to make choices lie within social care and voluntary sector services.*

She articulates set views of the medical profession suggesting that treatment is imposed on people, as opposed to social care where choices are offered. She clearly articulates anti-oppressive practice and equality of access as the underpinning values of social work.

Fig 136

What do you believe are the values, knowledge base & philosophy that provide the foundation of social work?

SWC1 *Umm, value base is around protection of human rights, equal access for all, non discriminatory, anti-oppressive approaches to people. Justice and equality.*

She proceeds to set these values within a context of professional responsibility and realism.

Fig 137

SWC1 *Um, someone that is knowledgeable about the services and resources out there that are on offer to help someone, yes, you need to have knowledge of what you can access. And um… being non-judgmental, definitely no snobby middle class people pretending to understand someone's situation that lives in a council flat with 6 children and no income!*

Her responses are passionate, but in some ways contradictory. Several times she asserts that social workers must be *non-judgmental* but follows swiftly with a judgemental comment about middle class people. There does appear to be a deep understanding of a person's distress as a direct product of their environment at this early stage of training.

Fig 138

SWC1 *Um, the knowledge base is around people's rights, models of understanding people, development, how they cope with life and the impact this can have on their abilities. Um….understanding of the influence that poverty, education, illness, wellbeing and family relationships can have on an individual.*

Her confidence in her knowledge of the social work role remains evident in her second interview.

Fig 139

Now I'd like to start, if I may, by asking what you think the unique core skills of sw are?
SWC2 *Um, I would say that social work is a systemic approach, and the theories that underpin it are based within the social model and its focus on equality regarding race, gender, sexuality…and so on.*

Her views on health care professionals are still fixed and negative.

Fig 140

What skills does an individual need to carry out social work, that are not required by say, nurses or occupational therapists in the same way?
SWC2 *Oh, ok. Um, the ability to focus on the individual person, and work with them in a non- judgemental way to achieve their own goals, I would say that nurses and OTs don't use that approach as they are focussed on implementing plans and treatment approaches.*
Right, so what skills do you have that would help you to do that?
SWC2 *Um, I'm not afraid to meet people where they're coming from. I'm not shocked by anything, and I don't feel the need to transfer my values to someone else, how they live their life is fine by me. I would also say I can build a rapport with someone quite quickly, on a professional level.*

The directness and self-assuredness of her approach to her role projected by her words is almost intimidating. Her use of absolutes gives the impression that she is angry, although she is assured that her principles and skills support the social work role. The interview following her multi-disciplinary team placement (Fig 134) sees quite a change in attitude, however. In this discourse, there is an absence of strong defining lines between the social and medical approaches as she states that the roles '*are pretty similar'*. Her direct experience has had an impact on her confidence.

Fig 141

Has your knowledge increased as a result?

SWC3 *Well, there is a lot that I now feel that I don't know! To be honest, I visited one of xxxxxxxx clients with him who he later had to section, and I was really quite scared. I was surprised to find out how much of the sectioning process, the responsibility I mean, lies with the social worker. That's quite scary.*

What did you find scary, the responsibility?

SWC3 *Yes. no, the power that the social worker has over someone's' life. Those decisions are life changing. And there are some people on my course that quite frankly, well it scares me to think that they will have that power one day.*

SW C admits to feeling scared whilst taking part in a client assessment, but it appears that the challenge of making decisions on behalf of a client and having to relinquish her ideals of always offering choice cause her the most discomfort. Her underlying values have also been tested in other ways.

Fig 142

Ok, during your exchanges and experiences with clients on this placement, have your values been challenged in any way?

SWC3 *Well, there were a few clients that were a pain in the arse I mean, very stroppy and difficult and I found my patience ran out with them fairly early on.*

Really? What kind of difficulties were they experiencing?

SWC3 *Well one had a personality disorder and she ended up running us all around in circles, threatening suicide, trying to get admitted, getting vulnerable adult referrals through to us via the police on a weekly basis, it's easy to see why some workers get fed up with some clients, you can only do your best.*

As evident from her choice of language, SW C challenges her previous non-judgemental values by referring to clients as *stroppy, difficult* and *pain in the arses*.

She is also quick to use a medical illness label for the client with the personality disorder.

Fig 143

Yes, this client group can present quite challenging behaviour.

SWC3 *Another client kept cancelling appointments, not turning up for things I arranged with outreach and day care and, well, I just ended up very frustrated, not getting anywhere.*

In what way do you think these experiences challenged your value base?

SWC3 *Well I've always maintained that the client is the expert and a social worker should be there to assist them in making choices and help them to achieve their goals. But some of these people didn't want to be helped.*

It sounds as if this frustrated you.

SWC3 *It did, on several occasions.*

It is evident that her placement experience challenges her values based on choice navigation. She had not anticipated clients refusing to comply with chosen services or being unhappy with the outcomes.

Throughout the course of the year, there seems to be a deepening of SW C's understanding of the social work role. Her ideals have been challenged with the reality of day-to-day practice but the overall result seems to be more down-to-earth and realistic.

Understanding what other professions do

SW C has had a number of years working as a care assistant in health and social care settings. At her first interview her understanding of the nursing role is more advanced than the other two social work participants.

Fig 144

Could you tell me what the role of a nurse is, do you think?

SWC1 *Well it's to carry out treatments and procedures on people, treating illness and working more under the direction of a doctor.*

Ok, would that count for mental health and learning disabilities as well?

SWC1 *Well yes, I think so. The structures are a little different, but people are still treated as ill and needing to be cured, rather than taking into account social and political situations.*

Could you tell me what skills you think a nurse might need to carry out their role?

SWC1 *Technical skills of applying treatments, being able to empathise and talk to people, those kinds of skills I would have thought.*

Would you be able to say what you think the underlying value base or philosophy of nursing is?

SWC1 *…..I think it's to treat people where you can, save lives, keep people free from pain, and protect people from themselves.*

How might they do that?

SWC1 *I mean in the case of suicidal people, keeping them under close supervision.*

She describes a mix of approaches, actions and treatments that are done to somebody; '*treating, protecting, curing, supervising'*, whilst also alluding to the need to be able to '*empathise'* and communicate effectively. In broad health care terms she also describes how the medical approach is '*disempowering', 'judgmental'* and *'hierarchical'* (Fig 131).

At the first interview she demonstrates some understanding of the role of occupational therapists in mental health settings.

Fig 145

Ok. What about occupational therapists?

SWC1 *I've heard of them, aren't they very similar to physiotherapists, but they also work in psychiatric hospitals doing basket weaving and clay modeling, those kind of activities.*

Well, they are increasingly becoming core members of multi-disciplinary mental health teams, so you will definitely have the opportunity to find out more about them during your course, I would have thought.

SWC1 *Oh.*

Would you be able to state what you think the skills might be that they would need?

SWC1 *I would have thought that they need practical and artistic skills to engage people in those kinds of activities.*

What about the values and philosophies of occupational therapy, what might they be?

SWC1 *Umm, that meaningful occupation is useful to distract people from their illness, that learning new skills can help people cope in other areas of their lives.*

She describes activities associated with occupational therapy departments in psychiatric hospitals, but shows insight into the philosophy underpinning the role. By the second interview, SW C continues to describe nursing roles and approaches in a negative way.

Fig 146

Ok, we discussed your understanding of nursing last time. Have your perceptions or understanding of their roles changed over the last few months?

SWC2 *No not really. I suppose I have a better understanding of what makes us different to nurses. Our approach is about the person, their family, their carer, the environment and how the whole system impacts on that individual, not just on the drugs they're taking or the history of the illness in their family.*

What about the skills they might need?

SWC2 *No. I think they need to know their treatments, they need to know manual handling, how to communicate with people and keep paperwork up to date, like everyone else.*

She is highlighting the differences in approach between social workers and nurses, focussing on treatment and illness. She elaborates by explaining where her views originate and describes the tasks that most nurses would undertake within a nursing home environment.

Fig 147

Yes. So do you think you would be able to tell me what the philosophy and values are that underpin nursing?

SWC2 *Not really. My experience of nurses having worked alongside them during agency work is that the philosophy is to care for people, which means doing things to them or helping them, hands on, physically to do things that they cannot do themselves. I think the problems with that is with many disabled people or mentally ill people, they cannot tell you what they want, so the nursing approach has to make assumptions, you know, about what is best for someone.*

So would that mean that the philosophy of nursing is to do what is best for someone?

SWC2 *Um, yes. To do your best to keep them comfortable.*

She justifies nurses who make decisions on behalf of people by describing the challenge of providing care for people who cannot, through either illness or disability, convey their own opinions. This seems to be a departure from her stance in the first interview where she was critical of the medical model. Her understanding and views of the occupational therapy role have not altered since the first interview.

SW C completes her multidisciplinary placement in a CMHT at the time of her third interview. The impact of this experience is dramatic in relation to her level of understanding and attitude towards nurses.

Fig 148

SWC3 *Well, the nurses were nursey, but I was quite surprised at their adaptability, they did see beyond the medical model, although they talked about medication all of the time.*

Any changes in your views on their skills?

SWC3 *Yes, I think they do very broad assessments of anybody and everybody, so they are quite good at assessing levels of risk. They also did a lot more therapeutic stuff like group work and anxiety management programmes, that sort of thing.*

SW C describes preconceptions about the '*nursey'* values and approaches suggesting that their approach is fixed and narrow and firmly entrenched in the medical model; a view which was challenged in her placement experience.

Now, she describes a more positive view of the nurses she encountered. She seems surprised by the breadth and scope of their role and the degree to which they worked beyond and outside of the medical model, as SW C perceived it. Interestingly, she uses the term '*therapeutic'* to describe the non-medical treatment approaches used by the nurses, rather than psychological or educational. The word therapy still implies that it is applied or done to someone. Her encounter with OTs on placement has a more unexpected outcome.

Fig 149

What about the OT, you said there was one.

SWC3 *Well, she was good, but I can't really see what was different in her role to the social workers, other than the fact she did not do the mental health act stuff or vulnerable adults.*

So the role didn't seem too distinct then?

SWC3 *No, her role was quite similar to ours.*

Any different views on the skills she needed to function in her role?

SWC3 *I suppose similar to the nurses in some ways, assessment risk assessment, I think her role was less trouble shooting or risk management though, more developing programmes to work towards employment or meaningful activity.*

Do you feel that you know what nursing and occupational therapy entails now, what values and philosophies underpin the approaches?

SWC3 *No, but I think if I were to do my 70 day placement in that team, it would make a difference. If I were there for longer, I would gain more insight into what it is they do, what the differences are.*

SW C likens the role of occupational therapy to social work stating that she could not discern any difference between the two. She describes generic tasks of assessment and care planning that she perceived as shared roles by all members of the team, whilst demonstrating an understanding of the distinct differences in role. She articulates her understanding of the roles of social workers, nurses and OTs quite succinctly. Overall, her journey over the year has challenged her confidence in her abilities and professional identity. Whilst her placement experience has presented significant challenges and promoted a deep level of introspection and learning it appears to have had a positive impact on developing her understanding of her own role within a practice context, whilst enabling her to develop her understanding of nursing and occupational therapist roles.

The next chapter provides a discussion of the research findings presented above. The research findings are discussed in relation to the research questions and reflections are made on the research methodology. General recommendations are also made which could inform future professional education approaches.

CHAPTER 4: DISCUSSION

This chapter discusses the findings of the study in relation to the theoretical and empirical IPE work previously undertaken and highlights the contribution that the study has made to this earlier work. The chapter has four parts. The theoretical frameworks I have drawn on for the analysis of my findings will be presented. This will be followed by an analysis of the findings in relation to the development of professional identity. In part three the findings in relation to knowledge **of own role** and knowledge of other professions will be considered. The final section presents my conclusions relating to the findings of the study, alongside a reflective appraisal of the research process.

Theoretical Framework

The aim of this thesis was to explore the development of professional identity and understanding of role and those of others in mental health student nurses, and OT and social worker students who had an interest in mental health, throughout their first year of training. The specific focus was on interprofessional learning experiences within taught and practice placement environments.

Throughout my research I adopted the following definition of IPE:

"Occasions where professionals learn with, from and about each other, and in doing so develop their understanding of how professionals can collaborate in practice."

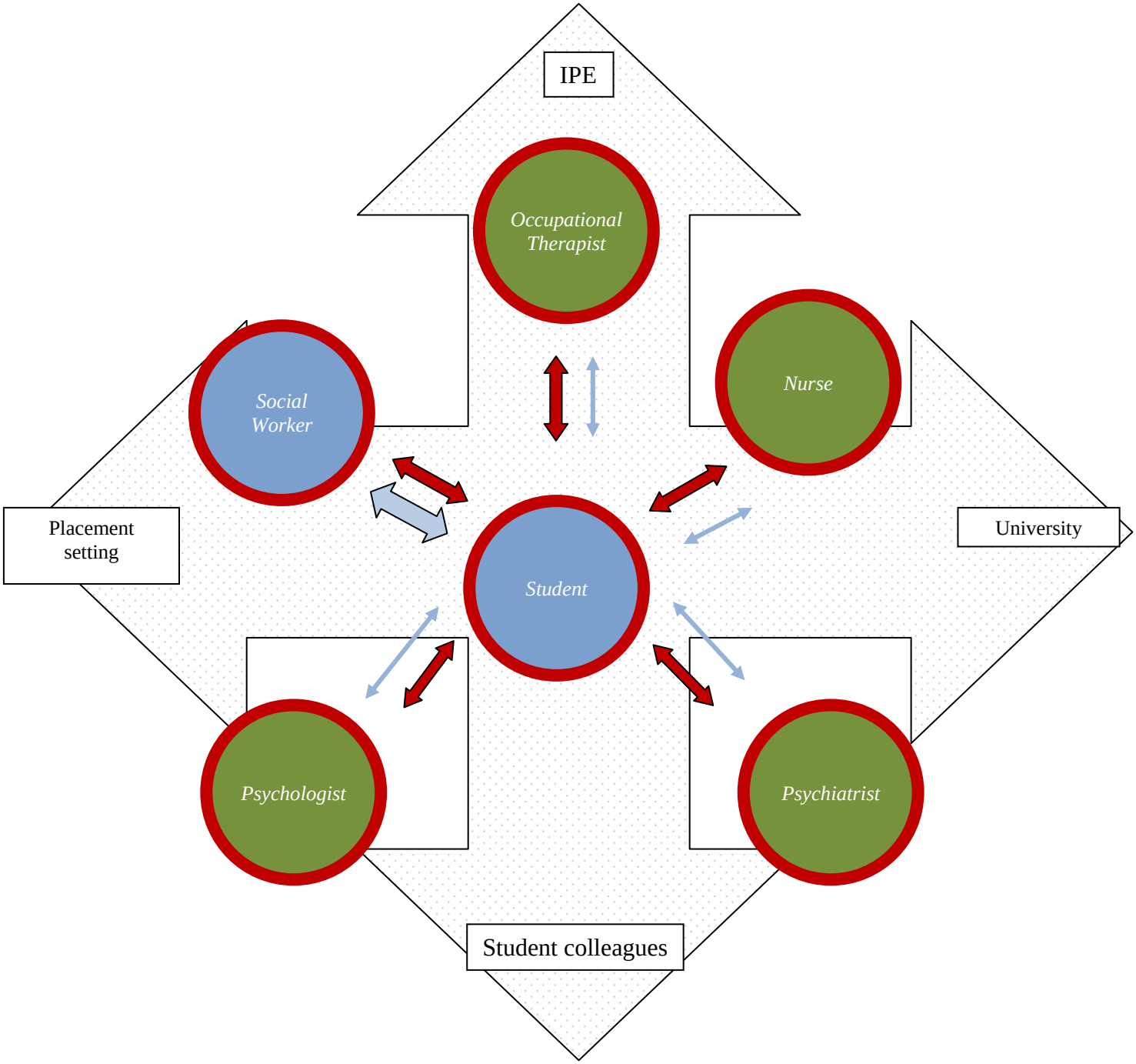
In reviewing the literature relevant to my research I found that the study of IPE has evolved without a strong theoretical base (Colyer et al, 2005; Freeth et al, 2002). The majority of empirical studies have focussed on the implications of IPE for interprofessional practice (Carpenter et al, 2006; Lindqvist et al, 2005) as opposed to developing models and theories relating to IPE (Sharland, 2007).

It was, therefore, important for me to identify a theoretical framework robust enough to use in analysing the findings that emerged from my consideration of programme literature as well as the interviews with participants. The framework I developed had three components: Social Identity Theory (SIT); Self Categorisation Theory (SCT) and Social Learning Theory (SLT). The contribution of SIT was its focus on the processes used by individuals to make judgements that distinguish them from other people as well as enabling them to look for people who they view to be similar, a group they can identify as one they belong to. In the context of my research this seemed a useful approach to use. Therefore, SIT was selected as a theoretical approach that could enable me to understand the processes underpinning the formation of professional identity amongst my participants, as well as exploring how they distinguished the characteristics of different professional groups and aligned themselves to a particular group.

However, SIT seemed to me insufficient in relation to understanding the processes that enabled the participants to explore the roles of others and potential interprofessional working. For this I needed to use a theoretical approach that would enable me to focus on how the participants identified commonalities with others and established their membership of wider groups. Self Categorisation Theory (SCT) was selected as an additional theoretical approach to enable me to understand these processes.

A key element of the study was the exploration of IPE within both taught environments in the university setting and within practice placement settings. I chose to use Social Learning Theory (SLT) to illuminate the changes in understanding and attitude that would take place as participants were exposed to the social experiences, including role modelling and critical experiences, that they would encounter within both the taught and practice based environments.

Figure 150. Theoretical framework showing example of social work student



Key:

SIT: identifying with others who are similar and development of professional identity

SIT: process of distinguishing differences/ characteristics of other professions

SCT: seeking membership with the wider mental health professional group

SCT: establishing similarities with others

Taught and practice based opportunities for social learning

Figure 150 illustrates how the three theories were brought together in the analysis of the interview data. SIT was utilised to analyse language used by participants within the interviews that would illuminate how they were distinguishing themselves from others and identifying with their particular profession. SCT was employed to analyse language use by participants that indicated that they were looking for commonalities between groups and moving towards a membership of the broader group of health or social care professionals, or mental health workers. SLT was utilised to illuminate language within the discourse that would indicate that there had been a change in attitude or understanding that seemed to be a direct result of exposure to social experience such as role modelling within the taught or practice environment, or significant interactions or learning experiences within the practice placement environment.

First stage: The development of professional identity

The following section aims to review the findings of the study in relation to both the taught aspects and practice placements elements of IPE that the participants experienced within the first year, and how these impacted upon their professional identity.

To begin with, the findings on the impact of professional identity formation will be discussed in relation to SCT. SCT proposes a process within which the individual looks to compare similarities across groups and look for commonality or membership of broader groups. It is my contention, and a view generally supported by the literature, that IPE within the practice context enables this process. It should then follows that the formation of a professional identity is created by students engaged in, learning about, spending time with and taking part in activities with professional colleagues to enable them to define what their role is and what is not. Understanding why students use particular terms and phrases to describe their

experiences may help us to understand the cultural context they inhabit both in the classroom and the workplace.

The three OT students undertook an IPE taught module, during which they learned alongside social workers, nurses, physiotherapists and speech and language therapists. Significantly, the OT students were the only participants within the study to indicate a development in their professional identity between first and second interviews. Hind et al (2003) found similar results in a study investigating the impact of IPE on professional identity across healthcare students, with students exhibiting a positive view of their own identity and being more open and more willing to identify with others.

The extent to which this was influenced by their taught IPE module is unclear. The analysis of the OT course syllabus revealed a clear articulation of the unique core skills of occupational therapists. The foundations of occupational therapy module which was studied alongside the IPE module may well have influenced the development of their professional identity, just as the development may have been due to a general increased confidence in knowledge of the role having completed three months of training.

However, for all three the IPE experience appeared to encourage consideration of their professional identity and develop understanding of not only their own role, but those of the other professions they learned alongside. The experience did not seem to challenge their understanding of roles, but appeared to have fostered a broader appreciation of the role of the OT and how the role compares and contrasts to other professional roles.

Norman and Peck (1999 b) assert that differences in professional culture can be understood and contextualised by IPE in pre-qualification programmes. What the IPE experience appeared to afford was the opportunity to consider professional identity, which enabled them to gain a better understanding of how their profession sits alongside other health and social care roles. Barrett et al (2003) found that the use of shared curriculum created a positive attitude towards collaborative working in both the learning and practice environment. The discourses of the three OT students that experienced taught IPE modules in this study suggest that their experience enabled them to position themselves in terms of their professional identity and understanding of their own role within the broader health and social care context. These findings also supported Linqvist et al (2005) who found that taught IPE between the five professions had significant effects on students' attitudes to different health professions over the course of the first year. The findings of this study and those of Barret et al (2003) and Lindqvist et al (2005) support SCT, as the taught IPE element appeared to provide students opportunities to seek out commonalities with other professions and establish membership of the broader health and social care profession.

The impact of practice placement experience upon the development of professional identity was also significant for the participants within this study. All of the nine participants experienced a practice based placement within the first year, the nurses undertaking two placements. For Nurse A, OT A, OT B and SW B, further development of their professional identity was evident within their discourses following their placement experience. There was a common theme of moving on from student identity to professional identity, a gaining in confidence to practice and frequent use of inclusive terminology. Nurse C’s professional identity also developed greatly following both placements, although these were in single profession teams. Moreover, the findings can be discussed in connection with SLT, which would hold that the practice educator role is vital in linking formal taught training programme

elements to the experiences encountered within the practice placement setting. An important factor in the delivery and planning of effective IPE programmes is the need to prepare the socialisers, the clinical practice teachers and supervisors for interprofessional attitudes and training students from different professions.

Mulholland et al (2005) assert that practice educators need to be able to encourage and enable a student to reflect on their experiences in a way that draws upon the interprofessional context in which it occurs. Martin (2005) supports this view asserting that the practice environment should be the central focus in IPE curriculum development, and that as a result of practice educators providing good role models for students through effective interprofessional practice, students will;

"Acquire the codes of behaviour, belief systems, language, customs, and rituals of their chosen profession but they will also acquire those of a health care professional who values interprofessional working." (p56)

However, the responses of SW A and SW C to their experience was unexpected. Although the placements themselves were different in professional mix and activity, the impact of the experience in relation to professional identity was confusion and dilution. Robson (1998) suggested that whilst the placement setting heavily influences the development of professional identity, shifts and developments that may or may not take place as a student interacts with colleagues on placement and fellow students on the course can provide a confusing environment. Brown et al (2000) found that multidisciplinary team working reinforced adherence and allegiance to professional identity. This was not the effect that the placement environment had on these two social workers, however. Dombeck (1997) in her description of 'professional personhood' (p 10), points out that professional training involves passing on

specialist knowledge, approaches and standards of practice, but it is the ways in which the profession are expected to behave that an individual will learn in the workplace. Utilising SIT to understand how the placement experienced impacted upon both of these students we could argue that for SW A there were no similar roles to compare herself to within the practice placement setting, resulting in her feeling that she did not belong to any professional group. For SW C the rigid judgements that she had previously made to distinguish herself from other professions were challenged by her placement experience, which meant her membership of the social work group was not as clearly defined as it had been prior to her placement experience. Adams et al (2006) maintained that critical experiences in a placement setting can trigger the construction of a professional identity and challenge self-conceptualisation associated with the work role adopted. Tracking how SW C contextualises her experience in relation to her further study and following placements would enable consideration as to whether or not this had ultimately been a positive or negative experience regarding developing understanding of the social work role.

In comparing development of professional identity with nursing and social work students who had not experienced IPE taught modules, there were no apparent shifts in professional identity between first and second interviews. A number of students however, displayed developments in their knowledge of their own role and that of others between their first and second interviews.

These findings further illuminate the differences in learning opportunities that can be provided by multi disciplinary as opposed to single discipline environments. Multi disciplinary or interprofessional practice can be understood in terms of team contexts, cultures, structures, processes, relationships and outcomes. Wenger (2000) presents the notion of communities of practice, suggesting that they are

"Building blocks of the social learning system because they are the social containers of the competencies that make up such a system". (p229).

I anticipated that at the third interview, following the participants' placement experience, I would identify developments in professional identity, confidence, a deepening of understanding of knowledge and understanding of own role, and for those who had the opportunity to work alongside other professionals on their placement, a better awareness of the roles of other professions and an appreciation of how the roles work together. What I found, however, was that for some students the placement experiences had far more significant outcomes. The impact that the placement experiences and the interactions with other professionals had on the students were complex.

Five out of the nine participants demonstrated a positive development in professional identity following their placement experiences. Amongst these placements there was a mix of single profession and multi disciplinary teams, and differing levels of existing professional identity on entry to the course. From the outset of the course, Nurse A, OT A and SW B demonstrated that they had a good understanding of their professional roles. Their placement experiences, although mixed in terms of multi disciplinary and single discipline, seemed to enable a significant development in the depth of understanding of their roles.

This would seem to suggest that the learning as a result of these social experiences within practice placements was helpful with regard to the development of professional identity. Dombeck (1997) maintain that professional identity or 'professional personhood' is brought about through group interactions in the workplace via informal and work-based learning that enables students to relate, compare and differentiate themselves from other professional

groups. The findings of this study can be located within both SIT and SLT. SIT can enable us to understand how the taught and practice placement experiences enabled the participants to distinguish the characteristics of different professional groups. However, SLT is also relevant as the findings indicate that they were learning though social experiences, both within classroom and practice placement settings.

Second and third stages: Knowledge of one's own role and knowledge of other professions

In this section the development of the knowledge of one's own role will be considered along with how knowledge of others' professions is formed. Attention will be given to both the theoretical underpinnings of how to understand this knowledge as well the insights gain from the placements. The impact of the taught IPE modules on the three OT students is discussed first, followed by a review of practice placement experiences.

A unique feature of the OT students was that all three were able to articulate knowledge of their own roles and those of others in the interview following their taught IPE module. The discourses of the three OT students in this indicated a shift towards a broader appreciation of the role of the OT and how the role compares and contrasts to other professional roles following their taught IPE experience.

OT A demonstrated a development in understanding of the OT role following his IPE experience, although his language indicated a broader health and social care student identity rather than that of an OT student. The review of the OT course syllabus identified that an enquiry-based learning approach was used within the IPE module to explore the role of social policy and health and wellbeing in context of the broader health and social care services. OT A's shift towards a health and social care student identity could indicate that the taught IPE

experience enabled him to grasp common goals and approaches across the professions and enabled him to locate the OT identity within this structure. Alternatively, it could indicate a level of role blurring. One could argue that the IPE experience weakened OT A and OT B's professional identity. Equally, the shift from OT to student OT identity could be a result of exposure to, and recognition of, the responsibilities and complexities of practice via IPE, and a retreat to the comfort and safety of the student role. What remains unclear with these students is whether the developments in professional identity are more aligned to an interprofessional health and social care student, rather than an OT within that context.

The impact of practice placements on understanding of others roles and attitudes towards other professions was significant. Both nurses who completed the study demonstrated a deepening of understanding of their own role by the second interview. While they had not received taught IPE training they both experienced a short three week placement in nursing teams. None of the social work students experienced IPE or a placement experience prior to second interview, although there was a noticeable shift for SW B and SW C in relation to understanding their own role and those of others by the second interview. In the absence of a taught IPE module or a placement, one can only assume that this development was enabled by taught elements of the course syllabus and social interactions with fellow students.

For Nurse C and SW A, SW C and Nurse B, their placement experiences had a demonstrable effect on their knowledge of, and attitude towards, other professional roles. For Nurse C, contact with social workers and OTs during both placements increased his understanding and appreciation of the roles. SW A's understanding of the mental health nurse role developed considerably, shifting from a perception of an illness and disease model focussed on treatment and medication, towards a broader view of recovery focussed work and care co-ordination. However, her placement experience afforded the opportunity to develop her understanding of

other roles within the mental health care system, perhaps at the cost of developing her own. Within the context of SCT, SW A's experience provided opportunities for her to identify with characteristics that she had in common with a broad and diverse group of staff that were a mix of both professionally and non professionally affiliated staff, which enabled her to develop a good understanding of others roles.

With regards to SW C, her placement experience had a surprisingly positive impact on developing her understanding and attitude towards nurses and occupational therapists. The rigid stereotypical views that she held prior to placement were challenged by her experience in the placement. Nurse B only took part in one interview within the study time period, as she left the course. However, what can be gleaned from the first interview is an indication of the impact that her brief first placement had on her understanding and perceptions of other professional roles. Her discourse indicated that her brief exposure to professional roles whilst on placement has stimulated consideration of the differences between the professions, the knowledge required and roles performed.

For SW B, although her placement left her with ambiguous understanding and attitudes towards nurses, her understanding of the OT role had developed significantly. Her attitude towards medical approaches was more tolerant and she seemed to be more accepting of an alternative viewpoint. With regard to OTs, SW B's discourse demonstrated a significant development in understanding of the role following placement, to a degree where she saw only similarity with her own role, stating '*I would struggle to say she did anything different to the social workers'*. SLT would suggest that the social experiences on placement including role modelling and opportunity to experience successful working together enabled SW B to moderate her views of OTs and gain a deeper understanding of the role. However, these findings would also support SCT, as SW B's practice placement experience enabled her to

look beyond the social work role to understand the wider roles employed within the team in relation to her own.

A number of authors (Dombeck, 1997: Hall and Weaver, 2001: Mires et al, 1999: Whittington, 2005: Barr, 2003: Norman and Peck, 1999 b, Wenger 2000) support the view that the socialisation experiences gained by working alongside other professionals can enhance understanding of other roles and provide opportunities for a student to compare and contrast approaches, skills and values of other professions with those of their chosen profession. Hewstone and Brown (1986) advocate that opportunities need to be presented to pre-qualifying students for informal and social learning that stimulate interprofessional dialogue, practice observation and the development of positive interprofessional attitudes.

For three participants in this study, however, the provision of a placement experience within the first year did not significantly develop understanding of other professional roles. For OT A, his experience was mixed, having a negative impact on his perceptions and understanding of the nursing roles, but a positive impact on his understanding of social work roles. The review of the OT course syllabus revealed that the ability to demonstrate accommodation of diversity in collaborative, interprofessional working was a specific outcome of the IPE module. Whilst OT As discourse implied a positive regard for nursing roles following his IPE experience, he did not appear to be willing to accommodate different perspectives or working practices within the placement context.

For Nurse A and OT B, the placements had little or no significant impact upon their development of knowledge and understanding of others roles. There was some development in OT B's knowledge of the nursing role from her contact within the placement, but her perspectives on their approaches and philosophy were shallow and without substance. In

addition, her contact with social work professionals appeared to have had little impact on her understanding of their role. Although Nurse A experienced two placements, it appears that as they were both within physical care single discipline teams they did not provide the opportunity to develop better insight into, or knowledge of, other professional roles. SLT would suggest that the single discipline role models provided by these practice placements failed to provide critical interprofesional learning experiences required to develop a better understanding of other roles due to limited opportunities to work alongside other professions.

Nurse C did not display an informed understanding of the nurses' role at first interview, but following both of his placements demonstrated a significant development in his understanding of the nursing role. His discourse was focussed on physical care activity, however, which may have been shaped by the communication within the inpatient team which in turn framed his understanding of new information and activities. It was evident that his understanding of the nursing role had developed during the course of the year and that his placement experiences had the greatest impact on this. For Nurse C, SIT can enable us to understand the direction that his development of understanding of the nursing role took in relation to his placement experiences. As both placements were predominantly uni-disciplinary environments, he was only exposed to the opportunity to identify with others in the same role.

Whilst the social learning experience within the practice placement had positive outcomes for SW A and SW C in relation to developing understanding of the roles of others, the impact on the understanding of their own roles was more complex. For SW A, the placement within a social care provider within a resource centre seemed to blur her understanding of the social work role with those of other professions. Her lack of social work role model to observe in day to day practice had a negative impact on the development of her understanding of the social work role. SW A's placement did not enable her to develop a deeper understanding of

the role. Her inability to differentiate between social work and the social care perspective was evidence of a blurring of role perception and a lack of professional modelling on placement. Using SLT to contextualise this outcome, the social experiences that reinforced SW A's learning were influenced by the lack of role modelling on placement. Martin (2005), suggests that the socialisation experience within the workplace can not only offer insight into the competencies, skills and knowledge required, but can also expose the student to situations that reveal the values and culture of the profession. Martin (2005) suggests that as a result of these experiences, students are;

"Encultured in the community's embodied knowledge; for example, they learn to speak its language, which enables them to become socialised as members of their own profession."(p56)

As SW A's placement was within a provider placement setting with no other social work students or qualified practitioners, the culture she became immersed within did not enable her to become part of a social work community.

For SW C the placement experience challenged her strong views regarding her own values and practice principles. SW C's placement experience seemed to confuse her and challenge the strong social work identity that she had demonstrated throughout the previous interviews. She was able to draw a distinction between the specialist tasks that only ASWs undertook, but seemed to view most activities as generic across the professions within the team. Both SLT and SCT can help us to understand the ways in which SW C drew on broader influences and roles within the team whilst on her practice placement.

Galvin and McCarthy (1994) and Norman and Peck (1999b) highlighted role ambiguity and inability to coherently articulate the culture and values of the profession as key weaknesses of MDTs. The impact was not one of blurring her understanding of the role, however, but more of challenge to her beliefs, which on one hand could be seen as a relevant and productive stage in her journey towards development as a mature practitioner. Her ideals were challenged by the reality of day-to-day practice and her underlying values had also been tested. Her discourse contradicted the strong values extolled in previous interviews, referring to clients as '*stroppy'*, *'difficult'* and '*pain in the arse'*. Her placement experience challenged her values based on choice navigation, as she had not anticipated clients not complying with chosen services or being unhappy with the outcomes. The language in SW Cs discourse described a reflection on the structures and experiences surrounding her on placement and reflected her view of the world at a given moment in time. Expanding on this example, the social constructionist framework allows us to see the continually changing environment in which mental health students work and learn as a 'lived curriculum', i.e., a set of circumstances and contexts, problems and dilemmas that also represent opportunities for development. It was unclear whether her placement experiences challenged her principles, revealed her true values or whether she became acclimatised and accepting of the practices, attitudes and approaches of team members through the challenging experiences she faced.

Galvin and McCarthy (1994) voiced their concerns that MDTs can have a role blurring impact if professions perceive that generic activities such as assessment and care planning can be done by any profession, diluting specialist skills into an undifferentiated pool of generic work. SW A's placement was not ideal, as she did not, in her view, get to experience the social work role, nor did she have a social work supervisor on a day to day basis. SW C did not encounter these problems, but still struggled to come to terms with the challenges that the placement gave her regarding her perceptions of her professional identity.

Section Summary

SIT, SCT and SLT reviewed within multidisciplinary practice settings enabled me to conceptualise the relationship between theory, practice and experience in the development of professional identity, knowledge of roles, and knowledge of other roles. SIT and SCT theory enabled us to understand some of the processes students went through in developing their professional identity and understanding of their own role, both across taught and placement based IPE. Understanding of the roles of others was also influenced by both taught and practice placement IPE, although a more mixed response arose from placement experience in this study. Where significant changes and developments in clarity of own role or challenges to understanding of the roles of others took place following placement experiences, the relevance of SLT and contact theory were evident.

Students appear to develop a professional identity that fits within a particular community of practice, which within multidisciplinary mental health teams, will constitute many disciplines. What is unclear is how confusing this may be for prequalifying students who experience this socialisation process within a number of communities of practice across the three years of professional training, and whether these provide complimentary or conflicting messages for their professional identity development.

Reflective appraisal of the research study

IPE within the classroom and practice placement context

My working definition of IPE was

"Occasions where professionals learn with, from and about each other, and in doing so develop their understanding of how professionals can collaborate in practice."

Looking at both taught IPE and practice placement enabled me to observe a number of occasions or settings where the participants in this study had the opportunity to compare and differentiate themselves from within and outside of their professional groups, and to consider the impact that the experience may have had on their professional identity and understanding of their own role and those of other professions.

Methodological approach

Social Constructionism was the epistemological approach used within this study as it enabled me to see the students' journey through their first year experiences as an ongoing dynamic process where they were acting upon their own interpretations and knowledge of their world. It was anticipated that the experiences of these students during interprofessional learning situations would be represented by and contained within their discourse. Working from an understanding of knowledge being derived from and maintained by social interactions, this study followed students through both taught classroom based and practice placement based interprofessional social interactions.

The methodological approach informed how I planned to go about exploring what I believed could be known, whether IPE taught or placement experience had an impact on professional identity, knowledge of own role and those of others. The use of discourse analysis as a method for collecting and analysing the data enabled me to explore how each student made sense of the experience within their own respective perceptions of reality at that time in their professional development.

This framework was successful in enabling me to experience from the students' viewpoint the continually changing environment in which they learned and practiced. The approach used

enabled me to travel with the students through their experience of a succession of problems and dilemmas within different contexts that presented opportunities for development, as a lived curriculum. The indicative findings of this thesis emerged from the richness of the data yielded by the methodology employed. Burr (1995) referred to socially constructed reality as an ongoing, dynamic process, reproduced by people acting on their own interpretations and their knowledge of it. Using the social constructionist approach to interpret the discourses within these interviews facilitated an in depth understanding of the experiences of these students during work placements and inter-professional learning situations. It enabled insight into how each student made sense of the experience within their own respective perceptions of reality at that time in their professional development. The use of Potter and Wetherell's (1987) discourse analysis framework enabled interpretation of students' discourses as frameworks of meaning, situated within educational and practice contexts.

Research design

The research design required participants to have a placement in their first year of training which meant that as the sole social work training provider within the region still offering this, Wolverhampton University were the only option. Due to established relationships with the School of Health, I had already progressed Ethics Committee approval for access to nursing students from Wolverhampton, so recruitment of both nursing and social work participants from this university was the most convenient option. The Coventry course was selected as it was the only provider of OT training in the West Midlands. It had also offered taught IPE modules across health and social care programmes for a number of years. Throughout the West Midlands in the academic year 2004/05 when this data was collected, no other providers of qualifying training in nursing and social work were identified as offering taught IPE modules.

One option would have been to have recruited all participants from Coventry University as then all participants would have experienced IPE, including nurses and social workers. This option would not, however, have enabled the comparison of interview data between participants who were exposed to IPE and those who were not. To address the research questions fully I felt that it was important to be able to make a comparison with students who had not experienced taught IPE to ascertain whether practice placement experiences alone could provide the IPE learning opportunities that could influence the development of professional identity and understanding of own role and those of other professions. Additionally, as with Birmingham University, from 2004/05 the social work degree programme at Coventry University no longer offered a placement within the first year.

There would have been great advantages of studying 6 course providers, including one providing taught IPE opportunities and one not for each professional programme of study. This may have doubled the sample size, and a slightly larger sample may have ameliorated the effects of participants leaving. To access this range of course provision the scope would have to have been broadened to a geographical area beyond the West Midlands, which would have presented significant logistical challenges.

Moreover, the positive impact on professional identity following taught IPE with the OTs within this study could well have been influenced by other elements of their taught programme of study or the ethos or approach towards multidisciplinary working within the faculty. Notwithstanding the issue of first year placements for the social work students, the opportunity to recruit all participants from one institution would have enabled me to explore whether the taught IPE element had the same impact on student accounts relating to their professional identity across all three professions. However, this would not have allowed for exploration of the impact of practice based IPE alone on professional identity and

understanding of roles. To fully explore these questions a longitudinal study over a three year period would be required to include at least two institutions that provide all three programmes of study, one that provides taught IPE and one that does not.

It is important to remember that the participants in this study were still in the very early stages of their training and professional development, and extending the scope of the study to the programme duration over three years would enable an exploration of changes and development in professional identity and knowledge of roles in relation to further course based intervention and exposure to different placement environments in years 2 and 3. These students only experienced one, or in the case of the nursing students, two workplace settings and an evaluation of their professional identity and role knowledge development following placements in years two and three would enable further evaluation of the impact of this first placement experience.

The decision to undertake in-depth face to face interviews at three intervals over the first year academic period informed the decision to recruit a small number of participants. Regrettably, two students left their programme of study during the research study timeframe and as a result did not take part in all three interviews. The loss of these two participants inevitably led to a loss in the insights gained from the research. Nonetheless, the exploratory design has opened up areas for further investigation that have not previously been considered widely within the literature. The research design was an insight orientated approach that was designed to enable me to identify factors within taught IPE and practice placement experiences that may impact upon the development of professional identity and understanding of roles, which it was successful in achieving. The study intended to specifically explore changes in perception of identity, and development of knowledge and awareness relating to professional roles in response to IPE. The research design added validity as accessing student discourse before and

after IPE and placement experiences allowed for the analysis of the subtle changes and developments in language use and terminology that revealed the students feelings and perspectives whilst the learning experience was still fresh in their memories.

The social constructionist framework, the analysis of discourse methods utilised and the research design employed yielded rich data that enabled a deep and detailed exploration of the student's journey throughout their first year and insight into the experiences that shaped their development.

Content Analysis

Once the methodology had been decided upon and discourse analysis chosen as the data collection and analysis method, a decision was taken to seek an appropriate source of secondary data that would provide insight into the perspectives of the educators and the language of professional identity and articulation of professional role, and potentially reference to multidisciplinary working. It was felt that course syllabi would be easy to obtain within the public domain, and that this level of information would be contained within it. This level of detail was not found within these documents, although content analysis did enable the identification of occurrences of reference to inter professional working, core skills and values of the profession, descriptions of IPE opportunities and practice placement elements. The content analysis also enabled comparison of module content across the three professions for the first year of study. Course syllabi provided only very basic detail of the placement length and where it occurred within the first year of training. There was very little detail on the nature, scope or setting of placements, other than to inform students that these would take place in a variety of settings and agencies. As the course syllabi documents did not contain the level of detail that was required, more appropriate documentation could have been sourced by discussing the content analysis element of the research design with the course leads in more

depth. Whilst it was felt important to analyse the same type of document to ensure consistency of approach, the variance between the course syllabi was so great that it may have been more relevant to gather and compare a range of documents.

What analysis of these documents did reveal was the extent to which preparation for practice was described within each course. There was a marked difference in emphasis between the nursing syllabus focussing on clinical skills preparation and the social work syllabus which placed greater emphasis on knowledge of the placement context, and preparing students for the role they are about to undertake.

Reflection on my role as a researcher.

My motivation to undertake doctoral research was fuelled by a wish to undertake what I believed to be 'good' research with specific and measurable outcomes. This reflected not only my previous qualifying programmes of study in nursing and psychology, but also the professional world of health service provision that I inhabited back then, and still do now. My understanding of research was framed within a positivist framework, that required measurable properties to describe reality, quantifiable measures of variables, hypothesis testing, and the ability to infer generalisability from a sample to a specified population. This understanding of what constituted good research that I held back in 1999 when I started this work is very different to my understanding of what constitutes good research now.

I wanted to try a new approach, to immerse myself within a methodology that was very different to any approach that I had taken before. I was comfortable with the understanding of reality constructed and maintained by social constructions such as language, consciousness and shared meanings, but still struggled to refrain from my positivist roots with the need to form hypotheses and define measureable outcomes. As a confident professional I was not concerned about my ability to carry out interviews with participants, but this confidence alone clouded my ability to recognise the extent to which I was able to influence research outcomes,

as a research instrument myself. Challenges in recruiting an adequate sample and encountering students with very little experience and understanding of their role at the very beginning of their programme of study all contributed to my growth and maturation as a researcher. This realisation only emerged through the writing up stage and lengthy challenging discussions with my supervisors.

What has emerged from my experience as a researcher has been the adoption of a more interpretive research approach, locating knowledge and understanding within the systems and contexts and processes in which they reside. My approach to my work role has changed dramatically as a result of my personal learning, although the strategic health care setting remains distinctly positivist and outcome focussed.

Professional Identity within Mental Health.

My journey throughout this research has impacted upon my professional world in many ways, but it has also shaped my career. When I enrolled on the taught doctorate programme I was a manager of mental health service provision, with an interest in mental health workforce education. Ten years and four posts later I occupy a mental health workforce specialist role. My professional experience to date had raised my awareness of the challenges faced by individuals in mental health multidisciplinary teams regarding professional identity, understanding of their role and those of other professionals they worked with. I recognised that IPE would need to play a significant part in the preparation of the new workforce entering mental health services, due to the multidisciplinary service models now in place throughout health services.

The study focussed on mental health professionals in a number of ways. The sample selection focussed on the three main professions that are represented within core mental health teams. The recruitment strategy was designed to recruit students who were interested in working

within mental health services, although it was accepted that this would not guarantee a mental health placement. The study recruitment flyers specified that students who were interested in working in mental health were invited to take part. Finally, questions relating to motivation to work within and understanding of mental health services were included within the semi structured interview schedule to ensure that they were discussed at each stage of the interview process.

There is a challenge in reflecting on established mental health professions at a time of a significant shift away from profession specific service models. At the time of data collection in 2005 the focus for specialist mental health trust was the establishment of the functional teams that had been outlined within the NHS Plan (2001a). Currently the Department of Health is focussing on tariff development within mental health services and the establishment of a care pathways model to inform the development of the tariff. In response to this service commissioners within PCTs are requiring specialist provider trusts to shape their services and workforce to deliver within this model. An increasing number of mental health care trusts are obtaining foundation trust status which affords autonomy to create new roles to provide services that are non professionally affiliated. The opportunities for new roles and new ways of working both within and outside of traditional professional boundaries are immense.

The Approved Mental Health Professional and the Approved Clinician roles introduced by the Mental Health Act 2007, and the new psychological wellbeing practitioner and high intensity worker roles developed with the introduction of the new Improved Access to Psychological Therapies service model involve graduates and qualified professionals from a range of health and social care backgrounds. The direction of travel these posts signify is a progression towards competency based roles and the development of entirely new communities of practice. However, for the majority of specialist mental health care providers within the West

Midlands nursing accounts for at least 80% of the workforce, indicating that there is still a significant need to focus attention on the preparation that qualifying trainees get to work within this uncertain practice environment. What the findings of this study have shown is the need to recognise the significance of practice placement experience and an appreciation of how the blurring of roles and potential role confusion will continue to be an issue within mental health services as they evolve. Within mental health services the focus on IPE within practice placement settings is key to prepare and develop teams that can function as a community of practice and deliver a coherent service to the service user.

Summary

This thesis raises a number of issues for further consideration. The processes that influenced the development of the students' perceptions of professional identity and levels of understanding of their own roles and those of others were illuminated by the students' discourses. Over the twelve month study period all of the nine students positioned themselves relative to the setting in which they were situated, and were never free from the influence of the professionals or fellow students around them. As the students reflected on choices made and were exposed to new and potentially contradictory discourses, changes in positioning occurred over time. These findings suggest that professional identity, understanding of own role and the roles of others may well continue to shift over the remaining two years of study depending on student interactions with professionals within work place environments and fellow students within the educational setting.

This thesis suggests that there may be benefits that can be achieved through IPE which would extend the learning of students about their professional roles within the broader context of health and social care. IPE can offer a means of preparing social work, nursing and OT students for the multidisciplinary team environments that they may work within on

completion of their training. IPE can also be of equal benefit to practitioners within single discipline teams to facilitate interdisciplinary working and foster a broader understanding of services available to clients form other agencies.

This thesis also suggests that the impact of placement experiences within the first year of study on identity and knowledge of own roles and those of other professions, whether in MDTs or unidisciplinary teams is significant. These findings indicate that education commissioners and providers need to give further consideration to the extent to which practice placements might provide IPE opportunities for students to test out theoretical knowledge in practice and further develop their professional identity, understanding of their own role and further understanding of the roles of other professionals.

Furthermore, this thesis has demonstrated how the theoretical approaches of SIT, SLT and SCT when brought together as a conceptual framework can aid our understanding of the processes involved. The particular contribution in bringing these theories together is that it enables the consideration of IPE in a wider context than taught modules delivered in a teaching setting. What analysis based on these three theories has shown in particular is that social learning is complex and informal learning within a practice placement setting may be no less important than taught IPE, and perhaps more significant.

These findings indicate that consideration should be given to the weight and significance of the first practice based experiences, as potent learning and development experiences that can shape professional identity and understanding. Evidently, course design can provide a number of opportunities for both formal and informal interprofessional learning opportunities. This can be restricted by availability and the nature of practice placement environments.

Further studies need to consider how IPE learning opportunities and practice based placements can be brought together within the training curriculii throughout the duration of professional training courses. A combination of inter professional educational input and placement experience may enable affiliation to the profession and the development of a professional identity which could afford individuals the opportunity to compare and differentiate themselves both with their own professional group, and with other professional groups. There is also a need for further exploration of whether IPE and placement experiences are best introduced within the first year of study early on in students' professional development, or best reserved until the second or third year of study once a deeper level of understanding of role and confidence is achieved. Further research may reveal benefits in delaying multidisciplinary placements until the second or third year of training when professional values, approaches and identity are well established. Longitudinal studies aimed at evaluating the impact of multidisciplinary placement experiences across the three years of pre-qualifying training on the development of professional identity, knowledge of own roles and those of other professions are required in order to identify the most effective and beneficial stage of training to introduce it.

Appendix A

Individual details

Age

Gender

Ethnicity

Type of professional training course

Name

Pseudonym for purpose of study

Course start date

Date of interview

Semi – structured interview questionnaires/ guides

Session 1 – beginning of course

Why do you want to become a….? what are the motivating factors behind your choice

Any life experiences that have persuaded you to wish to train as a …….

Did you choose this career, or has it chosen you

Had you considered any of the other health or social care roles? expand

What makes a ……different/ preferable to the other professions

What were your hopes & expectations of the course throughout the past year leading up to the commencement of the course

Have these altered now that you have been on the course for 2/ 3 months

What makes a good nurse/ ot/ sw

The core skills of occupational therapists / nurses/ sw are:

Are these unique to N /SW/ OT or are they shared amongst other health & social care professionals

What do you believe are the values , knowledge base & philosophy that provide the foundation of occupational therapy/ nursing/ social work

What are your own personal strengths & skills and areas for development

What is your understanding of the structure of mental health services in a)health and b) social care .

What is your understanding of multi-disciplinary working.

You have chosen mental health as a specialist area/ you have a mental health placement this year. What is your understanding of mental health services

Putting yourself in the position of ma mental health service user, what would be your expectations of a N/SW/ OT

What difference do you expect to make to a users life

Is there anything else that you would like to add

Session 2 – after at least twelve weeks of study/ course duration but before multi-disciplinary mental health placement

The unique core skills of occupational therapists / nurses/ sw are:

Explore academic and social support systems within their peer groups that have evolved

Are there any positive (or negative) role models provided by their tutors

Explore early professional identity – do they feel that they have one

Perceptions of other healthcare professionals

What is your understanding of the philosophy, core values and beliefs that provide a foundation for occupational therapy/ nursing/ social work

Has there been opportunity for you to explore your personal personal strengths and areas for development

How do you think these may link to your development as a professional

Explore identification of professional role

Explore development of the student's understanding of the various health and social care delivery systems and consideration the role of the occupational therapist/ nurse/ sw and inter-agency working within this context.

Basic overview of teaching style on course and syllabus content

Session 3 – following a mental health practice placement in a multi-disciplinary setting

Explore their perception of development of their professional identity, value base, purpose of role and approaches to clients and placement experiences, and their perceived development of knowledge and the relation of power to this.

Explore their understanding of the philosophy, core values and beliefs that provide a foundation for occupational therapy/ nursing/ social work

Do you believe there are core skills unique to occupational therapy/ nursing/ social work

Explore awareness/ insight into the effects of work environment socialisation and ways in which people identify with professional stereotypes/ etc, etc

Explore attitudes towards and perceptions of the roles of other health and social care professionals within multi-disciplinary mental health teams.

Explore awareness of educational culture differences and teaching styles and gain overview of supporting syllabus content

Explore the development of academic and social support systems within their peer group. Do they think this has influenced their professional socialization in any way

Have they identified any role models either at Uni or in the practice placement that they have been able to identify with

Explore level of confidence in their own professional identity and ability to function independently in a md team

Has there been the opportunity for students to explore their personal & professional strengths & skills and identify areas for development.

Has your placement experience afforded you the opportunity to practice and begin to evaluate the core skills of assessment, report writing and intervention planning through to closure and discharge.

Explore the student's understanding of the various health and social care delivery systems and consideration the role of the occupational therapist/ nurse/ sw and inter-agency working within this context.

Appendix B

Sections relating to year one of course included only

University of Wolverhampton

Mental Health Nurse Syllabus 2005/2005
PATHWAY GUIDE FOR ENTRANTS FOR ACADEMIC YEAR 2004/2005

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MENTAL HEALTH NURSING STUDIES.

WELCOME TO THE SCHOOL OF HEALTH, AND MENTAL HEALTH NURSING STUDIES.

Using this Guide

This guide will introduce you to the range of modules within the subject, so that you can consider and reflect upon the different career pathways within Mental Health Nursing. The guide will provide basic information about the modules and the related academic regulations. The Mental Health Pathway Guide should be read in conjunction with your Award Handbook, and individual module guides.

A brief introduction to Mental Health Nursing. (New Programme)

The Mental Health Branch Programme is underpinned by a number of beliefs and values regarding the nature of mental health nursing. This includes national initiatives related to mental health services and higher education provision e.g. Department of Health 1999 (NSF for Mental Health); DOH 2004 (Ten Essential Capabilities); the Nursing and Midwifery Council (2002, 2004); Mezirow, 1990; National Committee of Inquiry in Higher Education, 1997; UKCC 1999 – Fitness for Practice).

Mental Health Service Users and significant others represent a diverse population in terms of age, gender, sexual orientation, social class, ethnicity and disability. Therefore within the mental health programme students will need to continually examine and question their values, beliefs and prejudices with a view to respecting and valuing this diversity, and develop anti-oppressive approaches to their nursing practice. Furthermore, the programme embraces the principle of working in partnership with service users, carers, significant others and other professionals (DOH, 2004).

Mental Health Nursing is viewed primarily as an interpersonal process that seeks to help individuals, families and carers to address needs in daily living, promote autonomy, recovery and independence. The over-riding aim of pre-registration education provision and beyond is to assist students to develop the knowledge and skills required to deliver effective high quality values and evidence based nursing interventions.

In order to achieve this, the mental health programme is designed to provide students with a sound knowledge of the theories and concepts that underpin practice. We believe that learning is participatory, emphasizing a clear focus on best practice aiming at the integration of theory with practice. The aim is also to combing self-directed and programmed study based on the principle of reflective practice. In addition to developing clinical nursing knowledge and skills, the educational programme aims to equip students with key skills for life-long learning.

Modern mental health services incorporate a wide range of statutory, private and voluntary organizations. Opportunities need to be developed for shared learning and high quality practice experience in these diverse care settings in order to promote the concept of collaborative working. The progressive development of mental health nursing skills will be supported through effective supervision of students by clinical and academic staff both in educational and work-based settings. We believe in close working relationship with users, carers, practitioners and significant others in developing, delivering and evaluating the curriculum to ensure that it continues to reflect the realities of clinical practice and produces safe, competent and accountable mental health nurse practitioners.

The RNDipHE Course

This 3-year course is divided into a 12-month Common Foundation Programme and a 24-month Branch Programme in Adult, Mental Health, Learning Disabilities or Children's Nursing.

The Common Foundation Programme

The Common Foundation Programme is a competence based programme which serves as a foundation year for all pre-registration nursing students. All students, across the four branches, study a range of academic modules that provide a baseline for the development of Branch specific knowledge and practice. This is complemented by exposure to clinical practice and the development, under supervision, of core skills and professional awareness.

The Common Foundation Programme consists of modules attracting Level 1 Credits (See Diagram 1 on Page 5). These are designed to provide you with the opportunity to consolidate your pre-existing academic skills, and lay down the foundations for subsequent studies and your first three clinical practice experiences.

The learning outcomes in the 30-Credit modules in the award are set for theory and practice and are intended to enable you to meaningfully integrate theory and practice.

The Common Foundation Modules

NH1056 : **Holistic Nursing Practice in Context** 30 Level 1 Credits

The module aims to enable students to develop an understanding of the notion of health; the development of health care services and the delivery of services within a wide social , legal, ethical and professional context and to recognize the impact of the local and national health economy.

NH1057 : Introduction to Nursing 30 Level 1 Credits

The module aims to provide all students with foundation knowledge of sciences to support practice. Students will also be facilitated to develop a

range of clinical skills, enabling them to participate safely in care delivery under supervision.

NH1060 : Self-awareness and relating to others 30 Level 1 Credits

The module aims to enable the student to explore aspects of self-awareness and how they may relate to ‘others’ in a variety of settings. The student will explore the contribution of interpersonal and communication theories, identifying skills and attitudes required in order to develop effective therapeutic and inter-professional relationships (between the nurse and others).

As a consequence, the module will facilitate your personal development and prepare you for a wide range of psychological and interpersonal challenges that arise from working in contemporary health care services.

DIAGRAM 1
RN/Dip.HE COURSE STRUCTURE FOR BRANCH IN MENTAL HEALTH NURSING

	Semester 1 and Semester 2	**Post Semester**	**Total Hours**
Year 1 Common Foundation Programme Level 1	NH1056 – Holistic Nursing Practice In Context. 30 Level 1 Credits NH1057 – Introduction to Nursing 30 Level 1 Credits NH1060 – Self-Awareness and Relating to Others. 30 Level 1 Credits		**Total Hours 1687.5** Theory 900 Practice 787.5

RN/BSc – MENTAL HEALTH N URSING

The course aims to produce first level Registered Nurses who have the knowledge and skills to enable them to practice effectively in a safe and accountable manner and in a variety of health care settings. The development of intellectual skills, such as problem solving, decision making and critical enquiry will inform the patient/client care process. To achieve this the programme will enable students to meet the requirements leading to entry as Registered Nurse (Mental Health, Children, Adult or Learning Disability) on the Nursing and Midwifery and Health Visiting professional Register.

The Common Foundation Programme

The RN/BSc Common Foundation Programme is similar to that of the RN.Dip.HE as outlined above. The exception is that there is an additional 30 Level 1 Credits Module (See 2 Diagram on Page 8)

The Additional Module

NH1054 : Evidence Based Nursing Practice 30 Level 1 Credits
Module Leader : Sue Brock
This module aims to enable the student to reflect on practice and ask relevant questions, access and make sense of evidence and suggest how evidence may inform nursing practice. Integral to this will be the consideration of relevant frameworks, concepts and theories which will contribute to the development of knowledge, skills and attitudes required to underpin evidence based approach to reflective nursing practice.

DIAGRAM 2 RN/BSc COURSE STRUCTURE
FOR BRANCH IN MENTAL HEALTH NURSING

	Semester 1 and Semester 2	**Total Hours**
Year 1 Common Foundation Programme Level 1	NH1056 – Holistic Nursing Practice In Context. 30 Level 1 Credits NH1057 – Introduction to Nursing. 30 Level 1 Credits NH1060 – Self-Awareness and Relating to Others. 30 Level 1 Credits NH1054 - Evidence Based Nursing Practice. 30 Level 1 Credits	**Total Hours 1687.5** Theory 900 Practice 787.5

STUDENT LINK

This is an opportunity for you to work alongside qualified nurses (or other relevant personnel) in a variety of different settings. The main purpose of this link between the University and local NHS Trusts is to enable students to link theory, practice and research.

The placements are set in different areas at different times of the course and arranged by a placements officer. At each placement students have to achieve outcomes that are determined by professional bodies namely the Nursing and Midwifery Council (NMC), and Central Council for the Education and Training of Social Workers. Whilst working in the clinical areas students should be able to liaise with a named assessor and a link teacher. Practice is assessed at different levels within the Awards. It is necessary for all practice to be successfully completed in order to graduate. You can expect to be assessed by a nurse qualified in your chosen field of nursing namely Registered Mental Health Nurse, or by other appropriately qualified staff.

The Placements Co-ordinator is:

Mrs. P. Walsh
School of Health
Mary Seacole Building
MH Block, City Campus
University of Wolverhampton
Wolverhampton WV1 1SB
☎ 01902 518621
Email P.N.Walsh@wlv.ac.uk

The Subject Leader is:

Mr. M. Chellumbrun
School of Health
Mary Seacole Building
MH Block, City Campus
University of Wolverhampton
Wolverhampton WV1 1SB
☎ 01902 518619
Email M.F.Chellumbrun@wlv.co.uk

Pages relevant to year 1 study only included

Coventry University

School of Health and Social Sciences

BSc(Hons) Occupational Therapy Programme : Student Handbook Year 1 - Level 1

September 2004 – June 2005

PROGRAMME HANDBOOK

BSc(Hons) Occupational Therapy Year 1 Academic Year 2004/2005

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INTRODUCTION

Welcome to the BSc (Hons) Occupational Therapy programme and welcome also to Coventry University. At this point you may be wondering what you've got yourself into – but hopefully you will be excited at the prospect of the life-changing experience ahead of you. As the award team, we hope that you will progress through the next three years acquiring and developing the skills, competencies and professional attitudes of an occupational therapist. In order to assist you with some of the more pragmatic aspects of student life, the University provides you with guidelines and regulations. As occupational therapy students, the details of your award – BSc (Hons) Occupational Therapy - are contained in several volumes.

1. The Programme Handbook

This is specific for students on the BSc (Hons) in Occupational Therapy. The team compile a handbook at the beginning of each academic year to give you detailed information including contact details for the award team, relevant dates and details about the award for the forthcoming academic year.

2. Module Handbooks

Module leaders will supply you with module handbooks at the launch of each of the modules. Each module handbook contains detailed information about that module such as timetable, rooms where sessions take place, assignment submission arrangements and contact details for the module team.

3. The Faculty Student Handbook - Undergraduate Modular Programme

This is a general handbook for all students in this Faculty. It gives you information about the facilities on the Campus, assignment regulations, extenuating circumstances, late submission of assignments as 'late work', student representation and what to do if you are ill, want to withdraw from the course or are having problems with study.

IT IS IMPERATIVE THAT YOU READ THESE HANDBOOKS AND USE THEM TO GUIDE YOU – ignorance is no defence!

RATIONALE
YEAR 1 – Level 1

BSc (hons) in Occupational Therapy

Coventry University – School of Health

Core Skills and Abilities

Occupational therapy is concerned with human occupation and its importance in health for people form all backgrounds and of all ages.

In partnership with others, occupational therapists can facilitate development of services for vulnerable people with disabilities. Occupational therapists are active participants in either perpetuating or changing everyday practice and its context. They can influence change in that they are not trapped in fixed environment systems, routines or approaches. They develop client-centred approaches that enable people to reduce their own poverty by being more participative in public decision making. Most importantly occupational therapists provide support for people t o make use of their own capacity and potential. Their unique position in health and social care allows them to respond to individual needs through rehabilitation and promoting independence.

Core Skills

Occupational therapy is based on a unique conceptual framework.

The unique core skills of occupational therapists are:
> The use of purposeful activity and meaningful occupation as therapeutic tools in the promotion of health and wellbeing
> The ability to enable people to explore, achieve and maintain balance in the daily living tasks and roles of personal and domestic care, leisure and productivity
> The ability to assess the effects of, and then to manipulate physical and psychological environments to maximise function and social integration
> The ability to analyse, select and apply occupations as specific therapeutic media to treat people who are dysfunctional in daily living tasks, interactions and occupational roles.

Values and beliefs

- The potential of occupation in the promotion of wellbeing
- the empowerment of the service user to achieve independence
- The service user as central to the design and delivery of their service
- The opportunity to achieve a balanced lifestyle
- The holistic understanding of the needs of service users and their carers' needs and potential
- The mutual co-operation between therapist, service user and carers
- The development of partnerships to enhance service provision
- The promotion of an accessible environment

MODULE INFORMATION

Coventry University

Module Title Human Occupational Performance
Code UZY203D1
20 credits Level 1

This module aims to integrate student's knowledge of the components of occupational performance, health and wellbeing including the nature of social contexts, sociological theories and social policy. The aim is to acquire an understanding of human development and the components that contribute to human occupational performance including the form, function and meaning of occupation and its influence on health.

Module Title Foundations of Occupational Therapy
Code UZY200D1
10 credits level 1

This module aims to introduce students to the philosophy, core values and beliefs that provide a foundation for occupational therapy. It examines the relationship between occupation and health and the module introduces the theoretical foundations that provide a framework for occupational therapy practice.

Module Title Interprofessional Module 1
Code UZV203S1
20 credits Level 1
This module aims to examine the historical development and contemporary roles of professional groups in health and social care. The module seeks to foster an appreciation of power relations within the context of groupwork and enable students to explore the nature, scope and significance of social policy in the field of health and social care. Through reflection on their own health and well-being, professional role, and contribution to collaborative enquiry-based learning it is anticipated that this module enables students to accommodate diversity in collaborative, interprofessional working.

The Process of Occupational Therapy
Code UZV204S1
20 credits Level 1

This module will focus upon the application of knowledge gained in Foundations of Occupational Therapy to the practice settings. This module seeks to integrate the material gained in session A studies, to prepare students for both clinical/fieldwork experience and their future role as occupational therapists.

The module seeks to provide the student with an opportunity to practice and begin to evaluate the core skills of assessment, report writing and intervention planning through to closure and discharge.

Interactive Processes
Code UZV206S1
10 credits level 1

This module provides an opportunity for students to explore their personal and professional development. Professional roles and personal skills are identified and considered in preparation for the first professional practice placement.

On completion of the module, students will be able to identify personal strengths and areas for development through the ongoing reflective process encouraged throughout the programme.

Welfare, Health and Inequalities
Code UZV205S1
10 credits level 1
This module is designed for students on professional and vocationally orientated undergraduate programmes in health, social work and social welfare. Its objectives are to provide students opportunities to examine at an introductory level, the impact of key dimensions of social inequalities and consider how health and social welfare services may contribute to such inequalities but can work to challenge and combat them. The module provides an opportunity for students to learn to discuss these issues in an inter-professional context.

Introduction to Research
Code UZY205D1
10 credits level 1

This module seeks to provide an introduction to developing an understanding of research within a practice context.

Professional Development in Practice I (Fieldwork Education Placement)
Code UZY201S1
20 credits at level 1
Students will undertake a 30 day placement within a pratice setting.

PHILOSOPHY OF THE AWARD
The underpinning philosophy of occupational therapy is that the human being has the need to be occupied in order to maintain health and well being. The focus of occupational therapists is on the enabling of people to choose and engage in meaningful occupations in their personal care, their productivity and their leisure.
Therefore the philosophy of this award draws on this premise and develops it thematically through three levels which constitute the academic structure of the curriculum as follows: -
Level 1 – Occupation for Health
Level 2 – Challenges to Occupation
Level 3 – Enabling Occupation
Occupation for Health – introduces you to the concepts of occupational science, the disciplines of anatomy & physiology and psychology. These subjects will lay the foundations for you as a novice occupational therapy student to develop your knowledge and understanding of how occupation supports health and well being. You will integrate this with your own experiences of health and ill health as well as that of occupation. You will have some opportunity to explore and learn basic skills and competencies in using some adapted

equipment and modifying occupations. The exploration of the concepts of occupation and health will continue in your Fieldwork
Experience and the Interprofessional Module where you will also be expected to develop a professional attitude. The case studies provided would hopefully help you to make the links across the modules you will be studying. In your Fieldwork Placement early in your second year, you will be expected to consolidate much of your learning from your first year as well as develop some new learning in practice.
We look forward to working with you as you engage in some new occupations
on your journey to becoming an occupational therapist.

ATTENDANCE
Your studies are likely to take place between 9.30 & 4.30 unless indicated. Some sessions such as the Interprofessional Module may mean finishing later than this. The modules are timetabled according to the availability of the lecturers and rooms. We don't anticipate that every hour of each day will be timetabled. You will be expected to make effective use of time for your own private or group study and tutorials with your personal tutor.
You are expected to attend all the timetabled sessions and sessions which take place outside the University, which are arranged to support your studies. During the timetabled sessions, a register of attendance will be taken. Illness – yourself or within the family – are valid reasons for non-attendance, but it is your responsibility to catch up. If there are other reasons for you not attending please contact any of the lecturers before 9.15am on the first morning you are unable to attend. Their contact telephone numbers are also found on page 2 of this handbook. If you are absent through illness while you are on Fieldwork Experience (Green Weeks), it is vital that you follow the procedure used by the placement – this typically requires you to make contact with your fieldwork educator as early as possible on the first morning you are unable to attend. You may be required to self-certificate for your illness, as part of the requirements for your experience. Please let Gill Pirie know how long your illness has kept you absent from the placement, just as soon as you can.

SUPPORT AND PERSONAL TUTORS
You are all assigned a personal tutor. There is a list of the groups on the last page. We acknowledge that some of you may find you will need more support than is physically able for us to provide. Please consider a strategy to enable you to cope with the demands of the coming academic year. This may involve finding out how to contact the University's Counselling Service (see Faculty Student Handbook) and establish what kind of service they can offer. You may have to organise regular meetings with your mentor and your supervisor if you have one. Consider meeting up as a small support group, once a month over a drink or at a motorway service restaurant. Regardless of what support mechanisms you adopt, please keep us in touch with how you are finding support and if you are struggling with any aspect of your studies.

MENTORS
We strongly recommend that you find yourself a mentor who is a State Registered Occupational Therapist. This can be someone from your workplace, or a colleague from another service. Their role is to be a 'professional friend' for you while you are studying – to listen to what you're trying to come to terms with and if they can, to offer help & advice. How often you meet up and where, is entirely between yourselves. Some past students have managed to meet formally with their mentors in work time and others preferred to make the meetings a more social occasion. Past students have found mentors particularly helpful in the stressful times. We normally

hold an annual meeting especially for the mentors. If you don’t work in an occupational therapy setting and think you might have difficulty finding a mentor, we have been approached by some local occupational therapists willing to mentor students in this situation. Please let any of the lecturers know if you would like help finding a mentor. Fieldwork experience will be arranged in various settings and you must be available for this as timetabled. The placements are full-time, with one day a
week for personal study relating to the placement.

Appendix D

Pages relevant to year 1 study only included

UNIVERSITY OF WOLVERHAMPTON

Institute of Applied Social Studies

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1 Welcome from the Vice-Chancellor

I am delighted to welcome you to the University of Wolverhampton and to wish you every success in your study on the social work degree programme.

This is an exciting time to enter social work education. This is only the second year that students, all over the country have been able to register for the new social work degree launched by the Department of Health. The degree is a key component of the Government's strategy for raising standards in the whole field of social care.

You have made an important decision to enter higher education and come to the University of Wolverhampton. We recognise that this represents a significant investment both in terms of a financial commitment and personal responsibility. You now face the challenge of learning both during your university-based study and through the practice learning experiences arranged in local agencies by the University.

There are many factors which have influenced the development of the social work programme that you will follow. Drawing together expertise from the Social Work subject area with other academic disciplines including the School of Health and School of Legal studies has enabled us to demonstrate the collaborative nature of social care work. The programme has also been designed and developed in collaboration with representatives from a range of social work and social care agencies. This has helped us to ensure that during the course all your learning is relevant to a future career as a social worker registered with the General Social Care Council. This will provide the basis for your continuing professional development.

I hope that you will find this Programme handbook and the separate guide to practice learning, helpful.

Good luck with your studies at the University of Wolverhampton. I wish you every success in your academic modules and practice based learning and look forward to you achieving the award of BA (Hons) Social Work.

Professor John S Brooks

Vice-Chancellor

2 General Welcome and Introduction

On behalf of everyone involved in the teaching and running of the BA (Hons) Social Work programme, welcome to the University. We hope your career here will be both enjoyable and profitable.

We have been running qualifying Social Work Training at the University of Wolverhampton for over 10 years. We now welcome the opportunity to develop the Social Work degree programme, which incorporates several new developments as well as retaining components of the previous DipSW programme that have stood the test of time.

This Programme Handbook should be read in conjunction with the Students' Union Guide and the Practice Learning Guide. An outline of all the modules you will take is provided in this handbook, together with a summary of the regulations. This will help you to understand the management and operation of your course and also describes where and from whom to get assistance and advice.

We recognise that some students embarking on the Social Work programme will discover that professional social work is not for them. For these students, we offer the possibility of transferring to a non–professional degree programme during or at the end of year one.

We hope that you too will participate in the development of the Social Work Degree programme, perhaps by becoming a Student Representative for your year of the course. We would also welcome, at any time, your comments about the operation of the programme and any suggestions you may have for its improvement.

With best wishes for success in your studies,

Judith Holt
Award Leader

B. USING THIS COURSE HANDBOOK GUIDE

There is a considerable amount of information contained in this handbook, some of which will be of greater relevance to you as you work through the programme than it is at the start of your career in the University. It is, by design, concise and, therefore, at various points, you will also have to consult other sources of information, such as the Practice Learning Handbook and the University Regulations, which will be available via the network of Campus Registries and Learning Centres.

We encourage you to read the handbook through now since it will be a great advantage from the outset for you to be familiar with the various aspects of your studies that are described in these pages.

Please read the Sections D) and E) on “Communications” and “Sources of and Access to Information and Advice” with particular care.

In order to save yourself time, do please read the handbook carefully. The answers to most of the questions you will want to ask are contained in it. You should look particularly closely at the Section E. 6 on "How to Solve Some Common Problems".

In reading the handbook you will come across a number of words and phrases with which you may not be familiar. A list of explanations to keywords is included in Section H of the Handbook.

You should note that, occasionally in order to improve the programme, the details given in this handbook may be amended or revised. It is important that when this is done you note the changes and consider the implications they may have for your programme of study.

C. ABOUT THE BA (HONS) SOCIAL WORK PROGRAMME

1 Structure of the Programme

The BA (Hons) Social Work is an award offered by the University of Wolverhampton. The programme has been planned in close consultation with employers of social work staff, in particular with representatives of the Social Work Departments of Walsall Metropolitan Borough, Wolverhampton City Council, Telford and Wrekin Borough, Shropshire County Council and the NCH.

The programme is administered from the Wolverhampton City Campus of the University and taught on both the City and Telford Campuses.

1.1 Type of Course

The BA (Hons) Social Work is a specialist award with a prescribed programme of study. This means that with the exception of one 15 credit elective at Level 3, there will be no choice of which modules you study.

1.2 Levels of Study

Students on the Social Work degree programme will study modules at Levels 1, 2 and 3.

a) a) Level 1

This represents the introductory level of Higher Education and provides an orientation or balancing phase for students entering HE from a variety of different qualifications, experiences and backgrounds. It introduces you to the basic methodologies and principles of social work. Similarly, it provides an introduction to social work practice. Level 1 modules are normally studied during the first year of full time Honours degree course.

Full Time Course (3 years)

Year One – Level 1

Semester One	SO1005 Understanding Inequality and Exclusion Core - Standard delivery - 15 credits	SO1006 Values and Ethics of Social Work Core - Standard delivery - 15 credits	SO1007 Preparing for Practice: Communication and Intervention Core - Workshops and Skills Lab - 30 credits
Semester Two	SO1008 - Law for Social Work Practice (to week 6) Core - Intensive delivery - 15 credits		
	SO1009 Understanding Social Work Organisations Core - Standard delivery - 15 credits		SO1010 Practice Learning One (from week 8) Core - 30 days placement and workshops – 30 credits

2 BA (Hons) Social Work Calendar 2004/05
Level 1 – SEMESTER ONE

University Week No.	Date wk beg.	Monday	Tuesday	Wednesday	Thursday	Friday	Notes
		Telford campus	**City Campus**				
5	27/09/04	**Welcome Week**					**Start of Semester One**
6	04/10/04	SO1005 SO1006	SO1007 all day	Study time all day	Study time all day	Study time all day	
7	11/10/04	SO1005 SO1006	SO1007 all day	Study time all day	Study time all day	Study time all day	
8	18/10/04	SO1005 SO1006	SO1007 all day	Study time all day	Study time all day	Study time all day	
9	25/10/04	SO1005 SO1006	SO1007 all day	Study time all day	Study time all day	Study time all day	
10	01/11/04	SO1005 SO1006	SO1007 all day	Study time all day	Study time all day	Study time all day	
11	08/11/04	SO1005 SO1006	SO1007 all day	Study time all day	Study time all day	Study time all day	
12	15/11/04	SO1005 SO1006	SO1007 all day	Study time all day	Study time all day	Study time all day	
13	22/11/04	SO1005 SO1006	SO1007 all day	Study time all day	Study time all day	Study time all day	
14	29/11/04	SO1005 SO1006	SO1007 all day	Study time all day	Study time all day	Study time all day	
15	06/12/04	SO1005 SO1006	SO1007 all day	Study time all day	Study time all day	Study time all day	
16	13/12/04	SO1005 SO1006	SO1007 all day	Study time all day	Study time all day	Study time all day	**END OF AUTUMN TERM**
17	20/12/04	**Student Vacation**					
18	27/12/04	**Student Vacation**					
19	03/01/05	**Student Vacation**					
20	10/01/05	Study time all day	Study time all day	Study time all day	Study time all day	Study time all day	**SPRING TERM LAST SUBMISSION DATE FOR SEMESTER ONE MODULES**
21	17/01/05	SO1005 SO1006	SO1007 all day	Study time all day	Study time all day	Study time all day	
22	24/01/05	Study time all day	Study time all day	Study time all day	Study time all day	Study time all day	**END OF SEMESTER ONE**
23	31/01/05	Study time all day	Study time all day	Study time all day	Study time all day	Study time all day	

ASSIGNMENT DEADLINES
Dates will be given at the beginning of the modules

Module Code	Module Title	Assessment Deadline
SO1005	Understanding Inequality & Exclusion	
SO1006	Values & Ethics of Social Work	
SO1007	Preparing for Practice	

BA (Hons) Social Work Calendar 2004/05
Level 1 – SEMESTER TWO

University Week No.	Date Wk beg.	Monday	Tuesday	Wednesday	Thursday	Friday	Notes
		City campus	**Telford campus**				
23	31/01/05	Study time all day	Study time all day	Study time all day	Study time all day	Study time all day	
24	07/02/05	SO1009 SO1010	SO1008 all day	Study time all day	Study time all day	Study time all day	**Start of Semester Two**
25	14/02/05	SO1009 SO1010	SO1008 all day	Study time all day	Study time all day	Study time all day	
26	21/02/05	SO1009 Study time	SO1008 all day	Study time all day	Study time all day	Study time all day	
27	28/02/05	SO1009 Study time	SO1008 all day	Study time all day	Study time all day	Study time all day	
28	07/03/05	SO1009 Study time	SO1008 all day	Study time all day	Study time all day	Study time all day	
29	14/03/05	SO1009 SO1010	Study time all day	Study time all day	Study time all day	Study time all day	
30	21/03/05	**Student Vacation**					**Easter**
31	28/03/05	**Student Vacation**					
32	04/04/05	SO1009 SO1010	Study time all day	Study time all day	Study time all day	Study time all day	
33	11/04/05	SO1009 Study time	Placement 1	Placement 2	Placement 3	Placement 4	**START OF 30 DAY PLACEMENT 12/04/05**
34	1804/05	SO1009 Study time	Placement 5	Placement 6	Placement 7	Placement 8	
35	25/04/05	SO1009 Study time	Placement 9	Placement 10	Placement 11	Placement 12	
36	02/05/05	**MAY DAY BANK HOLIDAY**	Placement 13	Placement 14	Placement 15	Placement 16	
37	09/05/05	SO1009 Study time	Placement 17	Placement 18	Placement 19	Placement 20	
38	16/05/05	SO1009 Study time	Placement 21	Placement 22	Placement 23	Placement 24	
39	23/05/05	Portfolio "Surgeries"	Placement 25	Placement 26	Placement 27	Placement 28	
40	30/05/05	**SPRING BANK HOLIDAY**	Placement 29	Placement 30	Study time all day	Study time all day	**End of placement 01/06/05**
41	06/06/05	Exam week				**Year end workshop**	End of Semester Two and Summer Term

ASSIGNMENT DEADLINES
Dates will be given at the beginning of modules

Module Code	Module Title	Assessment Deadline
SO1009	Understanding Social Work Organisations	
SO1008	Law for Social Work Practice	
SO1010	Practice Learning One (30 day Placement)	**06/06/05 or 3 working days after end of placement**

3 Module Summaries

3.1 What you will study

Introduction
Over the course of the social work programme you will develop knowledge and understanding in six core areas:-
different modules will help you to develop in each of the six areas so that you will build on the learning from one year to the next.

1 the values and ethics of social work practice,
2 the policy, legal and organisational context of social work practice,
3 the experience of service-users,
4 theory of social work,
5 working in partnership with other agencies,
6 the strengths and limitations of the application of research findings in social work practice.

These areas are all introduced at level one and further developed in levels two and three, You will need to draw on knowledge from all the university taught modules in completing assessment for your practice modules. You will also find that your are asked to draw on experiences from your practice learning during study on University based modules.

Module Aims: Level One
SO1005 - Understanding Inequality and Exclusion
Introduces students to sociological explanations of the material conditions of service users. It offers students an opportunity to examine factors such as poverty, unemployment, ill health, poor housing, disablement and lack of education and how such factors affect human development and behaviour and can lead to exclusion. It will also look at some of the strategies to counter social inequality.

SO1006 - Values and Ethics of Social Work
Offers guidance to students regarding their behaviour with service users and to assist students to identify how their own values, beliefs and prejudices affect their practice. Will also introduce students to the historical and philosophical underpinnings of social work values and ethics, and their implications for current practice.

SO1007 - Preparing for Practice: Communication and Intervention
Ensures students are prepared and are safe to undertake practice learning in a service delivery setting. This will be achieved through the development of basic communication skills in interviewing, writing and recording. Will provide an introduction to time-management and task prioritisation techniques. Will provide an understanding of service user perspectives and to encourage service users to participate fully by working partnership.

Students should be able to identify agency policy and procedures and be able to show an awareness of the expectations of professional behaviour. They will be

provided with knowledge to be able to use and seek out professional support. They will also develop a basic understanding of anti-oppressive practice and then be able to apply this to practice. Students will develop an understanding of the importance of health and safety policy and team operational procedures and must develop an awareness of how these policies and team operational procedures affect their professional role.

S01008 - Law for Social Work Practice
Introduces students to the key elements in social work legislation across different service-user groups. The module will ensure that students have a sound knowledge and understanding of the legal context of social work practice to ensure they are "fit for practice".

SO1009 - Understanding Social Work Organisations
Develops student's understanding of organisations that commission and deliver social care / social work services and the working of teams within those organisations.

SO1010 - Practice Learning One
Introduces students and enables them to begin to participate in social work practice within a broad based social care agency.

3.2 Types of study

While you follow our programme you will be required to undertake different types of study: –

3.2.1 Directed learning
This is the term used for the learning that you do in teaching sessions at the University. This may involve formal lectures, group discussion or other group work activities such as discussion of case scenarios, listening to and giving presentations, seminars or tutorials, role play and simulation. It can also include classroom tests or exams. Most University based modules will have an allowance of 39 hours for this type of learning. That is three hours per week. You are expected to attend all teaching sessions.

3.2.2 Independent directed learning
This is learning that you are required to do, which has been specified by the module leader or tutor but which you complete in your own time and at your own pace. Level one modules are planned to require that you do 60 hours of *directed independent learning*, which works out at approximately 5 hours per week per module. Level two modules are planned to require that you do 39 hours of *directed independent learning*. This works out at approximately 3 hours per teaching week per module. You will not be given *independent directed learning* at level three.

3.2.3 Independent learning
This describes all the work that you do for the module outside the directed activities. It will include the time you spend researching for suitable reading, the reading itself, note taking, discussing the topics of the module with fellow students, or with colleagues on placement or at work if you choose to do part time work in a social care setting. It also includes all the time that you spend on assessment tasks such as

writing assignments, preparing for presentations or revising for classroom tests. At level one this would average another 3 – 4 hours per week for each module. At level two it will average 4 - 5 hours a week.

The time required to study is based on the expectation that students will spend approximately 150 hours, or 10 hours a week in study for each 15 credit University based module.

4 Key Skills

Through your work in your subjects you will acquire the skills necessary to evaluate evidence and hypotheses and to present arguments cogently. It is important that you are aware of the limitations of approaching a problem from limited perspectives.

All the modules you take as part of your Programme of Study are designed, in addition to developing subject based skills, to identify and improve a range of transferable personal skills in order to enhance your employment prospects at the completion of your course.

Thus, the modules making up your Programme of Study will aim to develop key skills in:

- written and verbal communication
- working with and relating to others
- application of numbers and IT skills (see 4.1 below)
- managing tasks and problem solving
- improve own learning and performance
- application of design and creativity

Module guides will show you which modules introduce and assess each key skill learning outcome. You will of course be drawing on these skills in other modules but they will not be specifically reassessed on each occasion.

4.1 IT Skills

While you are studying on the Social Work degree programme you will be expected to develop your skills in using Information and Communication Technology (ICT) in seven areas. These are;

1. Basic concepts of information technology
2. Using a personal computer and managing files
3. Word processing
4. Using a simple spreadsheet
5. Understanding the purpose and use of databases

6. Using the basic functions of electronic presentation software

7. Finding information on the World Wide Web and using electronic mail.

These seven areas correspond to those required for the European Computer Driving Licence. You will be encouraged to become proficient in using these skills in ways relevant to social work.

Because students vary in the level of ICT skills they hold on entry to the programme there, is no prescribed ICT course of study. Instead you will be introduced to relevant skills in modules at each level of the programme and given guidance as to how you can develop your skills as necessary to the required level. You will have access to a variety of IT skills learning opportunities and should select the appropriate ones for your skill level.

ICT skills are tested by various modules, as identified in the module guides. By the end of the programme you will have been tested in skills in each of the seven areas listed above.

5 5 Progress Files

While you are on the programme you will be encouraged to develop skills in actively managing your own learning. To help you do this you will be encouraged to keep a Progress file. This will help you to plan your learning, keep together records of your achievements and will provide a summary that you can use when discussing your achievements when going to a new practice placement or when you are looking for employment both during and after the course.

Your progress file will have three elements: –

- • Planning and review documents. These will include self-evaluation proformas designed to help you to identify your strengths and learning needs. You will be encouraged to complete these at the end of each semester.
- • Record of academic achievements. This should include feedback sheets and transcripts of results.
- • Record of practice achievements. This should build up over the years of your study so that you will have evidence of the range of settings in which you have worked. As well as formal reports of your practice you can include testimonials from colleagues and service users.

You will be introduced to the process of keeping your progress file at the beginning of the module Preparing for Practice and will do your first review of progress at the end of that module.

6 Transferring out of the Social Work Programme

It is possible that some students will find that social work, as a profession, is not what they expected. Others may find that their skills or personality are not well suited to social work. The recruitment process is designed to minimise this, but what should you do if you realise social work is not for you?

There is no need to give up your degree studies at the University of Wolverhampton. There are a number of different degrees that you can transfer on to at different points. In some cases you may have to do an additional year of study, either full or part time.

If you wish to transfer on to an academic programme at end of semester 1year 1, you will be able to move onto the joint Honours programme for Social Care and Social Policy. This may be a suitable degree for transfer at later stages in the programme. However, if you are considering transfer out of the social work programme you will received academic counselling to support you in deciding on the most appropriate route for you.

D. COMMUNICATIONS

One of the most important ingredients contributing to the success of any organisation is an effective and efficient system of communication. Therefore, it is important that you understand the lines of communication that exist between you and those responsible for providing you with administrative and academic support.

It is essential that you follow the guidelines set out below.

1 Contacting staff

Members of staff will normally notify you of the times and locations they will be available during the week. They usually publish their “office hours” on their office doors for you to consult. You should make an appointment to see staff during these hours whenever possible. Usually email will be the most effective way of arranging this. Remember that academic staff spend significant amounts of time in the class or visiting practice learning settings and consequently they will not always be available in their rooms for consultation.

Note that staff can also be contacted by email, telephone or via the School Offices and Campus Registry.

2 Staff needing to contact you

Staff may need to contact you for various reasons, often at short notice, possibly urgently. It is therefore essential that you regularly check your email, Award Notice Boards and Campus Registry Notice Boards preferably once a day but certainly once a week.

On the social work programme we rely on being able to use email to communicate with students as far as possible. Every student has an email account with the University, if you wish you could re-direct your University email to another account. Instructions on how to do this are available on the University website.

It is also essential that any change in your personal details, like change of address, is given to your Campus Registry and the Social Work Administrator, without delay in order that your records may be amended and kept up to date.

3 A Two Way Contract

Counselling and advice will be available to you [see Section E], however, the major responsibility for decisions affecting your personal and career development is yours. It is important that you realise you are entering into a form of contract or agreement with those responsible for your programme of study and that you have certain duties.

You will have to make a number of decisions affecting your study and by implication, your career and future. Only you can make these decisions. In particular you will be expected to ensure that:

You register for your Programme of Study in accordance with the award regulations by the relevant deadlines

You complete any documentation required by the General Social Care Council by the relevant deadlines.

You attend classes at all times unless special circumstances prevent you from doing so.

Coursework is submitted in accordance with the requirements of the module in question.

You take advantage, when necessary, of the counselling facilities available to you.

You inform the Social Work Award Management Team of any circumstances likely to affect your academic performance.

You immediately inform your Campus Registry of any change of address or period of absence from the University.

You check course and subject notice boards and, where available, pigeon holes at least once a week.

You respond without delay to notices and notes from your Award Management Team or subject tutors.
Requests for information from those concerned with the management of your award are responded to immediately.

4 Student Representatives

In common with all the University's courses the Social Work degree programme invites student opinion about the operation and delivery of the course as part of the University's quality control systems. Please feel free to discuss such matters with

appropriate staff at any time, the University is constantly trying to improve its modules and courses and welcomes student feedback.

You will be invited to stand as a student representative for your year or group during Welcome Week. Information about this role will be made available to you and if you take up such a post you will become a member of the Course Committee, which meets at specified intervals during the academic year. In this role you will be invited to express and represent student views and may also be asked to produce an annual report on the operation of your course. You will play a part in any major course re-designs and may be asked to discuss your opinions of the course with the External Examiners

5 Student-Staff Liaison Meetings

These meetings present an opportunity for all students to meet together with staff on an informal basis to discuss issues and problems. The primary role of such meetings is to consider and act to remedy any immediate problems relating to the teaching of the modules in your subject area. The meetings normally take place once per semester and are advertised on notice boards in your School. Wherever possible, problems raised will be dealt with quickly to ensure that modules and courses run as smoothly as possible. Outcomes of these meetings are posted on notice boards and, where appropriate, items will be carried forward for consideration by the Course Committee.

6 Module Results and Transcripts

The Student Registry will post module results to students at the end of each semester following meetings of examiners. They will not be placed on notice boards, although component grades may be placed there during term time. Please do not contact the school office for this purpose, as they do not have access to this information.

Module results following the September Examination Boards will be posted to students completing their courses but will be held in the Student Registries for progressing students to collect on their return to the University. Students should ensure that the Student Registry has details of the address to which the results are to be sent if this is different from your registered home address.

Results will not be released to any student in financial debt to the University until such a time that the debt has been cleared. A full transcript of results and advice about progression/ reassessment will be enclosed with the letter sent after the summer Examination Boards. If you have a query about any of the information in this letter you should contact your Personal Tutor and/ or Course Leader or use the publicised Results Hotline for your School at the earliest opportunity.

At the end of your course you will be sent a full transcript of all the modules you have taken to qualify for your award with the module grades. These documents are often very useful when making job applications since they provide potential employers with a snapshot of the content of your course.

1 Information on Practice Learning

Information on practice learning is detailed in the Practice Learning Handbook which will be distributed during the Preparation for Practice Module.

2 Personal Tutor

On admission to the University and during Welcome Week you will be allocated a Personal Tutor, who will be responsible for advising you on all matters relating to the academic aspects of your course and your progress on it. All full time, part time and sandwich students are entitled to the services provided by a Personal Tutor.

Your Personal Tutor will be a member of the Social Work teaching team and you will normally stay with them throughout your University career but you have the right to request a change of Personal Tutor for personal reasons. You will first meet with your Personal Tutor during Welcome Week.

Personal Tutors should then meet with their students at regular scheduled and recorded sessions each year. These meetings will be more frequent during your first year of study in order to assist you in settling into the University and understanding the various requirements made of you during the assessment. The actual number of meetings, however, will be determined by your School but will always be sufficient to ensure that the requirements of establishing and maintaining your Programme of Study are met and regular interviews of progress are made. Your School will advise you of the schedule of meetings with your Personal Tutor during Welcome Week.

In addition to the scheduled meetings referred to above, Personal Tutors will maintain a weekly advertised availability to see students whether by appointment or on demand. The Personal Tutor is also responsible, with your consent, for assembling information which may be held on file for use in preparing references you may need for job applications and the like. Your Personal Tutor will be able to recommend to you specialist student support facilities available either within the School or the University in general e.g. the acquisition of specialist study skills in your subject of study.

You are advised to keep your Personal Tutor up to date with your progress and make sure he/ she is aware of any circumstances that are adversely affecting your ability to study.

3 Award Managers/ Leaders

The Social Work degree Programme is managed by the Award Manager, assisted by year co-ordinators, together they:

- - Ensure that the Personal tutor system operates effectively
- - Arrange for staff-student liaison committees to take place
- - Manage the receipt and consideration of extenuating circumstances claims through the HLSS School systems

- - Have responsibility for the collection of assessment data for Examination Boards
- - Produce the Annual Monitoring Report as part of the quality control requirements of the University.

You will meet your Course Leader and Year Co-ordinator during Welcome Week and will be told his/ her room number, telephone number and email address (this information can also be found on the last page of this handbook). The occasions when you may need to make an appointment to see them are for example:

- - if you wish to transfer to another course
- - if you need to apply for leave of absence
- - for advice regarding annual progression on your course
- - for advice about problems with assessment results at the end of each academic year

4 The Student Registries

The Student Registries are located on each of the University's campuses. Details of the Student Registries that deal with the Social Work degree programme are set out below:

a) a) City Campus Registry

Campus Registrar:
Tel: 01902 322016
Room: MT106a
E-mail: v.m.wilkins@wlv.ac.uk
Fax: 01902 322970

Student Registry MT Block
Location: Room MT001

Registry Administrator: Anne Barclay
Tel: 01902 321171
Room: MT106c
E-mail: a.m.barclay@wlv.ac.uk
Fax: 01902 321159

Registry Administrator: Diane Brookes-Sankson
Tel: 01902 322468
Room MT106e
E-mail: dianebs@wlv.ac.uk
Fax: 01902 322379

b) b) Telford Campus Registry

Location: SB011

Campus Registrar: Mike Downs

Tel: 01902 321668
Room: SB002
E-mail: mikedowns@wlv.ac.uk
Fax: 01902 323960

Registry Administrator: Mark Shone
Tel: 01902 321704
Room SB002
E-mail: m.shone@wlv.ac.uk
Fax: 01902 323960

Student Registries are designed to help you with a number of issues concerning your life as a student. The **principal functions of the Student Registries** are set out below: –

- Help you enrol with the University and register your Programme of Study.
- Provide you with the necessary form if you wish to pay your fees by standing order.
- Help you if you need to amend any of your personal details (e.g. address) and explain the course of action you must take if you wish to amend your Programme of Study.
- Help you investigate any query you have about your fees.
- Provide you with term dates.
- Show you how to submit assignments and provide you with a receipt.
- Help you if you need to seek an extension to your assignment deadline.
- Help you if you have an examination clash.
- Help you if you need to request special examination arrangements.
- Provide you with 'seen' assessment tasks/ examination questions and resit assignments.
- Help you if you need to request that the extenuating circumstances you have suffered are considered by the Assessment Board.
- Provide you with the necessary form if you wish to resit a module.
- Provide you with the necessary forms if you wish to take a leave of absence, change your course, make a complaint or withdraw from the University.
- Provide you with details of Graduation Ceremonies.
- Provide you with confirmation of your qualification when you complete your studies.
- Provide you with a certificate and record of study for your final qualification.
- Help you obtain an academic reference.

5 Learning Centres

Learning Centres provide access to books, journals and other learning resources, including computer facilities and electronic information. They can offer support to students using the facilities and assist in directing students to other types of study support.

Your key to the Learning Centres is your University ID card, which also acts as your library card. It will be issued to you at enrolment, or you can get one at any time from a Learning Centre issue counter. To obtain your ID card you

need a current enrolment form and a recent passport sized photograph. Keep your ID card with you whenever you are on University premises – you will need it to get into the Learning Centres.

To find your way around the Learning Centres and make best use of the facilities and materials. Make sure that you participate in any induction sessions you are offered as part of the module/ course, and similarly any follow-up sessions on information skills and use of databases. There are librarians on duty at the Centres' enquiries desk to help you. If you are having any difficulties in using the Learning Centres and/ or finding information **PLEASE** ask them for assistance. There is a range of leaflets available from the Learning Centres to help you and our web pages also offer extensive information, you can find these at http://www.wlv.ac.uk/lib/, or try making enquiries on-line with our 'Ask A Librarian' service.

To borrow and return materials go to the Learning Centres' Issue Counters or use the Self-Service machines. If you have queries about your personal loans, staff there will be able to help you. To renew books, check the catalogue, reserve items, ask for information, and pay fines by card you can also ring Distance Services on 01902 321333, request renewals by fax on 01902 321986 or e-mail distanceservices@wlv.ac.uk.

For access to computers please ask for information at your local Learning Centre. These offer PC access, including standard Office software, subject databases on CD-Rom and Online, full text electronic journals online and access to the Internet. The Harrison, Telford and Walsall Centres have computer suites that stay open late for your convenience, while at most Learning Centres there are resources assistants and advisors to help with equipment and networked software. You will need to register for a University computer username and password; please ask either staff on the Centre IT Help Desks or Enquiries librarians for help. Centres also have a limited number of laptop computers for loan to students, ask at the Issue Counter for details.

If you need other equipment to support your learning you will find a range of equipment across the various sites, including audio-cassette players, binding machines, CD and DVD players, photocopiers, scanners, video editing and playback facilities. Ask at the Enquiries Desks for further details.

Most Learning Centres have Study Skills advisors stationed in them at set times. Ask at the enquiries desk for information on booking a session with an advisor. Some Centres also have Student Counsellors and Careers Advisors available for consultation; again the enquiries desk will give you information. Most Centres will also have study skills books and materials in stock plus there is a series of useful tip sheets on study skills available on the Learning Centre web pages. For advice on referencing see the Learning Centre web pages.

6 The Student Gateway

The Student Gateway – newly opened in 2002 – aims to supply a "one-stop" solution for many student queries, questions or concerns. The Gateway is conveniently

located across the way from the Harrison Learning Centre and next to the new Millennium Building on the City Campus. The contact phone number for the Student Gateway is ***01902 321020.***

If you're not sure who to talk to or contact, then make the Gateway your first port of call. If we can't help you, we know someone who can.
There is an expert, friendly and approachable Reception area where you can make appointments and obtain information or advice about the services available to you. These services are summarised below:

a) a) The Student Enabling Centre (SEC)
If you are a disabled student, the Student Enabling Centre is able to assist you with any disability-related issues. Our aim is to work with you to break down any disability-related barriers you may face and to make sure that you can take part in University life on an equal basis with non-disabled students.

i) i) Support for deaf students
Our Communication Support Unit specialises in supporting deaf and hearing-impaired students and is staffed by experts in various modes of communication. The unit can provide a range of services.

ii) ii) Support for dyslexic students
A new Dyslexia Unit has been formed to offer advice and support to students who are, or think they may be dyslexic. Please contact this unit to find out about their range of services.

iii) iii) Support for disabled students
A new Disability Unit has recently been created to offer advice and support to disabled students. The unit can provide a range of services including assessment of support needs, note-takers, general facilitators or personal care support.

More information on the support we can provide to deaf or disabled students can be found in our booklets entitled "Information for Students with Disabilities" and the government produced leaflet 'Bridging the Gap'. These booklets are also available in alternative formats. For a copy of either booklet, please contact the Student Enabling Centre.

Students should also seek out their Special Needs Social Work Subject Co-ordinator for further advice. Details of which should be displayed on school notice boards. If this information is not accessible, please contact the Student Enabling Centre for further details.

b) b) Personal Counselling Service
Personal counselling is for those students who have difficulties in their lives, which they are not able to deal with themselves. Counselling seeks to enable students to deal more effectively with those personal difficulties by helping them find their own answers. The Counsellor will help clarify thoughts and

feelings regarding the difficulties and enable the student to think about any choices or changes he or she would wish to make.
If we are not able to help you directly, we will help you find someone who can. You can make appointments either by calling by in person or phoning **01902 322572.**

c) c) The Student Financial Support Unit (SFSU)

SFSU offers advice and guidance on all aspects of the government Hardship Loan, Hardship Fund, Access Bursary, Continuing Bursary, Opportunity Bursary and Emergency Loan schemes on behalf of the University and in close co-operation with the Student Union.

The SFSU office in the Gateway is adjacent to the Gateway Reception, ring **01902 321070** for further information. You can also email any enquiries to money4students@wlv.ac.uk.

Application forms for the Hardship Loan and Hardship Fund can be collected from all Student Registries, Student Union, Higher Education Shop and SFSU. They can also be downloaded as a Word97 document from the University web site http://wlv.ac.uk under 'Advice and Support'/ 'Money Matters' or completed on screen.

Emergency Loans... may be available to assist students not in receipt of their first instalment of the government student loan at the beginning of their full time study. Contact SFSU for further information regarding application forms and eligibility.

Further Information

For information on tuition fees, grants, student loans and other University and government schemes before becoming a student contact the Higher Education Shop, Lichfield St, Wolverhampton; call 01902 321032 or email heshop@wlv.ac.uk. Contact the nearest Registry for information regarding fee-waivers for part time students. The Students Union can also assist with most issues relating to student finance including money management and debt counselling.

d) d) The Careers Development Service

The Careers Development Service (CDS) exists to help students make the most of the qualification they are studying for. CDS seeks to prepare students for the world beyond university by providing information and guidance on all aspects of careers and post-graduate study. In conjunction with academic staff, CDS works to equip students with the practical skills necessary to access their chosen career path.

e) e) The University Jobshop

The University Jobshop is a friendly service run by staff (and students) who understand the issues and financial responsibilities encountered by students today.

It offers a regularly updated source of employment opportunities that suit the lifestyle of students i.e. part-time during term time, or full-time during vacation.

7 How to Solve some Common Problems

This section is designed to save time for you and the University staff by detailing some of the more common questions or problems and where to seek information and advice about them.

Do not let problems build up; seek advice from the appropriate person quickly, you will find all staff approachable, friendly and helpful.
If your problem is not highlighted here, then use the Student Gateway or the Student Registry as your first port of call.

Query	Contact / Source of Information
Academic advice	Personal Tutor for advice on your Programme of Study and progress through your course. Your Personal Tutor may also be your first contact should you have any personal problems. He/she may refer you to the University's Counselling Service for professional advice. Students Union also offers advisory services.
Appeals	Discuss matters first with your Personal Tutor.
Assessment	Module Guides detail module assessment; see Module Leader for more details.
Assignments	*Handing in*: At Student Registries 9.30 to 17.00 Monday to Thursday and 9.30 to 16.30 on Friday during term time. *Getting back*: Module Leaders will advise on the method of return.
Attendance	If you are ill or otherwise unable to attend, you should notify your Student Registry and provide the necessary medical or other documents.
Careers	University Careers Development Service.
Changing your personal details	Notify changes of address or other details to your Student Registry.
Complaints, compliments or suggestions	Suggestion boxes, complaints and suggestion forms are available in Student Registries.

Credit for Prior Experience/ Learning	Personal Tutor in the first instance.
Enrolment	Student Registry.
Examination Timetable	Student Registry and University Intranet.
Extensions to Assignment Deadlines	Follow School guidance.
Financial queries	Financial Support Unit in Student Gateway.
International students	International Student Unit in Registry, Personal Tutor, International Tutors within each School.
Leave of absence	Award Manager; forms from Student Registry.
Loans	Financial Support Unit in Student Gateway.
Missing Examinations	Personal Tutor; forms from Student Registry.
Mitigating Circumstances	Award Manager; forms from Student Registry.
Progression between Years/ Semesters	Award Manager.
Regulations	Full copies for reference available in Student Registries. Award Manager for interpretation and advice.
Results – to discuss	*For a module*: Module Leader. *For a semester/ year*: Personal Tutor or Award Manager.
Special needs	School based Special Needs Tutors, also see Student Enabling Centre in the Student Gateway.
Student-Staff Liaison	Year co-ordinator/ Award Manager.
Timetable	Student Registry and University Intranet.
Transfer to another Award	Year co-ordinator/ Award Manager; forms from Student Registry.
Welcome Week	School Office, Student Registry.

F. QUICK GUIDE TO AWARD REGULATIONS

A full version of the University regulations can be consulted in the Student Registry and in each of the University Learning Centres. This handbook contains further important subject-specific requirements for the Award of the Social Work degree.

These regulations govern your programme of Study and will be binding on you. It is, therefore, important that you read and become familiar with this section of the Scheme Guide.

1 Module and Programme Registration

a) a) You must register the modules in your Programme of Study, recorded on the Module Registration Form.

b) b) You are only eligible for assessment on the modules for which you are registered. You will receive no credit for work submitted to modules for which you are not registered.

c) c) This Award Guide specifies the modules that are required to be taken as Core modules to satisfy the requirements of your award.

d) d) You will be required to register for your level three elective module when you enrol for that year of study.

2 Rates of Study and Progression Requirements

a) a) Full time students, including those on the employment based programme will normally study modules worth 60 credits per semester.

b) b) Part time students will normally study modules not exceeding 90 credits per year.

c) c) The maximum registration period for your award will be two academic years in addition to the period of study during which you would be expected to complete your award.

Thus the maximum period over which your award may be studied will normally be:

Route	**Maximum Registration**
Full Time	5 years
Part Time (over 5 yrs)	7 years
Employment based Route A (3 yrs)	5 years
Employment based Route B (4 yrs)	6 years

d) d) In order to progress to module [code] Practice Learning One (30 day placement), you must have confirmation that you have passed module [code] Preparation of Practice.

e) e) In order to progress from one year to the next as a full time student you need to pass all modules. It is not normally possible to progress from one year to the next if you have not completed any outstanding retrievals.

f) f) Progression from one year to the next as a part time student will be reviewed annually by the appropriate Award Assessment Board.

g) g) If you fail to achieve the progression requirements specified above you must discuss your options with your Personal Tutor and/ or Year Co-ordinator/ Course Leader without delay. Students who are unsuccessful in meeting the requirement to pass practice modules will where possible be offered the opportunity to transfer to the Joint Honours Award in Social Care.

3 Regulations regarding the content of your Programme of Study

The Social Work degree programme is a prescribed programme with one Elective Module at Level 3.

4 4 Exemptions/ Prior Credit

There are no arrangements for Accreditation of prior study for 2003/04 entrants. Arrangements for exemptions from University based modules may be developed in future years.

There will be no exemption allowed from practice modules.

5 Modules and Grading of Assessment

a) a) Each Programme of Study will be made up of units of study called modules. Modules are rated at 15, 30 or 45 credits.

b) b) Module results will be recorded using the Common Grade Point Scheme shown overleaf.

6 Credit Requirement for the BA (Hons) Social Work

For the award of the BA (Hons) Social Work you are required to achieve 360 credits: 120 credits from Level 1; 120 credits from Level 2 and 120 credits from Level 3. Please note that there is no Ordinary Degree, DipHE or CertHE with the title of Social Work. Students who cannot meet the requirements for the Honours Degree in Social Work may be offered the opportunity to complete an Ordinary Degree in a related area.

7 Failure of Modules and Compensation

a) a) You have the right to **resit** a module if you achieve an overall module grade in the range of E4 – F1. This means that you repeat the failed assessment task(s) without having to study the whole module again, in order to pass the module and gain the associated credits.

The Common Grade Point Scheme

Grade	Performance	Status

A16	Outstanding	Pass
A15	Outstanding	Pass
A14	Outstanding	Pass
B13	Above average – very good	Pass
B12	Above average – very good	Pass
B11	Above average – very good	Pass
C10	Average –good	Pass
C9	Average –good	Pass
C8	Average –good	Pass
D7	Satisfactory	Pass
D6	Satisfactory	Pass
D5	Satisfactory	Pass
E4*	Compensatable Fail	
F3	Uncompensatable Fail	Fail
F2	Uncompensatable Fail	Fail
F1	Uncompensatable Fail	Fail
F0	Uncompensatable Fail	Fail, no resit permitted
DNA	Did not attempt	
NYC	Not yet completed	

* There is no compensation allowed on the social work degree programme.

b) b) When you resit a module you are limited to a maximum of D5 for the assessment(s) you resit, regardless of your actual performance in the resit. The overall module grade will then be computed, including the D5 component(s), according to the criteria set out in the Module Guide.

c) c) If you fail the assessment(s) for a second time, you then have the right to **retake** the module, which means that you must register for the module again and all the assessments for the module must also be taken again. On the Social Work degree programme this will usually mean that you have to register as a part time student in the following academic year and defer your progression on the programme.

d) d) The grade awarded for a retaken or a replacement module will not be restricted.

e) e) Once you have passed a module, you have no further right to take more assessment in that module in order to improve the grade achieved.

f) f) On the Social Work degree programme there is no compensation for marginal failure (grade E4) in any modules at any level.

g) g) The Social Work degree programme has special regulations governing the failure of modules involving assessment of practice. [See section 9].

8 Extenuating Circumstances

a) a) These apply if you have experienced illness or other serious personal difficulty that has affected your performance in assessment or ability to undertake assessment for your Award.

b) b) The relevant Social Work Assessment Board on the recommendation of the Extenuating Circumstances Board may recommend that this be taken into consideration in judging your overall performance.

c) c) Requests for extenuating circumstances to be considered must be submitted **at least one week in advance** of the meeting of the Board concerned.

d) d) Further details about extenuating circumstances are to be found in Section G.6 of this guide.

9 Limitations on the Rights to Retake

You should note the requirement to complete your award within two years of the expected date (see section F.2c), also, the requirement that you must pass all modules at each level before progressing to the next. This means that you can have the opportunity to re-take modules on only two occasions.

10 Procedure for Ending Students Involvement in Social Work Training

The University regulations state that “Where a student fails a programme element designed to test professional as opposed to academic competence, the Award Assessment Board may exceptionally exercise discretion to withdraw the student’s general right of re-assessment” (Academic Handbook, Principles, Regulations and Procedures E.5.7). In line with GSCC this discretion will be used when “a student’s behaviour is confirmed to be damaging or dangerous to either service users, other students or programme providers, or creates unacceptable risk for themselves or others”.

In accordance with the above a student's registration on the programme may be terminated when either:

a) a) as a result of assessed practice a placement is terminated and the appropriate meeting takes the decision that no further placement opportunity should be offered; or

b) b) the programme manager is informed that a student is involved in behaviour which is not consistent with professional practice as defined in the GSCC code of practice, and which would lead to refusal of a partner agency to offer the student a practice placement.

In the case of (b)

- The student must be notified in writing within seven days that a concern has been reported to the programme manager.

- If the student is on a practice placement at the time of the reported incident the placement supervisor / practice teacher must be informed and the placement can be suspended immediately by the placement supervisor / practice teacher in consultation with the line manager for the placement.

- A copy of the notification to the student must be sent to the student's personal tutor.

University Disciplinary Procedure

If there is due cause, the matter may be referred to the University disciplinary procedures. In this case the student may be suspended form the programme with immediate effect pending a formal disciplinary hearing.

Investigation and recommendation

A meeting must be convened by the programme manager within one calendar month following an inquiry into the incident. The meeting must take account of the view of the student's personal tutor, practice teaching co-ordinator, programme manager and an agency representative.

The meeting must invite the student to present any information they consider relevant, to challenge the evidence presented in relation to their practice and if they choose, to invite a representative e.g. student union representative or friend.

The meeting will decide to recommend to the Chair of the practice panel either: -

a. a. the student should continue on the programme; any conditions for allowing the student to continue must be recorded.
b. b. the student's behaviour has made them unsuitable to undertake a practice placement. They are therefore not able to continue with their registration on the programme.

The meeting may defer their decision pending advice from an appropriate level of operational manger from within one of the partner agencies. (This is consistent with decision making in relation to criminal convictions and other employment issues at admissions stage).

Minutes of the meeting should be circulated within 10 working days of the meeting taking place.

Confirmation of Decision
The Chair of the Practice Assessment Panel will review the decision in consultation with external assessor. The decision will then be forwarded to the Assessment Board for confirmation. Where necessary, to avoid undue delay in the student's learning, the Chair of the Assessment Board may make an immediate decision and report this to the next Assessment Board Meeting.

The student has the right to appeal or complain about the decision using the University procedures.

G. ASSESSMENT

Assessment is the means by which judgements are made about the extent to which you have met the learning outcomes that are set for your learning.

Assessment methods vary from module to module and include any of the following:

> Formal examinations, phase tests, essays, reports, dissertations, multiple choice tests, seminar presentations, oral presentations, laboratory reports, workshop reports, problem solving exercises, studio performance, exhibitions, individual and group project work etc.

This wide diversity of methods reflects the variety of learning outcomes developed within the curriculum as well as the many teaching and learning methods employed by staff in the delivery of modules. Most modules will use more than one of the methods described.

There are a number of things that you need to know about assessment of your work and understanding these various points will assist you in progressing and enhancing the standard of your work.

Assessment methods and deadlines for submission will be clearly set out in your Module Guide issued at the commencement of every module you take, but if you are in any doubt about any aspect of assessment please ask your Module Leader. Assessment methods for Practice based modules are set out in the Practice Learning Handbook.

J. PROGRAMME MANAGEMENT

1 Programme Management Committee

Role and Responsibilities
The Social Work degree programme is managed by the School of Humanities, Languages and Social Sciences through the Programme Management Committee. The role of the committee is to ensure that all stakeholders in social work education have an opportunity to contribute their view to the management of the programme.

This would include issues surrounding recruitment and selection; curriculum; practice learning; assessment; monitoring and review.

Aims of the Programme Management Committee:

plan and develop strategic policy for the programme;
ensure that the programme meets GSCCs and the awarding institutions' quality assurance standards;
ensure that the programme's Equal Opportunity Policy is being implemented;
monitor the resources to ensure that students are able to meet the statement of requirements;
set and evaluate performance targets;
initiate and oversee the necessary remedial action when targets are not met or performance is unsatisfactory;
ensure the collaboration is working effectively, e.g. correspondence to and from the programme is appropriately shared and circulated;
the Programme Management Committee receives written and verbal communication on key issues and developments within the programme;
students are kept informed of decisions made within the programme.
sub-groups are established with responsibility for specific issues.

Membership

The membership will include

- a senior agency representative from each primary partner agency,
- three students representing those studying full time, part time and employment-based,
- a representative of voluntary and private agencies offering practice learning opportunities, nominated from an appropriate representative group or co-opted by the committee
- a representative of practice teachers, nominated from an appropriate representative group or co-opted by the committee
- a representative of service users, nominated from an appropriate representative group or co-opted by the committee
- a representative of practitioners, nominated from an appropriate representative group or co-opted by the committee
- programme manager
- year co-ordinators
- placement co-ordinator
- A senior member of staff from the University of Wolverhampton will chair the committee.

Operation

The programme management committee will typically meet three times a year. The meetings will relate to the School quality cycle as follows;

October – agree annual report including action plans for coming year
March – interim review of programme and progress on action plans
June – annual review of programme

1.1 Roles of the Course Co-ordinators

*Programme Manager**: Judith Holt***

The role of the programme manager is to:

produce a subject monitoring report for the University;
produce review and validation reports for GSCC and the University;
manage social work finances;
manage Award issues e.g. appeals, complaints and the termination and suspension of student placements;
act as GSCC correspondent for the programme;
liase with External Examiners.
ensure the programme's internal monitoring strategy meets GSCCs and the awarding institutions' requirements;
ensure the collaboration is working effectively, e.g. decisions within the programme are made collaboratively;
ensure the programme's anti-racist and anti-discriminatory policies are being implemented;
ensure GSCC is advised about any changes or modifications to the programme;
ensure co-ordinators are clear about the evidence they are required to produce and the dates when the information will be required;
arrange programme meetings, reviews and liaison with the GSCC Social Work Education Inspector;
provide annual monitoring reports for GSCC and the University.

Admissions Co-ordinator: ***Graham Tuckley***

The role of the admissions co-ordinator is to ensure that:

- The programme's recruitment and selection processes and criteria conform to the General Social Care Council requirements
- the Programme Management Committee are aware of the programme's short listing and interviewing procedures;
- candidates short listed and offered a place on the Social Work Degree meet the programme's requirements;

the admissions process offers all candidates regardless of gender, race, class, religion, age, disability, sexual orientation an equal opportunity to be considered and offered a place on the programme;
the admissions process represents minority interests, such as members of black and ethnic minority groups;
there are processes for effecting improvements in the admissions process;
complaints and appeals procedures are implemented.

Placement Co-ordinator: ***Mary Keating***

The role of the placement co-ordinators role is to:

co-ordinate placements for the full time, part time and employment based students on the programme;
co-ordinate off-site practice teaching arrangements for students;
co-ordinate workshops for practice teachers and placement supervisors;
chair placement co-ordination meetings;
attend Accreditation Panel meetings within social work agencies;
accredit voluntary sector placements used by the programme;
develop placement provision within the programme;
develop a system to monitor practice learning;
attend practice assessment panels and follow up any concerns about placements;
follow up any concerns about practice teaching and placement provision raised at panels and through annual monitoring;

produce a monitoring report for the Programme Management Committee;
endeavour to ensure placement providers meet the requirements of the funding plan;
send out placement request forms and process applications;
act as personal tutor to social work students.

5 Practice Learning Issues

All the information relating to Practice Learning can be found in the Practice Learning Handbook. Each student will be given a copy of this handbook when they start the programme.

6 Useful Contacts

Julie Savage **(Louisa Fulbrook, Administrator)**	**Training and Staff Development** **Shropshire SSD** **Julie.Savage@shropshire-cc.gov.uk** **017430 253842** **Louisa.Fulbrook@shropshire-cc.gov.uk** **01902 253840**
Jan Marr	**Training and Staff Development** **NCH Action for Children** **0121 355 4615** **janm@nch.org.uk**
Chris Dixon	**Staff Development Section** **Telford & Wrekin Social Services** **01952 202270** **chris.dixon@wrekin.gov.uk**

Appendix E1

Letter to participants

Dear……

I am writing to invite you to participate in a research project, which I am conducting as part of a Doctorate degree course in Applied Social Research at the University of Birmingham. I enclose an information sheet, which explains the title and aims of the project.

If you are willing to take part, you would be interviewed on three separate occasions over a nine month period throughout your first academic year. Each interview would take no longer than 60 minutes. Anything you say would be totally confidential and any notes made as a result of the interview would be destroyed afterwards. The interview would take place in a location of your choice at a time that is convenient to yourself. A report will be written of the findings and numbers or pseudonyms will replace all names so that you cannot be identified.

If you feel that you would like to be interviewed please indicate on the attached sheet and hand to the course administrator.

Yours Sincerely,

Teresa Hewitt- Moran

Appendix E2

Participants information
(Version 1) July 2004

Study Title;
The role of professional socialisation in the development of professional identification in mental health students

You are being invited to take part in a research study. before you decide it is important for you to understand why the research is being undertaken and what it will involve. Please take time to read the following information carefully and discuss it with friends/ relatives. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

1. **What is the purpose of the study?**

The aim of the study is to identify factors which impact on the development of professional identity within three professional groups which are commonly represented within the mental health workforce. I aim to explore these factors in detail by tracking the development and experiences of 9 undergraduate students entering professional training for nursing, social work and occupational therapy, who are interested in working within mental health services. This exploratory study will employ a qualitative methodology, utilising a longitudinal case study approach and semi structured interviewing.

Volunteers would be required to participate throughout the duration of the study, which would include their mental health placement. This will entail being interviewed on at least 3 separate occasions throughout the first academic year of study.

2. **Why have I been chosen?**

I am approaching Wolverhampton University nursing and social work students to take part as the courses provide placements in the first year of study. I am approaching Occupational Therapy students at Coventry University as they are the most local training provider. I will be recruiting three participants from each discipline, nine participants in total.

3. **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect your studies at the university in any way.

4. **What will happen to me if I take part?**

If you choose to take part, I will interview you initially for about 1 hour in a location of your choice. I will need to record the session so that I can make an accurate record of everything that is said during the interview. Once the recording has been transcribed, the tape will be destroyed and a number and a pseudonym allocated to your information so that you cannot be identified. We would then meet again for an interview approximately 1 hour long about three months later, once you have settled into your course. The final interview 9again about 1 hour long) will need to take place following the completion of your first mental health practice placement, which will be sometime in the Spring or Sumer of 2005. All interviews will be recorded, and tapes destroyed once encoded.

5. **What do I have to do?**

There are no restrictions which will apply to you as a result of having taken part in the research. Your participation will be partaking in three interviews during which you will discuss your views and feelings on a number of topics relating to mental health and your chosen profession.

6. **What are the possible benefits of taking part?**

There are no specific intended benefits to participants from taking part in the study. it is anticipated that the findings of the study may well benefit the training experience of future students on the course.

7. **What will happen to the results of the research study?**

The results of the study will be submitted as part of my PHD Thesis at the University of Birmingham, and as a result will be stored within the library there. I may seek to publish the results in a relevant journal. I will make full copies of the final PHD submission available to all participants in a format of their choice (CD or paper copy)

8. **Who has reviewed the study?**

The proposal for the study has been reviewed and passed by a review panel at the University of Birmingham. The ethical subcommittee at the School of Health at the University of Wolverhampton has approved the study.

9. **Contact for further information.**

I can be contacted for further information by the following means;

E-MAIL; Teresa.moran@blueyonder.co.uk

Phone; 01384 820598
Mobile; 07980 825829

May I take this opportunity to thank you for the interest you have shown in this study.

Appendix F

GENERAL CONSENT FORM AND RIGHT TO WITHDRAW:

Title of Project;
The role of professional socialisation in the development of professional identification in mental health students

Name of Researcher;
Teresa Hewitt-Moran

Please tick box

1. I confirm that I have read and understand the information sheet dated July 2004, version 1, for the above study and have had the opportunity to ask questions ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason ☐

3. I agree to take part in the above study ☐

Name	**Date**	**Signature**
……..	……	…….

Researcher

……..	……..	…….

Appendix G

Participant information

(Pseudonyms have replaced real names)

Nurse A;

Susan is a 42 year old female of white British origin. She has worked with older people in the private sector and her mother had been a nurse. She had also looked after her father who died five years ago. Although initially intending to do acute general nursing, she has been attracted to working in mental health due to recent experiences with her teenage daughter who has been experiencing mental health problems. Her placement was on an acute ward

Nurse B;

Nicola is a 21 year old white British female. She has studied massage and sports therapies and has previously worked as a life guard before deciding to undertake nurse training. She was attracted to mental health nursing as she had a number of family members who has experienced mental health problems, and she thought that nursing would be a stable career also. Her early placement wan on a mental health rehab ward, although she left the course after 5 months

Nurse C;

Howard is a 50 year old white British male. He has over 25years experience working as a cabinet maker, but has been a holistic therapist part time. His placement is in an inpatient unit for older people suffering with organic mental health problems

Social Worker A;

Rebecca is a 25 year old female of white British origin. She has worked with children in the voluntary sector, but was also attracted to community psychiatric nursing as well a social work. She had her practice placement in a mental health resource centre, within the local authority provision of day support and outreach, although there was a CMHT attached and she had opportunities to shadow the asws in that team.

Social Worker B;

Kam is an 28 year old British female of Asian origin. She had been in foster care during her childhood, and this had motivated her to work in social work. She has voluntary work experience in an Asian women's community group. Whilst she is determined o work in

children's serves to repay her debt to the service, she is very interested in mental health work. She had a placement in a CMHT within a resource centre

Social Worker C;

Lynne is a 30 year old female, white British. She has a number of years experience of working at a care assistant in local authority and private homes for people with learning disabilities and older people. She studied sometime ago towards a BSc in psychology, but only completed 18 months. It is this that stimulated her interest in becoming a mental health social worker. Lynne had a practice placement in a CMHT.

OT A;

Paul is an 18 year old white British male. He has no previous experience of working with people and came to university straight from college. Paul studied psychology at college which fuelled his interest to work in mental health. He had a placement in an OT department at a psychiatric hospital.

OT B;

Ruth is a 20 year old white British female. She has a cousin who has learning disabilities and she always wanted to work with people with learning disabilities, especially children. Whilst at college she had a placement in a school. Initially she had hoped to train as a physiotherapist but her grades at college whilst studying for her BTec in health and social care were not as good as were required, especially in biology, so someone suggested OT to her. She researched the role and information suggested a wide range of careers in OT. It was at that point she became aware of the mental health aspect of the role, and felt intrigued by this. Her placement is in a special residential school run by the voluntary sector for children with mental health and learning disabilities

OT C;

Claire is a 25 year old white British female. She studied to be a nursery nurse at college and decided on a change of career at the age of 23, when she had been inspired to train as an OT by the OT that had cared fro her grandmother who had suffered from Alzheimer's disease, Claire attended the first two interviews but was lost from the sample after six months on the course.

Appendix H

Teresa Hewitt- Moran
80 Hungerford Road
Norton
Stourbridge
W.Midlands
DY8 3AB

Judith Holt 7th May 2004
Social Work Degree Programme Manager
Institute of Applied Social Studies
Wolverhampton University

Dear Judith,

I am currently undertaking a Doctorate in Applied Social Research (part time) within the Institute of Applied Social Studies at the University of Birmingham. I am in my fifth year of study, and I am about to embark on the main research study.

The aim of the study is to identify factors which impact on the development of professional identity within three professional groups which are commonly represented within the mental health workforce. I aim to explore these factors in detail by tracking the development and experiences of 9 undergraduate students entering professional training for nursing, social work and occupational therapy, who are interested in working within mental health services at the outset. This exploratory study will employ a qualitative methodology, utilising a longitudinal case study approach and semi structured interviewing.

I am writing to request you permission to approach students embarking on their professional training within your department, to enable me to recruit 3 volunteers to take part in this study. Volunteers would be required to participate throughout the duration of the study, which would include their mental health placement. This will entail being interviewed on at least 3 separate occasions over a period of at least the first academic year of study. The ethos, values base and delivery style of the programme itself would be studied in context. Anonanymity and confidentiality will be assured for both participants and the institutions.

I look forward to hearing from you.

Yours sincerely,

Teresa Hewitt- Moran
MBA., BSc (Hons) Psychol., R.M.N.

07980 825829
01384 820598
teresa.moran@blueyonder.co.uk

Teresa Hewitt- Moran
80 Hungerford Road
Norton
Stourbridge
W.Midlands
DY8 3AB

Mike Chullumbrum 7th May 2004
Nursing DipHE Programme Lead
School of Health
Wolverhampton University

Dear Mike,

I am currently undertaking a Doctorate in Applied Social Research (part time) within the Institute of Applied Social Studies at the University of Birmingham. I am in my fifth year of study, and I am about to embark on the main research study.

The aim of the study is to identify factors which impact on the development of professional identity within three professional groups which are commonly represented within the mental health workforce. I aim to explore these factors in detail by tracking the development and experiences of 9 undergraduate students entering professional training for nursing, social work and occupational therapy, who are interested in working within mental health services at the outset. This exploratory study will employ a qualitative methodology, utilising a longitudinal case study approach and semi structured interviewing.

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I look forward to hearing from you.

Yours sincerely,

Teresa Hewitt- Moran
MBA., BSc (Hons) Psychol., R.M.N.

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Teresa Hewitt- Moran
80 Hungerford Road
Norton
Stourbridge
W.Midlands
DY8 3AB

Ruth Heames
Head of Occupational Therapy Department
School of Health and Social Sciences
Coventry University

7th May2004

Dear Ruth,

I am currently undertaking a Doctorate in Applied Social Research (part time) within the Institute of Applied Social Studies at the University of Birmingham. I am in my fifth year of study, and I am about to embark on the main research study.

The aim of the study is to identify factors which impact on the development of professional identity within three professional groups which are commonly represented within the mental health workforce. I aim to explore these factors in detail by tracking the development and experiences of 9 undergraduate students entering professional training for nursing, social work and occupational therapy, who are interested in working within mental health services at the outset. This exploratory study will employ a qualitative methodology, utilising a longitudinal case study approach and semi structured interviewing.

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I look forward to hearing from you.

Yours sincerely,

Teresa Hewitt- Moran
MBA., BSc (Hons) Psychol., R.M.N.

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UNIVERSITY OF WOLVERHAMPTON

School of Health
Educating for Health

Professor Mel Chevannes CBE FRCN PhD DSc MA BA(Hons) RGN RM RHV Teachers Cert RHVT
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HP/SA

Teresa Hewitt-Moran
80 Hungerford Road
Norton
Stourbridge
West Midlands
DY8 3AB

Dear Teresa

Re: **The role of professional socialisation in the development of professional identification in mental health students.**

The School of Health Ethical Sub-Committee met on Tuesday 13th July 2004. **Approved your project without amendments**, proceed with study following the procedures within your Local Trust/HA.

It was agreed by members for your project to be awarded the following Codes.

University Category: A

SOH Code:1

I would like to wish you every success with the project

Yours sincerely

pp Archibald.

H Paniagua
Chair – School Ethics Committee

INVESTOR IN PEOPLE

Vice-Chancellor
Professor John Brooks BSc PhD DSc CEng CPhys FInstP

Appendix J

Interview Transcripts

Susan 1
NA1

Why do you want to become a nurse. Are there any specific motivating factors

NAI Um, no specific factors. I had wanted to do it since I was 17 when I had a place at the Robert Jones and Agnes Hunt in Oswestry , but I had a boyfriend at the time who didn't want me to go, so I didn't.

Did it mean that you would have to move house

NAI Yes , I would have to leave him you see, so…

Now being 42…. well I've just wanted to do it for a long time. I sent for all the applications when my youngest daughter was 1 and I realised having talked to various students what the pressures were and I just thought I can't do this with a small child . so I literally waited and there has been a shift in my life where ,um, I have three children and the youngest has just turned 16 and they are all self sufficient, and I sent for the application form for my daughter and I ended up filling them in for myself.

So what have you done then, if you decided at school you wanted to do nursing

NAI I have worked in residential settings in between having the children. Um, I was deputy manager of a residential home but found it immensely frustrating because I had no qualifications and it was almost like swimming through fog, I didn't know what I was doing, the staffing, the actual employing of people I found very difficult because I hadn't got the training. They were more than prepared to pay me god knows how much a year and I just couldn't do it, it was awful because I just felt frustrated that I hadn't got the knowledge

So has it always been older people that you have worked with

NA1 Yes, I do like the elderly, I have always liked the elderly. I don't know why, its just one of those things. I don't think now having had children that I could feasibly do childrens nursing

Why is that

NAI Because I have children, and once you have children to do children's nursing you have got to be fairly strong and I'm a bit of a soppy old whimp and……..

You wouldn't be able to face it

NAI No, no. I would do it, but I would find it very, very difficult. But the elderly particularly I do enjoy.

So would you say that you have chosen this career then or has it chosen you

NAI Its probably chosen me. I mean somebody said 'oh you would make a good teacher' and I said there would be nothing worse than been faced with teachers, absolute horror… but another thing I like to feel that I have done something worthwhile, and to interact with people, I'm a people person. I mean, immediately before coming into nursing I owned a shop in Bridgenorth, a wool shop, and it was always dear little old ,ladies. They used to come inn for a cup of tea, I mean I was a useless shopkeeper, because I used to sit and talk to them most of the time but, you know. I was not a very good business woman

Would you suggest that you have any life experiences that have persuaded you to become a nurse. I mean it sounds like you have been through different phases of interest, your application when you were seventeen, and then again when your children were young

NAI There are several things. My farther died of a brain tumour 5 years a go, and my mother is a nurse, she works in primary care, she is a district nurse and a primary care manager. And when my father was dying I was very, very involved in that….um, and that feeling of um, its not an egocentric feeling, not an inward feeling, but that you've done something that has benefited someone else. I was very glad when my father died because the last few months had been horrible for him, he had speech dysphasia and it was fairly grim. Then I thought, well I'd like to do this. I mean it sounds a bit bizarre, that you like watching people die, but to be able to make someone comfortable at the end of their life rather than seeing them frightened and in pain, I think it's a real achievement. And yes you are right, when I was 17 I was pushed into it, well not pushed but advised as I didn't know what else to do and with your mums a nurse its assumed that you will be, and I didn't know what else to do. I wasn't ready, I was too young. Far too young, but having had three children and various things. I have a thing at home which says teenagers leave home now while you know it all. Because that is what your like, your omnipotent as a teenager, you know everything. But its only as you get older that you realise you don't know everything.

Yes I'd agree. So ho far are you into the course now

NAI ten weeks. At the moment I'm on a nursing home placement,

Already? Your in week ten of your course

NAI Yes, it's a two week placement. Some of the youngsters , well, they'll bring in a cup of tea to some one whose a paraplegic, and they'll put it at the end of the bed and then walk away. I mean to me that's like Chinese torture! And then they'll come in and say 'well he hasn't drunk his cup of tea!

Have you considered any other health or social care roles

NAI No. social work I think is terrifying, because I think… you are vulnerable, from what I've seen. From what you see on television, social workers seem to be the whipping boys, um you know. If something goes wrong it's the social workers fault, its not the fact that mr Jones stabbed his wife, it's the social workers fault.

Yes, the highly publicised childcare cases blame social workers for wither being to heavy handed or not doing enough don't they

NAI Yes. You're dammed if you do and your dammed if you don't with social work.

So what would you say makes being a nurse preferable to the other professions

NAI Crikey, umm. You have amore therapeutic relationship, with nursing the history….. when you put on a nurses uniform you become a nurse. With a social worker you are like the scourge of society, they really don't want to know you, but with a nurse historically they have been beneficial, they have been carers, they have been people to confide in. and I think history, because your uniform gives you a status, and I couldn't….mmm what am I trying to say…I think that social workers, where they are almost part of society, they are not held in the same regard as a nurse. It gives you a professional barrier, between your own personal life and your professional life. Its regard and esteem.

So you feel that you can operate better in a situation where you can step into a role and leave your personal life behind.

NAI Yes, yes

So, the other professions such as occupational therapists, physiotherapists, paramedic type jobs

Yes

What would make nursing preferable over those

NAI I've just never considered them as a career option

Do you think that you know enough about the different roles

NAI I probably don't know enough about them. As a sort of very young person I thought I wanted to be a chiropodist and then I looked at feet and thought , god they're disgusting. I was talking to someone the other day and I mentioned wiping someone's' bottom and she said 'uggh, I don't know how you can do that' and said, well, you do it because it makes someone feel better, you know. I have literally never considered doing anything else

When did you first apply for your nurse training.

NAI I first applied three days after having a hysterectomy in May of last year, while I was at home recovering

Wow, that was quite a short amount of time. Starting in September, they must have wanted to snap you up

NAI I had about 5 weeks notice

So back then, what were your hopes and expectations of the course

NAI That I would come out of it at the end a rounded , well educated knowledgeable person. I am a self confessed control freak, I do not like to feel out of control, I'm a bad passenger and

hate flying because I like to be in control. That's why I left the deputy managers post because I wasn't in control, not physically, but I just hadn't got the knowledge.

What about the actual content of the course, what were your expectations of that, what the experience was going to be like

NAI Um. I talked to my cousin who is in her third year, and I talked to another girl who convinced me that if she could do it, anyone could, and I knew from then when I applied what the course involved. Then after the first week at university- I could have walked away and never gone back. I felt so befuddled because I had never been in academia before, and I could get used to the jargon, and I've worked for myself for the last 12 years, and to have no control, were back to this control thing, I found very, very difficult. It was my husband who persuaded me to carry on.

How did they prepare you then or what information did you have in advance, to prepare you for the level of academic work, assignments etc

NAI There really wasn't any until we were actually here, and in the first week the modules were launched we were told the criteria, then there was the problem that I had never even turned on a computer. And that was a major stumbling block I was like- oh my god!

And did they give you any extra support

NAI They were very good. I mean I went to see the key skills advisor and the IT people, and they were very good. They didn't clutch their heads like the kids do 'oh mom!' I wouldn't say I'm proficient now, but I can use the computer quite adequately, do tables and I'm very leased with myself

Well done. To have achieved that in 2 months and have confidence

NAI Well you have to be a fast learner otherwise you would just sink

So have you had any assignments to complete yet

NAI I just handed two in

How do you feel

NAI Bloody marvellous!I did point out they weren't to lose them

What was the experience like for you

NAI The first was a key skills assignment which took 6 weeks to complete, I came to see the tutors, I went to assistants in the library, asked the kids, and went for help in every corner. Whilst I don't expect a good mark, I should pass as I have looked very carefully at the criteria and I have covered it all. The other one is development of professional practice, focussed around a scenario in the workplace and how you interpret the NMC code, 2000 words and that wasn't too difficult. We had an exam on Thursday, on practice nursing, I swatted like mad!

So that's another skills you have had to learn, planning revision, sitting exams, timing answers

NAI It is yes

Sounds like your coping well to me. Do you feel that the 18 year old school leavers in the group have an advantage

NAI No, no. we all want to lynch the 18 year olds

Why is that

NAI They are not committed, and they talk throughout the lectures. They don't take the course seriously, one the other day was thrown out of the classroom for behaving badly.

What's the percentage of school leavers to more mature students

NAI About 50/ 50

Have your hopes and expectations changed at all, following the three moths that you have been on the course

NAI Yes, I really thought that when I came in that I would find the academic work easy. Why I thought that, I don't know, but I have always found businessy things easy, you just do them. But when things require analysing and reflection, I struggle at bit. I'm not a navel gazer.

What would you say makes a good nurse

NAI I knew you were going to ask me that
Someone who will listen, of all the things you need to be a nurse, you need to be a good listener and you need to look as though you are listening. To be empathetic, rather than sympathetic. If your empathetic you actually do something about it, um

So being able to put yourself in someone else's' situation and imaging how they might feel

NAI Yeah, although I recently did my first sub cut injection and I could really feel it! I said to the sister that was really weird and she said 'stop putting yourself in the shoes of the patient, you've got to step back and be rational about it, and not think about how much this hurts, which .. I suppose is right

Ok if you can try and answer this question to the best of your ability, what do you think would make a good social worker then

NAI I don't know, I don't know what social workers really do

If you can imagine that you were having problems and you had a social worker allocated to you, what qualities would you hope that the social worker would have

NAI Um, jeepers..

Don't worry about not knowing, there's a chance by the end of your three years that you will have an idea!

NAI I honestly don't know, I mean along the same ideas of listening I suppose, and drawing on resources, but I've never had any contact with a social worker, I don't know any.

Would your answer be any different for OTs then

NAI No, I'd have to say I know even less about them

Ok. You talked about what would make a good nurse, what do you think are the core skills are

NAI The core skills or nursing? I still think listening is the most important, and being able to act on the information that you are given, and to be empathetic and to be professional. Not to stand back, but to.. disassociate yourself from your emotions if you can to put a gap between.. I don't know

Would you see that these qualities, skills , attributes are unique to nursing or would you see that these are needed to be any type of healthy or social care professional

NAI They are probably core kills that would have to run through all caring professions because otherwise you would get such a diversity you wouldn't be able to work in a multi disciplinary team cos you wouldn't all be heading in the same direction, you'd be going off at tangents everywhere.

Ok, what about values of nursing. What values underpin nursing, provide the foundation

NAI Trustworthiness, is probably one of the main things because if you are not trustworthy, you will find compliance very difficult, people will just say bugger off, you're not toughing me! Um, and also….

Put another way, what are you there to do as a nurse

NAI You're there to look after them, holistically- that sounds like I have swallowed my lecture notes. But as a nurse, you have to look at the whole person, and not just within the confines of the NMC code and the ethics but, your own personal sort of conscience that you are doing the best you can, in the patients best interests, rather than just treating the ulcer on the leg, you are making sure thy have good nutrition, and using your experience and your professionalism and your knowledge to treat the whole person, but in doing that you need to involve them in the whole treatment, to empower the patient to gain consent and autonomy, I have swallowed my lecture notes!

NAI Promoting the autonomy of the patient is what they keep telling us, . if someone feels that they are acting rather than being acted upon, it gives them a feeling of empowerment and makes them feel that they are contributing to their own treatment. I found that in one of the text books and I rather like it.

To summarise that last point, you are saying that you would rather do with than do to a person, I mean you did mention treat and look after, but other things seem to be around enabling

NAI Yes, you do need to look at the whole person. You cannot treat the specific symptoms without looking at everything that goes with it, the lifestyle, the assessments. I mean a case in

point. There is a gentleman at the nursing home who has extremely bad bedsores, but his nutrition is very poor. It is his choice however, even though we try to get him to take ensure, etc, but he refuses point blank, and its so frustrating. His ulcers will never heal as s nutrition is so poor, he's just eating enough to stay alive. As a nurse you cannot force somebody, or surreptitiously bung him vitamins, you just can't do it.

What about knowledge base then? What specialist knowledge does a nurse need

NAI Anatomy, drugs, psychology, umm, ;icing up on qualified nurses knowledge

So would that be procedures and approaches

NAI Yes, such as putting up an iv, you need to learn the procedure, such as you can't do B before doing C. Its the same with washing a patient, or oral care. They need to be learned parrot fashion really,

Ok, again I am going to ask you questions about the professions you feel you know nothing about, but any idea of the values and knowledge base of a social worker would be

NAI No.

And again. OTs any idea at all

NAI No.

Ok, looking at yourself then, what would you say are your own personal strengths and skills are, and are there any areas for development

NAI Yes, my it skills, they are getting better. People skills don't bother me, I've been meeting people & interacting for years. I'm fairly organised, I am very aware that one placement, there are 4 of us, toe of them are under 21 and sometimes I worry that I can behave like their mother and do everything for them.

You also confessed to being a control freak. Is that ever a problem for you, in as much as you may try to take responsibility for others

NAI Yes, I physically and mentally have to pull myself back. I'm a natural organiser, and I'm probably sometimes supremely irritating! I can be guilty of riding roughshod over people. I know that's a problem.

Can I ask you, could you give me your understanding of what the structure of health services is. Above hospitals.

NAI I don't know an awful lot.

So would you have any idea what structures lie between you as a nurse on a ward and the department of health

NAI No, isn't that awful? I know you've got PCTs, the primary care trusts, responsible for services in the community, then you have hospital trusts that are responsible for the actual

running of the hospital. Then the area health authority is on top of all of that, and then Whitehall.

Not bad! Could you describe to me what mental health services look like.

NAI Yeah. You have cpns, consultants. My daughters been involved in psychiatry

Right

NAI There's therapists involved, social workers as well

So would this be through GPs surgeries or hospital based

NAI It would depend how acute the problems is I think. You get GP based care as the first port of call then you get referred to the consultant and then they will decide where you go, what treatment you have whether its therapies. My middle daughter suffers with depression, so we have been involved with the childcare team in Telford.

Oh right, is she under eighteen

NAI Yes

Did you have to wait long

NAI No she was very ill, suicidal so she was seen in three weeks. She was terrible, I've never been so scared in all my life, it was awful.

It must be terrifying as a mother

NAI You're absolutely helpless. I mean its not something that's going to get better with an asprin. It take so long for any of the drug therapies to work. When your 16 year old is lying on the floor in a foetal ball and says she wants to die…… you think oohh god, what do I do now?

Were the services good, were they helpful

NAI Yes, Mr xxxl is so good looking ! They were very helpful, and her nurse was great, but ……. Is a lot like me and she doesn't enjoy the navel gazing and she said I don't want to sit there and talk about my problems, I just want to get better and I said its like a round about, you've got to do one to get the other, and you also have to learn to live with it. I mean I can recognise all the sign snow before she starts , so I can get something in place to avoid the crisis. We did very well this winter, its seasonal. Not seasonal, time cyclical, and I can see her beginning to fall again.

So you work on coping strategies and support in place

NAI Yes, then you go to the GP and she says' we shouldn't really prescribe these drugs to under 18 year olds anymore. At which point I almost had a heart attack! When I said 'what is the alternative' she said there isn't one!

What drug was that

NAI Erm, cipramil

That's a very established drug.

NAI Right.

So things are ok at the moment

NAI Yes

Ok, right…..could you tell me, do you have any idea how social services are structured

NAI No!

Do you know who employs a social worker

NAI No. I've no idea. Who does

Well, the social services department of a local council

NAI Oh right

And local councils are accountable to central government

NAI Oh

Ok. What's your understanding of multi-disciplinary working

NAI Multi-disciplinary working is when you have, doctors, nurses, social workers, OTs, physios and with an assessment tool, the patient is benefiting from all of their little bits and being looked at holistically. Everybody is working together and they are getting… what's the words they use…. Continuity of care, everyone is working to the same aim, rather than one doing one thing and one doing another and never the twain shall meet. And in a multi-disciplinary team there must be good communication otherwise it just becomes farcical.

That's a really good explanation, thanks for that. OK……This may be easier for you to answer, bearing in mind the experience you have had with your family. Putting yourself in the position of a mental health services user, what would you expect of a nurse

NAI Knowledge of the illness, empathy and some sort of constructive feedback or suggestions or treatment. Knowledge of the illness in the peer group that I would be.

So if you were a young person, knowledge of how that illness commonly affects young people and what the preferred or most popular treatments are

NAI Yes, and the prognosis. I know with Sarah they were very blunt and told her that she would have this for the rest of her life, so she had to get a grip on it and manage the depression rather than the depression manage her.

Um, what difference do you expect to make to patients life

NAI I would expect them to be leaving hospital feeling that they have had everything possible done for them, and that they had been involved in their treatment, and that they had been treated with respect and dignity.

Do you see your work as being in hospital then

NAI No, no, it can be in the community, homes, anywhere. But everyone has the right to respect , its one of your basic human rights. You should also respect peoples cultures.

I would like people to walk away and think ‘she was nice, and she actually did something’.

Well those are all of my questions aimed at trying to gain insight into the early stage of your development of professional identity. Is there anything that you think I have missed, or you would like to add

NAI No.

Thanks very much for being interviewed.

Susan 2
NA2

Hi Susan, thanks for coming to this second interview

NA2 Oh its no bother, I quite enjoyed it. it was really weird reading the transcript, it seems weird seeing your own conversation in text!

well some of the question I will ask you this time will be similar to those I asked in the first interview. Its so that I can track development an changes across the year – is that ok.

NA2 Oh yes, no problems.

Right Susan. Could you tell me what the unique core skills of a nurse are

NA2 Um, putting yourself alongside a patient and being able to really empathise with how they feel

Do you think that all nurses can truly empathise with how a person feels

NA2 No ,. I think everyone should have a stay in hospital ,because when you are on the other end of it, you are acutely aware of the power people have over you, physically and decision wise. I remember when I had my hysterectomy I had an epidural, and I was lying here wandering how on earth do people manage when they can't move, and you need to have an all round awareness of what it feels like to be that person in the bed. You need to be able to pick up on the non-verbal signs that people give you, that give away how they feel.

Do you think these skills are unique to nursing

NA2 Maybe not empathy, but I do think that nurses undertake very personal tasks that invade peoples personal space, and I think this is unique to nursing, so being able to empathise and…understand how that may feel, is key for nurses especially

Ok, what about the core skills require for social work, has your insight or knowledge of their ole changed since we last met

NA2 Not a sausage, sorry I don't know

Ok, and the values and philosophies a that underpin social work

NA2 Don't know, I'm sorry but I don't

That's ok Susan. What about OTs, any views on the skills, values and underpinning philosophy

NA2 No, sorry

Ok, thanks for that. You mentioned last time that there was a good informal social support group that had emerged within your student group

NA2 Yes with a small group of us- the older ones, well, more mature

Has this group evolved or changed in any way

NA2 Um, no, we have continued to meet up and support each other, nothing more than over a coffee though, we're not in each others pockets or anything

Ok. What about academic support

NA2 Well apart from the IT help I needed initially, I've done well with my assignments- I've passed them all so far

That's great, you must be very pleased

NA2 Oh, I am.

You have had a placement already haven't you

NA2 Yes, the nursing home

When is your next placement.

NA2 In two weeks- I start on a surgical ward

Do you know when your placements will be throughout the year.

NA2 When they will be yes, but not where. I'm still hoping for a mental health placement, but we are not guaranteed one in the first year, this is the foundation programme, I'm not on the mental health branch until year two.

Do you feel that you have a professional identity as a nurse yet

NA2 Crumbs,….er, yes I think I do. That's not related to the university course work or lectures though, its being on placement, doing the job that I'm comfortable with- that's where I feel like a nurse.

Have you come across any role models, either at uni with lecturers or tutors, or on placement

NA2 No. that's a bit sad isn't it (laugh)

Well, yes it is really

NA2 It isn't that I haven't met some good workers, just non that have truly inspired me.

You talked about the values of nursing earlier. What then, is your understanding of the philosophy and beliefs that provide a foundation for nursing practice

NA2 Philosophy and beliefs. That we should support life, keep patients free of pain where possible, and alleviate stress and distress through care and support. That we should use evidence based treatments to treat identified illnesses within agreed protocols, following care pathways. I suppose the beliefs are that dignity and respect for a patient, or client is paramount and nursing is about being trusted to provide care and comfort when it is needed.

Ok, thanks Susan. You mention some very medical terms there, but you also talk about more generic principles, such as dignity and respect above all for the person. Would you perceive that other professionals, such as social workers and occupational therapists would hold these principles also

NA2 Yes, I'm sure that with social workers and occupational therapists that dignity and respect are important, but there is still the intimacy of nursing tasks that these other roles don't do. well at least I don't think they do.

Has there been opportunity for you so far on the course to explore your personal strengths and areas for development

NA2I would say so yes. Apart from the educational aspects with exams, assignments and so on, we have had practical workshops and lab as they call them where our skills and abilities in rather practical terms have been tested. I suppose it remains to be seen how the placements go for the rest of the year.

How do you think awareness of your strengths and weaknesses may link to your development as a professional

NA2 Well as a professional it is my responsibility to be aware of any shortcomings or development needs and to ensure that I address them. Once a nurse becomes registered, then there are no exams or tutors giving advice, its up to the individual nurse to ensure that they remain fit to practice. . Now I've swallowed the code of practice- sorry!

So it seems from what you are saying that you do have a professional identity as a nurse

NA2 Oh yes, I would say that I have- just not a qualified one yet!

Last time I asked about your understanding of the various health and social care delivery systems and the role of the nurse within those. Has your understanding developed over the course of the last couple of months

NA2 Well we've just had our module on holistic nursing in practice where we have discussed the role of nurses in various settings, and that has broadened my horizons somewhat. I do understand some of the basics any way, due to my mother being a community nurse for so long, and as a residential home manager I had built up a working knowledge of the systems, but of course they were not in Wolverhampton. The services here are still new to me

Well that brings me nicely to my last question Susan, which is about the overall style and content of the course design. Do you feel that it has enabled you to develop as a professional nurse

NA2 Well yes and no. I think the modules and the content are appropriate, but I think if the university selected students more carefully, then the whole student experience would be better. I think the placements are too short, ánd I'm not sure that I think the foundation year works that well. We have not really addressed mental health yet, and I don't suppose we will until year two, but we have covered adult nursing at length, its not equitable.

OK, Susan, thanks for your time.

Susan 3
NA3

You re now 11 months into the course, you are starting your second year soon, and youv'e recently finished your placement

NA3 Yes, I'm at new cross on gastroenterology. Its medicine, and mostly alcoholic liver disease

Oh, right. Quite busy then

NA3 Yes.

So when does this placement finish

NA3I have two weeks left of a ten week placement

So, so far, have all of your placements been in acute settings

NA3 No, first was a nursing home, second on a surgical ward, and this one on medicine

But still no mental health placements in your first year

NA3 No, there will be next year though, all from branch onwards will be. They don't promise to provide out with a placement of your branch specialism in your foundation year, crazy isn't it.

I think so. Right. My questions this time will be somewhat more in-depth , as you are more experienced. I'm going to ask questions that explore your perception of the development of your own professional identity. Do you think this has actually happened. Have you developed an identity as a nurse over the past year

NA3 Yes, um.

What do you think has facilitated that. Has it been events, as a results of just carrying out the work and feeling fulfilled in what your doing, or has it been your interaction with other nurses or professionals, what do you think

NA3I think its been a combination of all of those I think. My confidence has grown because there are certain things like taking observations that you know when somebody is ill. I now know that I can go to a doctor and say, look, this mans temp is this and I think he is unwell, which I did the other day, only to be told he was having an angina attack, and I thought why does he have a temp of 39 if he's having an angina attack and thought, well, its nothing to do with me..

Are you saying that you felt you had the confidence to address one of the doctors

NA3 Yes, I've also found that if you want to be a wallflower then you can. You could do the whole 12 months with your hands in your pockets and no-one would know because they are so busy. If you don't offer to help or let me say, what can I do…….. I spoke to the new students coming in and told them that you have to put yourself in, they are too busy to

mollycoddle you along. Um – and I do feel more able to approach other people and do referrals to primary care, or to social workers. I feel totally comfortable with that now

And has that confidence arisen by just doing it, hands on practice

NA3 Yeah, just by doing it and standing there and spotting support needs and checking the notes. The other thing is that as a student, you are privileged in as much as you have more time to talk to patients , you learn things that the doctors don't learn. Many of the patients are elderly, ad they view the doctors as some kind of deity and they don't tell them things. I had one lady where the doctor asked how many times have you had your bowels open and she said, 'oh once a day'. Well I had taken the commode from that lady on at least ½ a dozen times and she wasn't telling him what was actually happening, she told him what she thought he wanted to hear. So I had to say to the doctor, excuse me, just check her charts.

So would you say that the professionals are just so busy most of the time that it is easy to , well miss things

NA3 Yes, they do, but they are only human. They can't do everything, they are short staffed, we are running on agency staff most of the time.

It sounds to me that you are saying that you feel quite competent in carrying out a lot of tasks. Do you feel that you learned the theory and basics at uni then had the chance to come out and practice these skills, or do you feel that its more of a practical level of watch one, be watched doing one, then be deemed competent to go it alone.

NA3mmm. again, it's a combination. Because I'm old…I'm more confident. Some of the 19 year olds are very worried all of the time and I say, look its ok, but ..i feel like their mother! So it is a case of watching somebody do it and being supervised. The other day the nurse said, right you can run the bay. And I thought oh my god what am I supposed to do! Even though I have been there six weeks and I know hat to do. One lady needed catheterisation and she said you can do that. I told here that I have never done it and she said well I'll sit with you and I thought that was really bad. I mean I looked and I thought, where do I put it?

Catheterisation is a tricky procedure, particularly on women.

NA3I did do it, but I felt very sorry for the patient

Yes, would you like to be that patient being practised on for the first time

NA3I would not! You know, she was a very nice elderly Lady, and with your anatomy when your older, well, it disappears!

Oh.

NA3I didn't think that was an appropriate learning experience, although I knew the next time.

There are better ways of learning through.

NA3 Absolutely , I ask lots of questions when I am observing people. I mean watching and learning is useful. I questioned a nurse the other day who was testing naso-gastric tubes about best practice, and her answer was 'this is the way we do it here'

Surely its your role as a student to question. What about approaches to clients.Is your approach and attitude to patients the same as it was on entering your training or has your perception changed

NA3 Umm. The nurse….from my approach I don't think I have changed, apart from being much more confident. I walk straight up to patients and introduce myself

You expressed very strong values with regard to your approach to people, and patients in your first interview

NA3yes

Has that changed at all

NA3 No. I have very strong views on the fact that, I have been a patient, and I can remember being in that bed, unable to move, being in pain, and feeling completely helpless. I've also experienced two bed baths, which was a vile experience, I felt like a piece of meat. I can empathise.

So your own experience as a user of the service informs your own practice and you remind yourself of that from time to time

NA3 Yes. You care for people at their own pace. Patients are often frightened. I have strong views on how people are handled physically, it can be degrading, and we are not in the profession to degrade people. You need to make the most of what they can do for themselves.

What about development of knowledge. Have you developed a strong knowledge base

NA3 Yes, I thought my brain would burst at times

Has there been a constant steady input or in chunks

NA3 Its been in chunks, when I've been on placement. You can cover all the theory you like but its when you get out on placement you think- hang on a minute! This is not how it is, and you have to adapt you theory in the best possible way to approach whatever it is your dealing with.

So is this like a conscious thing with you, where you think oh-oh, this isn't what we were taught in school, I need to adapt here

NA3 Yes. The main thing that sticks out is manual handling. The equipment is not there, or staff don't want to use equipment. I was horrified to find that people didn't use equipment. On one occasion I refused to not use the hoist and this nurse picked this man up and dumped him in the bed like a piece of steak, it was horrendous.

Do you think that most students would feel able to stand their ground or challenge staff

NA3 Oh many wouldn't. I did challenge him, but he tried to tear a strip off me and make me look stupid. I turned my back and walked away. I mean with regard to himself, he could injure himself, he is leaving himself wide open to litigation, and he could injure the poor patient.

What about power. Have you felt with the acquisition of knowledge and experience, have you felt more powerful, or in control
NA3 Control over the patient

Well maybe, or over the job or your workload

NA3 In a professional capacity yes, I do feel more in control and the knowledge base I have now enables me to make unilateral decisions about somebody's care. I seek out information for myself to inform decisions. I have more confidence, and yes I suppose it is power, yes.

We talked before about philosophy and core values of the profession. Has this moved on at all. Following your placements & experience, lectures and academic experiences, could you say you are building up a knowledge of the philosophy and value base of nursing.

NA3 The values of nursing, putting the patient first. …we had one lecture whether the nhs was run for patients or staff, and we voted at the end that we thought it was for staff, and it has to, or else it wouldn't work. Um you couldn't run it.

What about the philosophy and core values

NA3 The philosophies that we are taught….um.. a difficult one. I think you adapt things into the workplace, because when you are presented with awkward or difficult situations you have to make it fit. One recent situation, a relative was demanding a larger fan for the patient, and at first my gut feeling was, you know, you want a larger fan, what for? But then you have to realise, its not about the fan, they are upset and they want to be doing something. That theory you were taught about displaced emotion informs you that they are being aggressive towards you because they are upset and they are venting their spleen on you because there is no one else to shout at. So what you are taught in university does make you think and it makes you detach yourself from the situation to think what is really going on here, rather than reacting.

That's really interesting, a good example. Do you believe then, over the last years experience, whether there are core skills that are unique to nursing over ot & social work.

NA3I think the core skills like listening and empathy are not unique to nursing, all of the caring professions need those skills.

What about if I was to say that you have to invade peoples personal space, carry out physical procedures on people. Does that set you apart as nurses from ots & sws

NA3 Yes, but having said that, when you put on a nurses uniform, it almost gives you a right. People think, oh she's a nurse, its ok. Just out of courtesy you should ask if you can carry something out. Even feeding is a very personal invasion. It seems that the general public feel that as you are wearing a uniform, you have a right to carry out whatever procedure you wish to.

Is that really how it feels?

NA3 Yes. One of the palliative care nurses who don't wear uniforms was putting a syringe driver in, and her (the patients) daughter turned up and asked us whether she was a nurse, that

is how strongly the uniform appears. People will tell you their most intimate details when you are wearing a uniform.

That is a very powerful element to the job. Do you think that power could be abused?

NA3 Oh yes, you have to remember that you are an advocate for them

What about the work environment and socialisation, the fact that you have worked alongside other nurses of different grades, na's and other students. Do you feel socialised into the nursing community

NA3 That all depends where you are. The surgical ward was social, everybody talked, we had breaks together. Other wards, there is a very straight hierarchy, sister, charge nurse, d, e grades. If there is a general feeling of unhappiness on the ward, people don't socialise, they wander off for breaks on their own. You need to work as a team, because if not, communications breaks down and things get overlooked and missed.

Are there any sort of unwritten rules then, the this is the way to do it really

NA3 Oh yes! The ng tube testing was one, this is how we do it here! The ward I'm on at the moment we do an 8 ½ hr shift, but sister insists that we have our break at 10 in the morning, no other break, so we have to eat our lunch at 10 o clock in the morning!

Buts that's against European regulations, you should have ten mins at least every 4 hours

NA3I have challenged her, and told her that I don't want to eat my lunch at 10am and she said this is how we do it on this ward student! How totally bizarre!

If you were to stay in Wolverhampton, do you suspect that you would become a Wolverhampton type nurse, that perhaps nurses in Birmingham or Walsall or at another hospital have different approaches or experiences.

NA3 Yes. But it differs from area to area, like medicine to surgery. I'm sure mental health will be different again. They are different approaches to nursing. What are the care plans and standards not uniform? They should not change from ward to ward.

Have you identified any role models either at Uni or in the practice placement that you have been able to identify with

NA3 Umm, poor role models yes!

Oh dear, that's a shame

NA3 Well, there is one sister and a few staff nurses that I have thought, wow, I hope I never become like you!

And there have been no positive ones?

NA3I suppose thats unfair, there have been one or two staff nurses who work hard and have the patients best interests at heart, they are the ones I would be more likely to model myself on.

Well, one of the problems I have here is that I had hoped you would have been on a multi-disciplinary mental health placement by now, but you haven't

NA3 No

I would have liked to explore your perceptions of the roles of other health and social care professionals within multi-disciplinary mental health teams.

NA3I'm afraid I have no idea

No, but you have been able to articulate the development of your awareness regarding other professional roles within the environments you have worked in though, so thanks for that. Have you had no contact at all with social workers or OTs

NA3 Mmm, social workers purchase care packages.. I have had to contact them when we have needed to look at discharging someone with complex social needs. Social workers do in depth assessments for residential care, or any ongoing care needs. The single assessment process means that we share some of the same assessment process. Umm I've come across physios, but not OTs, no. I do have more of an understanding of how an OT might work in mental health, if its along the ones of physios in general health care.

Ok, thanks SusanUmm…. If we can go back to school as it were… and discuss the educational culture teaching styles. You have talked a little about some of the syllabus content, but tell me if you can, what the culture is like, and how they teach you how to be a good nurse.

NA3 Well……..mmm that's tricky….educational culture. It feels very adult, we have lectures that guide our thinking and prompt further study. A module launch I think is designed to stimulate interest and prompt us to go to the library and get out the relevant books and read up.

So is it all lectures

NA3 No, no. we have practical sessions where we get hands on tuition, such as manual handing, bathing, obs etc. We do have some group activities, but I am always , well… The group are sort of split into people that want to work, and people that don't, and so those of us who know we will get the work done get into groups together.

So would it be fair to say that you think the modules are structured in such a way as to stimulate thought and encourage wider reading and debate, allowing you to come to your own conclusions.

NA3 Pretty much yes. If you want to learn and you have the motivation, they will give you the guidance.

What support systems are in place then, if people struggle and need help.

NA3 Well we have personal tutors who we see on a monthly basis, mine's ……, she's great, really supportive. Umm, I know there is a lot of help for people who struggle with assignments and IT and stuff.

What about students supporting each other, does it feel like you support each other, is there a peer network

NA3 Um, yes. Like I said, those of us who want to work get together quite regularly

When you are in school

NA3 Well yes, but at other times as well, we meet for a coffee and discuss our placements and problems. I have a close group of friends, about 5 or 6 of us, and there is good support

Can you see that support network lasting throughout your training

Well I hope so, I find it immensely useful, I'd like to think I'm useful to them also

Ok. Would you say Susan that you have had the opportunity via the input from uni and on practice placements to explore your personal and professional strengths and skills and identify areas for development.

NA3 Oh yes, without a doubt. The uni lectures and training have made me question my own beliefs and values, and helped me to look hard at myself, so personally I've been able to develop. I think skills wise, it has been on placements that my knowledge and skills have been tested, and I've become aware of what I need to brush up on and what I am already quite competent at.

Could you give a couple of examples

NA3 Well, with things like certain procedures, understanding the actions of drugs and specialist knowledge, I am aware that I do not have it and I have a lot to learn. With some of the basic elements, like communication skills, empathy and dealing with people, my placements have only reinforced what I already believed, that my skills are quite strong in that area.

That's really positive. Are these self assessments of skills strengths or needs formally recorded anywhere, by yourself, your tutor

NA3 Um, no…maybe my tutor keeps notes, you know I don't know, I'll have to ask her!

So there is no skills development plan in writing

NA3 Well, each placement supervisor has to complete a report about you, your skills, what you have done well and score you, but they spend so little time with you, the placements are so short, they really are…….quite superficial.

Ok. On these placements have you had the opportunity to carry out assessments, report writing and intervention planning through to closure and discharge.

NA3 Yes. On my current placement I have been able to carry out initial assessments and construct care plans, under the observation of a staff nurse of course. That would entail me completing the relevant forms and constructing a file and treatment regime with all the relevant obs charts and so on. I don't make entries into the notes though, I'm supposed to report it to s staff nurse to do that

Is that because of legal issues and students

NA3 Something like that. I've been doing it all my life and now I can't be trusted to know what I'm writing!

Yes it does seem a little silly, doesn't it.

NA3 Yes, you could say. Um, you mentioned seeing people through to discharge

Yes. Have you had the opportunity to follow these people you have assessed through to discharge

NA3 Oh yes, some patients stays are incredibly short, just a day or two. However, sometimes you carry out an assessment and do all the paperwork only to go off duty for a weekend and when you come back- woof, they've gone!

Wow! A quick turn over then

NA3 Yes, well its quite nice, quite refreshing.

Well that brings me on to one of our final questions. Do you remember in the last two interviews I've asked about your overview and understanding of the various health and social care delivery systems and consideration the role of inter-agency working within this context. Has your last placement helped with your knowledge and understanding in this respect

NA3 Well, not in a structured way, nothing I've been taught, that is. In a practical way, my understanding has developed. I have been aware of the systems in place when a patient is out of area. There are different political issues- potential merger of Wolverhampton with Walsall, building a super hospital, the chief executive of the pct being sacked, the headline stuff.

Have you gained any more insight into the workings and relationships between trusts and PCTs, the SHA and the DOH

NA3 No, not at all. Hopefully we will though, over the next couple of years.

Well, that's about it Susan. Thank you, very much for your time and commitment. I'll e-mail the transcript over for your approval

Nichola 1
NB1

Hi Nicola, thanks very much for agreeing to take part in the interview

NB1 That's ok

Some of the questions I ask may be difficult for you to answer, but that's expected at this early stage in your training. I hope to be able to track changes and developments in your knowledge and views in the following interviews

NB1 Ok

Could we start by asking why do you want to become an RMN?

NB1 Because I have known a lot of people with mental health illnesses within the family and friends, um and I don't want to be just a normal nurse I want to be something, um well a bit more demanding,

When did you decide that you would like to do your nurse training

NB1 Well , about a year ago, the end of 2003. I had thought about it before, but then I thought ,well, it's a job for life

OK

NB1 Its not some thing I'd be brilliant at but you can work up through the different levels and you've got it for life.

So would you say that your experience of people in the family & friends experiencing mental health problems sparked your interest in wanting to work in the field

NB1MMMM. Yeah, I also watched programmes on the telly, and what you hear… I just wanted to learn more about it as well

Did you feel that apart from your personal experiences in relation to mental illness that you had any specific skills that you could bring to mental health nursing

NB1 Well I do see myself as a good listener, um the only other thing that would make me want to help people would be if someone fell over, I used to work as a life guard, so worked with young people, and whatever. And I was always one of these people that whatever I was doing I could always click out of it, sort out the problem and get back to work

So emergency situations don't phase you at all

NB1 Not normally, not unless its like something really, uuggggghhhaa!!!

So is that what you did on leaving school

NB1 When I left school I went to college and did body massage for a year and sports therapy for two years. I took a year out and then started this course

And you were a lifeguard at the same time ? Quite a varied path since leaving school

Yeah

Do you think that you have chosen this career, or has it chosen you

NB1I chose it

What about the other heath and social care roles? There is social work, occupational therapy in mental health, on the general side there is nursing , physio and other medical roles

NB1 Mmm, I'd like to look into the other ones ,like social work as well

What made you choose nursing over those

NB1 Well I was interested in them, but after looking into what I would have to do to get on the course, like qualifications and whatever, I didn't have good enough marks to get on them

Did you think that the information on these professions and courses was out there on social work, occupational therapy and such

NB1 It was easier to find the nursing information

Is it fair to say that the route was more complex to get on the other courses

NB1 Not complex, but you just needed a lot more than I had to be able to get on the course, grades wise

What qualifications did you need then to get on the nursing course

NB1I used my sports therapy to get onto the course because I didn't have enough GCSE grades to go just on those

Right. Was that a btec

NB1 Diploma

What do you think makes a nurse different to the other professions. I understand that this is early on in your course and don't worry if you can't explain it terribly well. What makes a nurse different to a sw or ot

NB1 They tend to have a higher level of knowledge of medical expertise, what to do if something happens to a person on a ward and such. Also they have to learn to deal with people differently to a social worker. They have to be with a patient all the time every day, where as a social worker comes in once or twice a week to see how they are doing.

Uhum

NB1 So they do things away from the patient where as we do it there and then like

So nursing is more hands on?

NB1 Yes

So you talk about nursing being ward based. Is that your understanding of mental health so far?

NB1 Well we haven't been at university that long, 6 or 7 weeks at uni then straight onto placement.

What did you think about that?

NB1I was shocked. I was under the impression when I went for my interview that you would spend half a year at the university and then the other half out on placement. You do, but its in like blocks.,

How do you feel about that

NB1I think its just crazy. I said what happens if someone does this or does that and its like 'you'll be alright, you'll be with someone whose qualified'

I would have liked a lot more training first. I mean, I've been quite lucky, I haven't had to do things that you would have to do on a general ward. Here its just making sure that the people are ok. But for the people going out on to a normal ward, I'd just be frightened, up a corner

Ok. You stated that it was about a year ago that you decided to do your training. What were your hopes and expectations of the course back then

NB1 Um. I hoped that a lot of it would be practical based, things that you need to do practically.

do you have anxieties about your learning needs with regard to your dyslexia

NB1 Yeah. Um..

So you had hoped to get practice, on the job experience during your training

NB1 Yes.

have your expectations changed? You were talking earlier about your expectations around the university/ experience split.

NB1I don't know really. I was expecting to do training to be a 'nurse'' nurse first during the first year and spend the next two years training on mental health. But we haven't done anything yet on mental health at uni but my first placement is mental health, and the rest of my placements this year apart from one will be in a mental health setting. I would have thought that as I will be a registered nurse as well as a mental nurse that there would be a hell of a lot more general registered nurse training. I mean I don't know I may get more over the year, but I thought there would be a lot more.

I must admit that that was my understanding as well, that the focus of the training was general for the first year, then mental health focussed from then on. mmm

Ok. You have been on the course for 3 months now. Have your expectations and hopes changed

NB1 Not really. It hasn't been long enough. But there are a few things that I would like to look into now. But its near enough the same as it was

So is it fair to say that you were very much looking forward to the experience of doing your training and that you still are quite positive

NB1 Uhum

Ok. What would you say makes a good nurse

NB1 Someone who will listen, who has a good knowledge and understanding of … things that can happen to people. Not someone that people feel they can't talk to or ask about something. Have an understanding of everything as well, and not be too pushy

Ok. Taking into account that you have already indicated that you do not know that much about social work and occupational therapy roles, what do you think makes a good social worker

NB1 It would depend on what they are doing whether it be child or adults, they would need to have a understanding of what the childs going through and what they are feeling. If they are being abused, either violently or whatever hey need to know how they will be feeling and why. They might never have experienced it but at least they will have known a number of people who have and have been through it and will know what to look for, and then they go out and see people.

So an understanding of their client group and what they might experience

NB1 Yep.

So what about occupational therapy. Would you be able to say what you think would make a good ot

NB1 Not really, I'm not sure what they do

That's ok.

NB1I've heard of them. The only occupational therapist I know are the ones at new cross, they are qualified staff that do a job that a doctor could do but a nurse could do as well to take the strain off the doctor. That's what I kind of think they do

Ok. now, you were talking about what makes a good nurse. What do you think the core skills of a nurse are.

NB1 Communication, customer care,…um

What do you need to be able to do the job well

NB1A qualification

What about knowledge. What might you need to know

NB1 Well you'd need to know all the policies that can affect a nurse. So, what a nurse can and can't do, what a patient can and can't do to a nurse, um all the communication skills.

Yes

NB1 Record keeping, knowledge of the different types of drugs, and knowledge of the different types of procedures that go on. Um, that you can do as a nurse. What happens when you do such and such thing, and what happens when it goes wrong.

So some of its around specialist knowledge like medication, and a lot of it I around communication skills, but also about procedures and how to safely practice

NB1 Yep.

What do you think then would be the skills needed to be a social worker

NB1 From the people that I have me that are social workers you need to have a lot of patience, um I don't know about people who haven't got mental health illnesses, but on this ward you need a lot of patience, and they have to sit there and listen to people who keep stopping half way through a sentence and swapping back. Um you need to be able to sort out 10 things at once.

So good organisational skills?

NB1 Yep. organisation. um being able to interpret what a person is saying, um…probably all I can think of.

you were talking with the nurses about specialist knowledge about mediation and procedures..

NB1 Like all the parliamentary acts that affect their client group. Like the child act and the mental health act. And all the legal stuff, like what their client can and can't do

What about ots. Would you have any idea of what core skills they would need

NB1 No. I'm not sure what they do

Ok, no problem.What would you imagine then might be skills that are shared amongst all the mental health professionals

NB1 Communication. You have to be able to pass on information that is important, both ways. If a worker finds out something about a patient they have to tell the staff about it., and the same the other way round. Um, probably something else buts that all I ca think of.

Ok, thats fine. Do you think there are skills that qualified social workers will need on qualification that you will not have as a nurse

NB1 Basic skills wise, no, but it would be all the legislation and law stuff because they won't be any differently from a nurse, but there will be extra ones.

Specialist knowledge

NB1 Yep.

Ok. What is your understanding of the values of nursing, underpinning philosophy and values?

NB1 Um.. not sure …

In other words, put simply, what is a nurse there to do? What's the prime focus

NB1 Um. Were here to helping whatever way a patient needs or feels that they need.

OK Imagine I'm a member of the public asking you' so your training to be a nurse? What does one of those do? What would you be telling me

NB1I don't know yet as I'm only 3 months into my training.

Is it fair to summarise that you were saying your role is to assist people in achieving goals that they set

NB1 Yes, or depending on what they want. Like if someone wants to be able to cook, you'd help and assist them in whatever way they could be help, or if they needed help to go to the bathroom you would assist them in any way they need help. Um, it all depends on what they want. You need to know how to do most things to be able to help.

Ok. So what do you believe the values of social work might be

NB1 Um from what I've sort of seen so far, the nurses are here to help with their health, and social workers are here to help with their social problems. So once they are better and well enough to go home, they will help find them somewhere to live, make sure they are ok when they are there, phone bills, you know, bills and benefits if they need them, help them to get a job, help them back into the community, and we as nurses help them to get better to be able to do that.

Right. What about ots. Any ideas what the values might be that underpin their work?

NB1 God – no

Right. What would you identify as areas of strength and skills for you, and what do you think you need to build upon?

NB1 Um, my strengths are definitely in the practical stuff that I have done so far

Uhum.

NB1I have picked it up really easily, and I can do that. I'm alright with the communication, speaking to patients and staff. Its just remembering all the little bits, so the legislation, the cans and can't dos, because there so much of it, you don't know where to start and where to…

What have been the main messages then so far on the course. Lots of do's and don'ts that you are trying to keep in your head. What have they mainly been about

NB1 Um. Safety and confidentiality. Basically, if you've got something, don't say it, keep it to yourself. Its remembering all the facts, cos you look at the book and its…. You can do this if…blah, blah, blah or in this situation….

Right, would this be with things like the mental health act

Yes

Is it because of your experiences of education with your dyslexia, you are anxious about the information you are expected to take on board

NB1 Yes. Um when I was at college I didn't tell the lecturers or anyone that I had problems, so they just thought I was being lazy. It wasn't until the last couple of months that I decided to say something, and then it as 'do you want me to do that for you' and 'don't worry, I'll write it all down for you' and. I didn't like it.

Right.

NB1 And I took a year out and decided I would do this. Now I have told everyone about it, everyone knows. I feel that there is a little bit less pressure to remember everything, but I still have to remember it.

So you didn't like the experience of being treated differently.

NB1 No.

Is that something you have come to accept now, that to do the best for yourself you do need a sensitive assistance

NB1 Yep.

Right. Ok where do you feel that you need to improve skills

NB1 So far I couldn't really s ay anything really major, because we haven't none a lot, it would just be talking to people a bit more, getting stuck into things, and if someone is doing something 'oh want you doing, can I help. Just things like that. The things that you sort of after a couple of days you start to do anyway.

Do you think that the course is going to help you identify areas for personal growth.

NB1 Up it will probably help me be a lot more patients, because I tend to be' why haven't you done this? You need to do it now, now, now! But I am starting to be a bit more patient already, especially with some of the ones off this ward.

Do you think you might learn more about yourself as a person, what makes you tick

NB1 Probably yeah

Ok. Again, I'm expecting at this stage in your course that you may not be able to answer this one well. But what is your understanding of the structure if mental health services.in health first. You seem to have an understanding of wards, what about the rest of the hospital and the other parts of the services, how it related to the department of health and such. Have you got any ideas what it all looks like

NB1I know when people are admitted to this hospital, this is the last ward that they come to. You have got the other wards where they are all closely watched um they help see why they were brought in and what they can do to help them get back on track

Would you know what happens if someone goes to their gp with a mental health problem, where they would go to from there

NB1 Um. I think it depends on the severity and whether they have got help for it already. I know some of the sections there are, but if you go to a gp, I think they refer you on to a psychologist or something, and then the psychologist would assess you, and if they thought you had something major, they would probably admit you to hospital or something, or it would be chest infections or. I know that mental health isn't very big, like not a lot of people know about it. Its one of those push it away into a dark corner sort of things. Most people understand general nursing.

That's very helpful. What about social care then. Have you any idea how you would access social workers if you were having problems, have you any idea of the structures there

NB1 Um I know you can see counsellors through your gp surgery and if you say your'e not coping with such and such they will refer you on to someone who can help you sort stuff out.

Do you know who employs social workers

NB1 The government?

In a round about way, it's the local council.What about the structures above hospital level, and the nurses out in the community, who are they accountable to

NB1 It will be the trust that they are with, um depending on whether it is part of the nhs. There are different trusts in the nhs for different areas, or a private one, like BUPA. I think it depends which trust it is.

Do you know which trust DPH is accountable to

NB1 It's the Walsall trust

Great. Ok. What about your understanding of multi disciplinary working

NB1 Um a multi disciplinary team is lots of people from different areas helping a [patients. There would be a social worker, a nurses, doctors, all types of people all doing their little bit to help that person in the specific area that they trained in.

Is this a good approach, a sensible one? Do you see any problems with this approach?

NB1 The idea of its good, but there are not enough people out there for the amount of patients there are, from what I've heard, for each 1 social workers you've got 5 or 6 patients or more, and that just seems like that's a lot of work for I person to do. So we really need to get more people in, and things would run a lot more as smoothly. I think the idea of it is good, because you can't put everything onto just one person.

So do you think that it's a good idea to get other perspectives on a persons problem

NB1 Yes

This is a rehab ward.Are you part of the ward reviews on this ward

NB1 Yes I sit on some of them and we get all the different people who all know something about the person they come to see that se may not have noticed here. They may have noticed that the person does something differently at home that they do in hospital or when their out. So you can sort of see all of the person rather than just what you see here on the ward

How many weeks have you done on the ward

NB1 This is my 4th week, and I have 2 more weeks left

Short placement isn't it. Its just like a taster placement isn't it

Yes

Ok putting yourself in the position of a service user, perhaps as a patient on this ward here. What would you be expecting of a nurse , what would you hope that the service would be

NB1 That they would treat me like a real person. i might have a problems but i am still a person .to have patience and listen to me and try to help as best they can to get me better in whatever way I need to get better.

What about the social workers, what would you expect from them

NB1 To help keep everything in order, um so if I'd got bills and whatever to pay… I don't know really.just to keep me informed of everything that's going on with me outside of hospital. So whats going on where I live, if my house is ok, if there is anything that needs to be done, to let me know.

The stuff you have talked about is very important. You have talked about their attitudes to you as a person and helping you to do things at your own pace, which is good, but is there any specialist knowledge

NB1 Specialist knowledge yes, but you can't expect one person to have specialist knowledge in ten different areas so a broad knowledge of different subjects or procedures, whatever and specialise in one of the main problems that people have.

Say for instance it was schizophrenia, would you expect a nurse to know everything about the illness

NB1 Not completely, but have a good understanding, of the different types you can get, the different types of medication you can take for it,. And know what they are going to do to me, but also know enough about me to know whether I can take them or not. I would expect them to know I was gong to be allergic to it.

what would you expect social workers to know about schizophrenia

NB1A basic understanding of it, and to be filled in from the nurses and doctors. Not to know everything about it, just what it is and how it affects people and their judgements. And s it fair to say from your earlier answers that you would not know hat to expect from ots, around knowledge or skills

That's right. What difference do you expect to make to a users life

NB1 Umm.i'd like to be able to offer them help and advice to the best that I can do.i'd like to be able to help in lots of different ways, not just in a physical health type of way. I'd like to be able to help with health and social issues, to help them get back to their old way of life.

Sounds like you see your approach as an enabler helping people to regain independence and control of their life

Yes

Do you think you need training to be able to do that, or would you be able to do it anyway

NB1 Um, id like to hope that I could do it on my own, but everyone needs to have that extra bit of knowledge to be able to do it properly, nit just go out to a total and utter stranger and tell them how to do things, do this and do that, then they could come back and say you have ruined my life

It is an issue. What do you think about the idea of giving advice

NB1 Um. I've always been told that I give good advice, sensible advice. But it is scary for someone to come and ask you for advice, and then go ahead and do what you tell them to do, you have to think about it a lot. You can't just tell someone to go and do something, you have to think about the con sequences of their actions.

They could come back and blame you an say' you told me to do this'

NB1 Which is why you have to have the training to be able to know whats going to happen if someone does something.

OK, thanks so much Nicola for agreeing to take part in this interview. I'll e-mail a transcript of the interview to you for your approval and comment if thats ok

ok

Howard 1
NC1

Hi Howard, thank you for agreeing to take part in this interview. How far are you into your course

Um 4 weeks now

I have a number of questions to ask you today, and it should take about an hour. Also, some of the questions you may not be able to answer, and that's fine. I'm trying to track your development and understanding over the three interviews

OH. OK

Could you start by telling me why you want to become a mental health nurse? Why nursing, and why mental health.

NC1 Well it goes back quite a while in respect that I've been a cabinet maker for most of my working life but I got into holistic therapies.

Really, how did that come about

Well, two young ladies that I know said , well you do a manual job all day why don't you try reflexology, at least I could sit down and rest my elbows on my knees but still work, so I did reflexology, Indian head massage, ran my own business as a reflexologist, I got to listen to a lot of things.

So did that make you think differently about working with people then

NC1 Well, when i thought of doing my nurse training I took a job locally, in learning disabilities to learn on caring and how things are done, rules , regulations and some training for myself.

Did you enjoy working in that role

Erm, yes, I did it for 18 months. They asked me not to leave I'd already got a post as a support worker and they offered me a senior support workers job, but I really want to work in mental health

Was there any reason why you decided on nursing as a progression on from your holistic therapies and learning disabilities experience, rather than any of the other health or social care occupations

NC1 ummm, it was just mainly mental health. I'd done a little bit of reading around it. I'd heard bad reports of social workers and different things and I'd heard a lot of stories about social workers… but nursing runs in the family, there's a family attachment as well, even though its in a different area.

So you had heard unfavourable things about social work

NC1 Yes

So would you say that you had a general understanding of the field of nursing

NC1 Yes, also a lot of my friends and colleagues are nurses It was skills but also that I think I've got time to sit and listen to people and folks have pointed out to me before hand that on general wards you don't have time to sit and listen and offer advice as you are short of time. That was the pathway I wanted to go down.

So if I was to say did you choose this career or has it chosen you, what would you say

NC1 I've chosen the career, but you can say, yes it has chosen me because of what I've known in the past. As a reflexologist I have worked in different areas with mental health , elderly, young, all different ages. Um.. but no, I've been guided towards mental health

What do you think makes nursing different to the other professions, sticking to social work and occupational therapy as two other professions that work in mental health. What's different about being a nurse

NC1 I'll have a job to answer that I think, as I don't have sufficient knowledge about the other occupations. I'm not sure whether some of the other occupations actually see an end result, I hear of social workers with very large caseloads and files being passed on, which is the same as patients. They do move from one ward to another. But there are times when no doubt you will come into contact with people you have dealt with at a later date and there may be re occurring problems, or you may have more long term contact with individuals. On the basic wards they can be in and out in a few days, they can be just a number rather than any personal problems, its just a name attached

Some of the questions you may find difficult to answer at the moment, which is exactly the point. You are new and will struggle to answer them, but by the time I interview you in the summer you will have a better idea of systems and professions in place

NC1 Yes, of course, its all learning at the moment, its all relatively new. There's a lot of information coming my way, some of its sinking in, a lot of it isn't.

So can I ask you what were your hopes and expectations of this course whilst you were taking the access course over the previous academic year. As you were looking forward to starting this course, what were you hoping it would be like?

NC1 After following through off the access course, I haven't been to school for years, so it was a little bit of a shock to the system. The access course gave me a little bit of grounding to be able to take on this course. Its just, I'm..... I'm expecting a step up in the standard of education

Has that happened yet

NC1 Yes, our assignments are due in January. We are still working on them now

That leads me to my next question, which is have your expectations altered at all now that you have completed two months of training

NC1 yes, I was expecting to be struggling more than I am, but there is a lot of stress and pressure on us at the moment

You mean academically or workload wise

NC1 Academically

Do you perceive that this is a problem for you personally, or all of the students. Do you think you are struggling, or is the course taught at a fast pace?

NC1 Em, I think I'm the one that's struggling, realistically its because I am older, but I can look around the group and see the ones that are quite happy, who can absorb information. You can also pick out the ones that don't really want to be there in the first place

Really? That sad

NC1 Yes it is

Why are they there

NC1 Most probably because they hadn't got anything else better to do at the time
But no, the workload coming my way, I'm struggling to absorb it. I'm expecting it to get a lot harder. Next term I've no doubt there'll be a lot of assignments

What are your expectations then of the balance between working shifts in a ward/team environments and the actual educational academic work that they are going to be expecting.

NC1 Yeah, I don't know how its going to work. Working shifts at the moment, I'm lucky that I can pick the shifts that I work. Currently on placement, I'm choosing to work long shifts over 4 days so that I can plan my lifestyle, 1 day at college and the weekend.

You are on a placement already

NC1 yes

How long is this placement

NC1 6 weeks.

What setting is it in

NC1 Um, its a nursing home for older people

And as a nursing home then, it's a totally nursing environment, no other professionals

NC1 Uhum. Nurses and nursing assistants and a few other students
How is it going, its quite early on in your course, how long have you done

NC1 Um10 weeks so far

Wow. Did you feel prepared for the placement

NC1 Well, I've got a lot of experience in this type of environment really, so yes, I felt ready

Yes,. But those without any previous experience may have struggled so early on in the course

NC1 Um, I don't know

I appreciate that this is still quite early in your course, but could you tell me what you believe the core skills of a nurse are

NC1 I'd be really struggling on those at the moment, what the core skills are

OK

NC1 At the moment we are doing the common foundation programme, so until the end of the first year when we definitely decide which branch we are taking, we'll I'm hoping to have a better idea at the end of the year what is expected of us in the mental health branch. The way people are talking at the moment, there doesn't seem to be a lot of difference in the approaches to adult and mental health.

Right

NC1 Everything runs parallel. The mental health lecturers do more discussions on the ethical side, ethical issues

So if you were talking to someone on the street and you were trying to describe what a mental health nurse does, would you be able to easily summarise the role for them

NC1 I support and care for people with mental health problems , helping them to cope with their illness and providing treatment

You were talking earlier about the bad press you have heard of social workers. In the same vein, what might their core skills be

NC1 I'm not sure that I know. They seem to have a lot of power to interfere

Could you tell me what they do, what their role is

NC1 Deciding when children can or cannot stay with their families, such as in abuse cases

Ok, what about wok with adults

NC1 finances, like organising care packages for people with learning disabilities, buying beds in care homes, that sort of thing.

Ok, so what kind of skills may they need

NC1 I suppose being able to talk to people and make difficult decisions I would say, but I really don't know

OK. What about occupational therapists, do you know much about that role

NC1 Um, I've come across them on learning disabilities, they help people recovering from illness and accidents, that sort of thing

In what way, what do they do that

NC1 They help people get the right adaptations to help them around the house, climbing stairs, getting into the bath, that sort of thing

so you wouldn't know what they might do for someone experiencing mental health problems

NC1no idea

Ok. You were talking about supporting individuals with problems they are experiencing as a mental health nurse. Is there any other profession that you think would also share that role or approach

NC1 No I'm not really sure. Within leaning disabilities their role as support workers are similar.

What about your background in holistic therapies. Do they support people with mh problems

NC1 Officially no, we cannot diagnose or give advice. We can give advice on what we are trained on, but we are not allowed to give advice otherwise

You could potentially find people who have found their holistic therapies to be of more help that a psychiatric nurse

NC1 Some people yeah. People relax when they are with you, and they talk and open up. You hear a lot of different problems, and its good to listen to these people

What do you think is happening that is enabling these people to share their problems with you

NC1 The encouragement I suppose comes from me. I mean, you start with the confidentiality issue, that you won't pass information on etc, and it is often this fact, and the fact that you don't know the individual that opens people up. But most information goes in and out, and I discard it at the end of the session. I don't take peoples problems on board

What would you suggest that you are providing a mental health service

NC1 Basically, I'm providing healthcare with the reflexology, more than mental care

But you'd agree that you provide support

NC1 Yes. Some times when people say they feel better you now its partially the treatment, but partially psychological relief

You have talked about the ethics lectures that you have had, have they talked at all about values, philosophy, knowledge base of nursing

NC1 They say that we must have a knowledge base and evidence base to use in our practice

So they reiterate that it needs to be evidence based practice

NC1 Oh yes. The main discussions we have had are on ethical issues on how you work with different religions, etc. Confidentiality is the main thing that they push all the time

What do you think might be the values and philosophy of social work

NC1 I don't know. Protecting vulnerable people I guess

Ok, what about occupational therapy

NC1 Helping people top be independent following injury or accident

Ok, thanks for that Howard. If I could move on now to your own personal strengths and skills, and where would you identify there is a need for development

NC1 Uhh…m..

Would it be safe to say from you discussions already that you are a patient person and a good listener

NC1 Yes, I can listen. Things that I don't get right. I try to do the best I can. Other strengths are that I can learn, I can get other people to relax. Weaknesses..... I don't really know yet. Later on this evening I'll think of 1 or 2, if I mention it to the family I'll get a list!

Do you think that the make up of the course has been geared to enable you to discover your strengths and weaknesses

NC1 Yeah, parts of the course are. I think we discuss ethics and practice in group work, that kind of stuff

Ok, then what's your understanding of the structure of mental health services, if we look first at the health sector.

NC1 Not really sure on how they are structured, I have very little knowledge , although, the times I've spent in mental hospitals have been on wards.

Where have you been

NC1 Shelton, I've spent time there. That helped me to decide on mh as a career. I have visited people at Shelton from the early stages, when they find that they can't cope and book themselves in for a couple of weeks to try and get some support, but there are areas where the clients are a lot more demanding .

So you've seen ward environments

NC1 That's right. I've seen open wards where you can book yourself in to restricted wards where you are fenced in.

So you have a good idea of the hospital environment, any idea what the structures are in the community

NC1 No, I've come across an eating disorder unit, um, drug placement area, but I've not much idea outside of that.

Well hopefully by the end of the year you'll have a clear picture. So have they covered on the course what happens above the hospital level, what the structures are above

NC1 No.

What's your local health provider

NC1 Telford and Wrekin PCT, who have just merged with Shrewsbury to off load debt

Do you expect to gain a better understanding of health politics on the course

NC1 Um, not in this first year, but I would need to know how the structures have evolved later on.

Do have any idea of how the link is made between the department of health and front line practitioners.

NC1 No, not really

Do you have any idea of the social work system and the structures of social care.

NC1 No I don't know, but they do link between ward staff and families. They do have to try and sort out care packages for people and bring everyone together.

Would you have any idea of social services, or council structures.

NC1 No sorry

Ok. What is your understanding of multi-disciplinary working

NC1 Professionals working together to provide a package of care to an individual

That's a nice succinct statement, thanks. I wish it was so straight forward to multi disciplinary teams

(laugh)

When will you know what mental placement you will get

NC1 I don't know where my placements will be, sometimes its only one or two days before you go.

Oh dear. Can they be any placement

NC1 Yes, any kind of environments. There's no set placements

What about if I were to say put yourself in the position of a service users of mh services. What kind of help would you like to think you could expect from the services, and from a nurse specifically

NC1 I would be expecting answers to my problem and I'd be expecting people to be coming up with why I have the problem, what can I be doing to get rid of the problem. I'd want answers there and then.

I suppose what you are saying is that you would want a diagnosis

NC1 yes

Would your expectations be any different of a social worker.

NC1 No my expectations wouldn't be different, but I wouldn't know about their knowledge. They might be able to pass you on.

So can I ask you, what difference to hope to be able to make to a users life

NC1 I don't know whether I will be able to make a difference. I hope to be in a setting where I can make individuals a little bit more comfortable, help them feel more secure. I'm not sure, within 3 years mental health will change significantly.

Thank you so much for your time. I'll transcribe this interview and send it to you for a check of accuracy and to ensure that you are happy with it, if that's ok

Great.

Howard 2
NC2

Hi Howard, thanks for agreeing to meet with me again. How are things going on the course

Ok I think

Right, some of the questions I ask you today will be similar to last times, I'm not trying to trick you, just trying to measure the impact that learning and placements have on your level of knowledge

Ok.

Could I start by asking you to describe for me what the unique core skills of nursing are

NC2 Listening to people, supporting them, making them feel t ease and comfortable in their environment, supporting people with health problems that are not medical.

Sorry, do you mean not physical

NC2 Yes, mental

Ok. Since e last met. Have you had the opportunity to gain more knowledge or insight into the core skills of social work

NC2 No, I've been in meetings with social workers in then short placement we just did in the nursing home but no further insight into the skills they need, no

What about occupational therapists

NC2 Now interestingly I did come across these on the placement, as it was for elderly people, and there was an ot on a local team that used the respite beds, and they spent some time assessing their capabilities, it was quite interesting

Any further idea son the skills they need

NC2 Well, this person was a good communicator, and I suppose if they deal with people who have had strokes and other debilitating illnesses, then the communication gets even harder,, doesn't it, so they need to be clear communicators, and good listeners I suppose.

Any other skills

NC2 Assessing peoples physical ability to carry out tasks...this one lady could not get herself to the toilet or make a cup of tea and this ot put a programme in place for us to try and work towards , well help her tom work towards that goal. She told us what aids to use.

That sounds like a really positive encounter you had there with the occupational therapist

NC2 Yes it was

OK, Howard, I'd like to explore with you any academic or social support systems that have developed around you during these past 14 weeks.

NC2 The workload is starting to build up but at the moment so I'm trying to take it easy, laid back, trying to take the information in and take the course as it comes.

Are there any study groups, or informal gatherings of like minded students where you can discuss course work or work together on assignments

NC2I'm working alongside a number of students who have come straight from colleges, 18 and 19 year olds, 20, who can still absorb a lot of information very quickly. I was expecting a lot of problems . It still is a problem. I have to go over a lot of my work a second time, I will go through today's stuff again this evening when I get home. So i suppose I am not looking to others to work through this, i would rather approach it on my own, at my own pace

is there support at hand from tutors

NC2you can make an appointment to see your personal tutor, but they don't help you through assignments there is it help, but I don't think I need that

Are there any role models on the course in the teaching teams or in the staff on your placement

NC2 Not really. The tutors seem a little detached, i think its a long time since any of them were at the sharp end.

Oh really

NC2 Yes, they seem, well they are lecturers, i don't think of them re still practicing nurses

What about the placement

NC2 The manager and her deputy are ok, too detached for my liking, some of the staff nurses I guess, but no-one that has inspired me

Would you say Howard that you have a professional identity as a nurse yet

NC2 No! Some one made a comment today that we are just monkeys out on the wards, and that hasn't gone down to well. You don't get any feeling of belonging at all.

Was that a fellow student

NC2 Oh yes, we were having a particularly negative discussion about out placement experiences. I mean mine wasn't negative, just didn't feel that I was learning nursing skills.

Do you feel that, from the placement and the lectures and other course aspects, that you have a better understanding of the core values ,philosophy, and beliefs that provide a foundation for nursing

NC2I think that we have talked a lot in lectures about values and ethics, but they are all encompassing

What do you mean

NC2 Well its about enabling people, not making judgements about people based on you own latent prejudices, helping people to help themselves, that sort of thing

Ok

NC2I think the ethics thing has been the strongest, evidence based practice, not operating outside of your competence, always ensuring that you are observed in carrying out procedures that you have not been deemed competent to carry out on your own, that kind of thing, the code of conduct and all

That's really interesting. Do you think these may differ from the philosophy, core values and beliefs underpinning social work

NC2 I'm not really sure what the social workers do, but they do support individuals more within their own homes or care homes than within hospitals. I know they are brought into hospitals to help with individuals. If I looked at it longer I may feel that there is not much difference between them and the mental health nurse because mh covers the individual, but social workers also cover the extended family and other events that do occur, particularly children of course

what about occupational therapy, do you have a better understanding of the core values, philosophy and beliefs that underpin ot at all since we last met

NC2well, seeing the ot worker at the home, the values are clearly similar to nursing, but more focussed on enabling, putting things in place to help people to regain independence

what are you overall view Howard about the way healthcare professionals work together in am ultui disciplinary way to provide the best care and treatment for an individual then

NC2 I find it good. Within the hospitals I know very little of it. My experience in ld services has been that it works well. As senior support worker I would have to arrange and negotiate meetings with all disciplines to bring them all together to negotiate how the person can get the best care. ….as key worker to an individual. Its not been so good in the last placement, it was much more nursing and medically focussed, but the other professions were involved.

Would you say that there has there been opportunity for you to explore your personal strengths and areas for development , both on the course and during placement

NC2 Yes. I suppose so. one of my weaknesses is not coping under pressure, competing pressures I mean. within work its not a problem, but at home, they pick up on it very quickly.

How do you think this may link to your development as a professional

NC2 Well, I need to develop better ways of organising myself and working with competing demands. I mean, I can cope with emergency or difficult situations really well, and running a meeting or something is fine, and the paperwork. I doubt very much that I would be able to manage a hectic busy ward with 30 patients on though.

From what you know about the style of teaching and course delivery, do you think that will be addressed

NC2 Well, they launch modules, you can decide whether or not to attend lectures, or so it seems, and you submit assignments. I don't really see any close attention being paid to our strengths and weaknesses as individuals

What about on placement

NC2 Well our placement supervisors completes paperwork and makes judgements and comments about your performance, but I don't see where they will be picked up

Do you think you have gained more insight and understanding of the health and social care structures and systems

NC2 No, not really. My placement was in a nursing home, run by a private , sorry independent organisation, which is the type of organisation i worked in before. I need to wait to get to work ion community teams or on wards to get a real feed for the NHS

But you won't know where that will be until you start, near enough

NC2 Yes, that's right.

Well, that's all of my questions Howard. Thanks for your help on this, I'll transcribe the interview and forward it to you for checking if that's ok

Ok

Howard 3
NC3

Howard, thanks again for agreeing to this final interview. If I could just remind you that some of the questions I will ask today are very similar to those asked in previous interviews, I need to have a measure of the impact that the experiences and learning you have u8ndertaken in then last year have had on your knowledge and perceptions

That's alright

I 'd like to know whether you have confidence now following your first year teaching and two placements, the last being in a mental health setting, in your knowledge of the purpose and role of nursing

NC3 Yes, I think following that last placement, I think that nurses are expected to deal with anything and everything

Oh gosh, that bad was it

NC3 Its been very hard work yes. I have to say that the amount of psychical work and physical care that goes on in an elderly mentally ill ward is unbelievable

Was this what you expected

NC3 In a way yes, when I new I was going onto an elderly ward I new there would be some personal care, well more than on wards with younger people, but it really did take over

I was going to ask more specifically about the placement later on, but i think it would be better to discuss now. Cold you tell me something about the placement and the types of problems clients experienced

NC3 Well it's a 20 bedded emi ward that's part of an older peoples unit in a psychiatric hospital. The ward is for people suffering from mainly organic illness such as dementia and Alzheimer's and Parkinson's disease.

What was the age range of the clients

NC3 Surprisingly wide actually, from late sictis to late nineties

Ok where is it

NC3 In Shrewsbury

Ok. What are the roles in the team

NC3 Well there is a matron over the unit, one of those modern matrons, a ward manager, deputy ward manager and staff nurses, nursing assistants and lots of students like me.

are there any other professionals associated with the team

NC3 Oh yes, there are 2 old age psychiatrists who admit patients to the ward, and an occupational therapy department in the hospital that serves all of the wards.

What kind of interactions did you have with them

NC3 They come on to the ward and assess individual patients for independent living skills, like making a cup of tea, cooking a light meal. They run groups, based on reality orientation and memory provocation, that sort of thing, organised physical activities and games that helped the patients keep mobile, such as catching balls or playing skittles

Quite a lot of interaction with the clients then

NC3 Oh yes. i think the work very hard, but they only work 9 – 5 which I thought was a bit pathetic really

Do they mot work weekends

NC3 No, its just the nurses that work around the clock

Any other professionals that were allied to the team on the ward

NC3 There was a community team that worked with both of the psychiatrists for that part of the city, and there were cpns, an ot, and two social workers

Oh, and what was there interaction like with the ward

NC3 Well they come to ward rounds every week and take part in case discussions and case conferences. the social workers would often pop up to the ward to see the patients and be towing and fro-ing from the patients relatives and the ward. I think they do a good job making sure the relatives are coping ok

Do you think overall the team worked in an interdisciplinary way

NC3 You know it does work at the end of the day, everyone needs to speak the same language, if you can get multidisciplinary working and getting the family on board. Having open discussions on how you see the care of a patient going.

Is that how it worked

NC3 It seems crazy that we would consider not pooling knowledge and experience isn't it, but it takes time to sort it all out, peoples problems, and everyone thinks their side of things is the ,most important.. There needs to be a point of contact, that when information is coming in, it comes in to one person, but that doesn't mean they are responsible for doing al the work

Well that's how the care programme approach works in adult service isn't it

NC3 I think so

I don't think it will be long before it is adopted by older peoples services

NC3 Well lets hope so

How would you describe the approach to client care on the ward

NC3 I think it was thorough, with a focus on choice and people being comfortable, but with the difficulty of communicating with very demented and confused patients. Sometimes they don't even understand what y oar asking them, and you just have to cajole them along to have a wash or get dressed or eat a meal.

What were the skills that you required to carry out that role

NC3 Lots of patience, trying to find ways of communicating with people, definite unconditional positive regard for people, as sometimes they can be quite rude and hostile towards you, but you have to constantly remind yourself that they don't have the cognitive ability to be aware of what thy are doing

Do you think the nursing skills for this client group are different in working with other client groups

NC3 Well I have spent 10 weeks bathing, toileting and feeding people, that's what it feels like.

Hard work

NC3 Yes, but I know the experience wouldn't have been the same ion the adult wards. I think I may have had more opportunity to get involved in therapeutic interactions, counselling, talking and listening to people talking about their problems. Communication was a problem with the older patients

Do you believe there are core skills unique to nursing

NC3 Yes I do, I think that supporting people day in day out, making them feel comfortable and anted, and looked after, whether they can be helped or not, whether they want help or not, nurses need to have the strength of character to stick it out. I don't think iys quite the same for other professions

Why is that

NC3 Well if clients don't want help or are beyond help, they can do nothing for them. The nurse will work 24 hours a day watching, assisting and caring for someone to keep then fed, safe and warm

It sounds like quite a powerful position to be in Howard.

NC3 I suppose it is. You have a responsibility to take decisions for the client when they cannot make choices for themselves, but there best interests must be at heart at all times. It's a big responsibility

Do you think your training has prepared you for that up to now

NC3I suppose so yes. At university we spent a lot of time talking about ethical codes of conduct and legal and moral responsively. You have to take your professional responsibility to society seriously

You have talked about the core skills of nursing Howard, Could you articulate for me what the value base is that underpins nursing

NC3 I understand the values of nursing, putting the patient first. …we had one lecture whether the nhs was run for patients or staff, and we voted at the end that we thought it was for staff, and it has to, or else it wouldn't work

Wow, was this a debate in uni

NC3 Yes, people obviously say you have to run a service for the patients, but its just not feasible, the service, the NHS to run as a massive concern has to be facilitated by staff, so the structures and processes that facilitate the delivery of services are there for the benefit of staff- to help them do their jobs

What about the philosophy and beliefs that provide a foundation for nursing Howard. Are they different to the values

NC3 Yes, I suppose I have covered it already. it's the responsibility for caring for someone 24/7, ensuring they are safe, warm and fed, help them with the activities of daily living that e all take for granted, that we need to survive, but for some people who are ill, they cannot do for themselves

Would you say at this stage in your training, that you have a professional identity as a nurse

NC3 Yes, I think so. I thinks the job is different to what i have done before in social care, its all embracing, the responsibility is huge

So you feel like a nurse now

NC3 Yes I think so. I've been doing nursing tasks on the ward, which feels different to any other setting. You feel part of a bigger team in a hospital

Do you think you made the right career choice

NC3 I think so, I would hope that I will get amore varied experience of services in the next two years. I have had not involvement in psychology yet so that's something I would hope to get experience of

Can I just check out with you then Howard, whether you views on any of the following have changed following a year of training and your placement experiences; the core skills required for social work

NC3 I'm sorry Teresa but I can't remember what I've said before

Do you feel that you have more in sight into the role of social workers in the context of older people with mental health problems

NC3 Yes and no, I didn't get a chance to get involved in what they were doing, I did get to speak to some who ha sectioned the patients to come in, that must be a very scary part of their job

Indeed. What about the value base o social work practice then

NC3 Again, I can't remember what I've said before, but I definitely feel that they are focussed on equality And peoples rights, and protecting the vulnerable from abuse

Ok. Now onto occupational therapy, do you have further insight into the core skills required

NC3 Well I have had more to do with the ot department on the ward, and the ots and the ot assistants seem to be very upbeat, full of energy and extremely positive, I think that is a skills or disposition more like that they would need to do the job well, enthusiasm and infectious motivation

That sounds fabulous- infectious motivation

NC3 Yes (laugh)

What about the value base that underpins their work

NC3 I would say its about enabling people towards independent living, helping people to remain independent for as long as possible

Ok. Is there any other effect that the placement has had on you, other than exposing you to nursing practice in the real world

NC3 I'm not sure I understand the question

Do you think that just working alongside other nurses, and other professionals that you have been able to dispel or confirm stereotypical images that you may have had about nurses and other professions

NC3 I don't know, I'd have to think about that. I suppose in have been disappointed with the psychiatrists, I thought they might do m0ore with patients

Do you feel now that you have a better understanding of the various health and social care delivery systems and how the role of the nurse fits in.

NC3 I understand the inpatient process quite well, how people get admitted, what the care process is like, and the types of ser ices that are out there for older people with mental health problems

Do you have any idea of the social care services, or voluntary or independent sector provision

NC3 Yes, there are a number of day care centres that our patients went to, and quite a ot of domiciliary care organisations that provide care at home. The social workers have to organise access to those services most of the time

Has your placement experience afforded you the opportunity to practice and begin to evaluate the core skills of assessment, report writing and intervention planning through to closure and discharge.

NC3 I've completed admission and assessment forms, I've done a lot of case note writing, and I've done a case study on one patient. I did write care plans but I didn't do any of the discharge process, the staff nurses seemed reluctant to let me do that

Would you say that you have confidence in your own ability to function in a multi disciplinary team in the community, if that's your next placement

NC3 Oh I'm not sure about that. I thin it will be a very different environment indeed

Have there been any role models either at Uni or in the practice placement that they have been able to identify with

NC3 There was a nurse, well a couple actually who were extremely dedicated and ard working, and had a really string empathy with the clients, I would like to look to them for inspiration, I'd be happy to be like them in the future when I qualify

Do you think there has been the opportunity to explore your personal & professional strengths & skills and identify areas for development.

NC3 With some of the basic elements, like communication skills, empathy and dealing with people, my placements have only reinforced what I already believed, that my skills are quite strong in that area. I think there is a massive knowledge gap that needs to be filled, and only experience and lectures and assignments can fill that.

Ok

NC3 We do a reflective journal which will give me the opportunity to discuss events, what I did, what I should have done, and what would I do in the future, so it gives you that opportunity to reflect in your own mind as to where you may go wrong

How would you describe the culture of learning or teaching at uni

NC3 I think they spoon feed a lot of information, but there are helpful debates, they encourage thinking for yourself and most of all put the responsibility for learning on the students. We are adults after all, this isn't school

What about the syllabus content, has this felt appropriate this year

NC3 No, not at all. Some of the basics like holistic approaches to nursing and ethics have been essential really, an we have learned something of the healthcare system we are going to work in, but I had really hoped to have done at least a little bit of mental health

Have you really not touched on it al all

NC3 Well we have done self awareness at a basic level and something about coping mechanisms but nothing about mental illness

And you have enrolled on a mental health nursing course

NC3 Well yes, my thoughts exactly

the syllabus must be more mental health focussed from next year as you branch

NC3 yes, I hope so

.

My last question Howard is about the academic and social support systems within your peer group. You stated last time that you have shied away from study groups and other informal support groups, and you didn't seem to be making much use of the formal processes either, like the personal tutor

Yes

Is that still the case

NC3 I think I will get much more out of support from colleagues on placement and placement supervisors that other students on the course. I don't have much in common with the 18 and 19 year olds on the course, don't have the same interest

Ok Howard, thanks a million. I'll transcribe the interview as before and send it to you. A big thank you to you for agreeing to these interviews with me

Not at all, thank you

Paul 1
OT A

Session 1 – beginning of course

Hi Paul, thanks for agreeing to take part in this interview

OTA1 No problem

I have a number of questions for you, and I'll start with asking why you decided to become an OT .

OTA1 Um, why did i… I suppose I didn't know what I wanted. I did biology , sports massage and psychology at college and at that I time I wanted to work in sports therapy or physiotherapy. It wasn't until I started looking into what my options were for uni that I came across occupational therapy

Oh, I see

OTA1 So I thought, um, that sounds cool, lets go for that

So before looking at uni options you say, you hadn't thought about it as a career before

OTA1 Um, no

You've indicated that you are interested in working in mental health

Yeah

Is there any particular reason for that interest

OTA1 Um, well I did psychology at college and I've always been kinda intrigued about mental illness and stuff, but I thought that doing a psychology degree wasn't for me. I wanted to train and start working straight away, if you know what i mean.

I think so, you would have to do further training after a psychology degree to become a psychologist

OTA1 Absolutely. Burt when i looked at this course there was a big focus on mental health and learning disabilities and I thought, this looks interesting

So at any time did you consider any of the other health or social care roles in mental health, such as nursing or social work?

OTA1 Um..not nursing, no. social workers don't train in mental health do they?

Well, they receive some training in mental health during their training and they can opt for mental health placements, like in OT training.

OTA1 Oh, I see

What would you say , Paul, makes occupational therapy different or preferable to the other professions

OTA1 Um, I'm not sure . I think it offers a wide variety of options for areas that I could work in afterwards, when I've finished training.

Ok. If I focus on nursing and social work as the other professions fore the purpose of this interview, do you think it offers more scope and variety than they do

OTA1 Um, yes, well I suppose I don't really know about that

What is your understanding of nursing.

OTA1 Um, caring for peoples needs, administering treatment..that sort of thing?

Yes, , whatever you understand the role to be

OTA1 I don't really. I don't know any nurses, so i only go by what I've seen on TV and in films.

What about social workers – what's your understanding of their role

OTA1 Assisting people who are having difficulties, socially deprived people I suppose mainly

How would you describe socially deprived people

OTA1 Um, with no job and income, perhaps in bad housing...um old people who are struggling with money and bills on their pension,, that kind of thing

Ok. How do you think they might assist these people then, what would their role be in relation to those you describe

OTA1 Um, sorting benefits for them, knowing where they can go for help, day centres, that sort of thing

Ok, thanks for that. Could you tell me what your hopes & expectations of your OT course were throughout the past year leading up to the commencement of the course

OTA1 Um….i was hoping that it would be challenging, hands on, um…. I was looking forward to meeting new people

Ok. Have these altered now that you have been on the course for 6 weeks

OTA1 Um. No, not at all. Its been really challenging. You know. Only last week, one of your tutors got us into pairs and got us to undress to our underwear in front of each other, then told us we had learned our first lesson in how never to underestimate how embarrassing it can be for our clients to have to strip for therapy, because we will inevitably become blasé about it

Wow what a lesson

OTA1 Yeah..(laugh)

I know this is early days, and very early on in your course, but what do you think makes a good ot

OTA1 Um, someone with patience, common sense, um I think you need a practical approach to problem solving, um, thinking things through

Ok, bearing that in mind, what might the core skills of occupational therapists be?

OTA1 Core skills, like what you need to do the job?

Yes

OTA1 Well, the job, I think, requires skills in assessing peoples needs, social and daily living skills, employment work and stuff …and enabling people to relearn practical skills and being able to get around and care for themselves when they have experienced illness, injury or accidents..

Ok, so what core skills would enable someone to carry out that role

OTA1 Patience, an ability to strike up a relationship fairly quickly and easily with some one. You need to work with people to encourage a positive attitude. I mean some people may need to relearn how to dress themselves or even go to the toilet.

Ok

OTA1 I mean, i don't think its rocket science, helping someone to prepare a meal for themselves, its not about having skill in the actual task, but being able to make someone fee comfortable with you helping them to do that.

And do you think that these skills are unique to OTs or are they skills that other health & social care professionals need

OTA1 Umm..i think confidence and people skills are needed in all of the health and social care jobs really.. i should think

What do you think the core skills may be for nurses

OTA1 Listening and communicating well with patients, um practical skills such as lifting and handling..... giving injections and those sort of hands on interactions

What about social work, what do you think may the core skills required for social work

OTA1 Um, again, listening to people and being able to communicate well. I would think that being able to explain things to people in ways that can be easily understood would be important.

Ok. What do you believe, then Paul, are the values , knowledge base & philosophy that provide the foundation of occupational therapy

OTA1 Umm, values are to promote independence and enable people to live as independently as possible

OK

OTA1 What was the other part. Other than values and philosophy

Underpinning knowledge

OTA1 Well, ...occupational therapists help people to overcome difficulties, which may be the result of physical or mental illness, an accident or the ageing process, so i suppose you need to have knowledge bout physical illness , mental illness, the types of injury people might have and the affect this may have on their independence, the ageing process, that kind of thing.

Thank you, that's really useful. What would you envisage are the values and philosophy underpinning nursing

OTA1 Um...would it be something about caring for people when they cannot look after themselves and helping them in their recovery? I don't know

What about their knowledge base

OTA1 Well again, that would be about anatomy and physiology, drugs, the nervous system...that kind of thing

What about social work then, how might you describe the values and knowledge base and philosophy underpinning social work

OTA1 Ummm.....values and philosophy might be....i don't know I'm guessing it would be...helping people to access services that they cannot access themselves

What underpinning knowledge may they need for that

OTA1 Good knowledge of benefits and the law, and peoples' rights.

Ok, thanks. What are your own personal strengths & skills and areas for development

OTA1 Mmm.....personal strengths. I'm a good talker.. and listener. I think I can make people feel at ease with me. I've got a good sense of humour. I think I'm quite mature for my age, which helps. And I have a really positive attitude to life, you know?

A strength in all walks of life I would say

OTA1 Yeah!

Paul, do you think you could tell me what your understanding is of the structure of mental health services in health care.

OTA1 Mental health services

Yes

OTA1 Um, not really. I know there are mental health hospitals, with occupational therapist teams in them, that's about all.

Ok, what about mental health in social care

OTA1 Not a clue really. I know there are mental health day centres and learning disability day centres that are run by the local authority.

Ok, thanks for that. Can you tell me what your understanding of multi-disciplinary working is.

OTA1 Well its people from different disciplines , professions working together on a case to help make sure all of their needs are met? Is that right?

I'm not sure there is only one right answer, but that sounds find to me

OTA1 Oh!

You described what you understand mental health services to be in health and social care and you have indicated that you would like to work in mental health and you hope to have a mental health placement this year. What kind of placement do you think you might be in within mental health services

OTA1 I dunno. I would have thought within an ot team in a mental health hospital

Ok. Putting yourself in the position of a mental health service user, what would be your expectations of an OT

OTA1 I would expect that an ot would be able to help me overcome difficulties that have resulted from illness or injury, to be able to teach me ways of coping so that I can live in my own house without the need to be assisted by other people.

What difference then, do you expect to make to a users life

OTA1 I would like to think that I would help them get home quickly, back to where they want to be rather than staying in hospital longer or needing to go into care or have people helping them at home

Ok, thanks for that Paul. That's been really helpful. I'll, be back in touch to arrange another interview in a few weeks, will that be ok?

OTA1 Yeah, no problem at all

Paul 2
OTA2

Thanks for agreeing to this second interview Paul. Some of the questions I have for you today will be the same or similar to the ones I asked in the first interview. This is just so that I can capture any changes that have taken place over the last 3 months, is that ok?

OTA2 Yep

I'd like to start if I can asking you to tell me what you think the core skills are that an occupational therapist requires

OTA2 Am I supposed to give better answers than last time?

No, not better- but maybe different, depending on what you have been exposed to over the last 3 months on the course

OTA2 Ok (laugh). I think a core skill an OT needs is to have the ability to form effective working relationships with people who may be disillusioned, disappointed, lacking in motivation...that takes patience, determination and a positive attitude.

So you would say the main skills are around communication and relationship building

OTA2 Well yes, but also the ability to understand and accept other people's priorities and lifestyles. What you might think is appropriate and achievable may not be what they think..... you shouldn't impose your views on a client.

Would these be the same core skills required for nursing, or would they need different skills

OTA2I thinks some of them might be similar..but I would see nursing as providing more distinct treatments when someone is acutely ill, so perhaps choice and working at someone's pace isn't an option. I would say they have more practical application skills as core, around treatments and medicines.

and what about social work. What are their core skills required to practice

OTA2I would say a lot more similar to occupational therapy, around relationship building, communication. Perhaps they need to have more confidence and skill in challenging discrimination, working on behalf of others ..... i'm not sure. I think there is a lot more that they have to learn around the law, rights and policies- that sort of thing

Thanks Paul. Could you describe for me any academic support systems within your peer group that have evolved

OTA2 My peer group- do you mean other people on the ot course

Yes, or other students at uni with you on other courses

OTA2 Well we have tutorials in small groups with lecturers, they are quite useful. We have one to one tutorials with our individual tutors- is that the sort of thing you mean

Yes. Are there any study groups or online discussion groups

OTA2 Um, no

Ok. What about informal, or social support networks- is there anything emerging

OTA2 There are some great people on the course, I've met some lovely people

That's great

OTA2 Yeah, but the thing that has surprised me is how.. mature and sensible the other students seem. They really take the course seriously. There are a couple of ..groups of like minded people shall we say, that have met up to discuss assignments and stuff.

You have talked about the positive influenced from fellow students. What about the tutors or lecturers. Are there any role models that are impressing you at the moment-

OTA2 Um, depends what you mean by role models

Well, is there any one tutor or lecturers who seems to emulate for you what a good practitioner ot should be and, whom has inspired you, or made you feel like you would want to be like them in practice

OTA2 No, not really. There are some knowledgeable people, but i don't really see them modelling what an ot should do in practice, its more...i dunno

Do you feel that they are teaching you how to practice

OTA2 No, more the background , theory and research behind it. I think

Do you think you have a professional identity yet Paul, as an ot

OTA2 No.....I'm not anything yet, I'm just a student. I think I know more about the difference between my chosen profession and the other health and social care roles

Really? Why is that

OTA2 Well, on the inequalities module I've been doing these last few weeks we have focused on all of the health and social care professions really, on the approaches they all take and the values they are based on. That's not to say that we haven't focused on the role of the ot- I'm also doing a human occupational performance module which really does focus on the foundations of occupational therapy practice.

That leads me nicely into my next question Paul, which is about your understanding of the philosophy, core values and beliefs that provide a foundation for occupational therapy

OTA2 Well, i would say the core values are promoting independence and enabling people to live their lives in the way they wish to, the philosophy..... is to help people to lead full and satisfying lives as independently as possible.

Would you say that you understand what the philosophy and values that underpin social work are

OTA2I think they ate similar in many ways, but more about challenging society to treat people equally, with regard to access to services , that kind of thing.

What about nursing- philosophy and values

OTA2I think they are more about caring for people, keeping people comfortable, preserving life, although the equal access thing wood be the same.

Have you developed any views about the social work and nursing profession over the last few weeks? You said in your first interview that you didn't really know much about them. Has that changed at all

OTA2 Well I have spent time with social work physiotherapy and nursing students in lectures, which means that I have got a broader understanding now of what their work is about, but I can't say that I know what they do. Mind you, I don't think I can say that about occupational therapy either.

Has there been opportunity for you to explore your personal strengths during these modules, or identify areas for development

OTA2 Um, that's tricky... I can't think of anything at the moment. I know that I have a lot to learn to enable me to carry out in depth assessments of peoples abilities regarding daily living, domestic skills, cognitive functioning....that kind of thing. There is a large knowledge gap that needs to be filled.

How do you think this may link to your development as a professional

OTA2I don't know what you mean

Well, do you think that id f you gain this specialist knowledge around assessment tools for instance that you will be well on your way to becoming an ot

OTA2 Yes, I think once I have the specialist knowledge, and experience of course

Could you try and briefly explain for me Paul, as if I were Joe public on the street, what an ot does?

OTA2 Right....we work with clients on a one-to-one basis and adapt treatment programmes to suit each individual's needs and lifestyle.

What sort of treatments, what would the programmes be?

OTA2 Well for example, we might teach a patient recovering from a stroke how to dress themselves

Ok

OTA2 We might undertake an assessment and offer advice regarding appliances that will enable a person to carry out everyday tasks in their own home, such as washing, cooking..

What about mental health, what specific services might you offer.

OTA2 We can provide counselling and support from patients and their families , particularly helping them to adjust to problems and disabilities.

In your last interview I asked you about your knowledge of the health and social care systems. Has this progressed or developed at all during the last few months at uni

OTA2umm, I'm not sure I know or understand any better the high level organisational stuff. I think its more about learning about the other professions and how they approach patients

ok. So you don't think that the course so far has address ed the wider service delivery context

OTA2no, not at all

Do you think Paul that you could give me a very basic overview of the delivery style and methods used on your course and the subjects you cover- this year

OTA2 Well, I'm just coming to the end of aN inequalities in health and welfare module, which is for students from a whole range of courses. It's been really useful because we've been able to look at how each of us in our professional roles and interventions can address some of the inequalities

Was this one of the first modules you undertook

OTA2 Yes, amongst others. We have been focussing on the foundation of occupational therapy and the core principles, but this module, the inequalities one has been really interesting,

Could you give me an example of the courses that other students are on

OTA2 Oh professional courses mainly, such as social work, nursing, physiotherapy.

I see, and you have found leaning alongside these students helpful

OTA2 Well, its been interesting to hear how the different profession tackle problems differently.

OK Paul, that brings me to the end of my questions, do you know where your placement is going to be

OTA2 Yes, I managed to get a mental health one, on an inpatient unit in Birmingham, I'm really pleased.

That's fantastic, I'll be in touch in a few weeks then to double check this transcript and arrange another meeting. Is that ok?

OTA2 Great.

Paul 3
OTA3
Session 3 – following a mental health practice placement in a multi-disciplinary setting

Hi Paul, thanks for agreeing to meet with me again

OTA3 No, that's ok

You are just coming to the end of your placement ar4en't you

OTA3 Yeah

In qeph

OTA3 Yes, the ot department

I'll ask you more about your placement and the experiences you have had a little later if that's ok. I'd like to start if I may returning to the core questions that I asked in previous interviews. Apologies for the repetition

OTA3 That's ok

Could you tell me what you understand to be the value base and philosophy that underpins occupational therapy

OTA3 to work with clients to enable them to live the lifestyle of their choice, um understanding and accepting those choices and enabling people to live as independently as possible

ok. what about the values underpinning nursing

OTA3mmm, from my experience of nurses in the hospital I'd say completing paperwork (laugh)

really, is that what you saw them doing most

OTA3well, the qualified ones seemed to just spend all of their time in the office. I can't remember what o might have said before…something about caring for people when they are unable to do so for themselves I think

is that what you think now?

OTA3 Well I didn't really see much caring, more keeping safe. There were definitely some challenging clients that were , well really quite abusive, physically and verbally. The nurses were the ones dealing with that

So would you say their value base is caring for people and keeping people safe

OTA3 Well yeah,

Oh,
what about the underpinning values of social work

OTA3I think its about advocacy, working on behalf of clients to enable them to access help such as finances, benefits, housing and services that they cannot access themselves

ok, could you explain for me what the purpose & role of an occupational therapist is

OTA3right…Improving quality of life is the main role. our focus is on the whole person, the holistic approach. We… enrich the quality of peoples life, the things that are important to them. our approach is holistic, seeing every part of their life and experience as equally important to clients. Through occupation and activity, we try to enrich that life' psycho-educational interventions such as anxiety and anger management,

what about the purpose and role of a nurse

OTA3well form what I saw on the wards it was preventing suicide, managing aggressive behaviour and administering medication

goodness, that doesn't sound too attractive a a career option

OTA3well, its what I saw. They didn't do ,much with the clients, know what I mean? Talking or therapeutic activities- they sort of looked to the ot department for that

ok what about the purpose and role of a social worker

OTA3I think the social workers ensure that practical issue are dealt with, such as housing, benefits and finances services are dealt with when people cannot do it themselves

Do you think you could explain how the different professions work together within the inpatient setting that you have been in.

OTA3 How they work together

Yes, how do they communicate, cooperate, provide a service to the client

OTA3I would say they mainly communicate in meetings, like ward rounds,…and through written records

Do you think they communicate well

OTA3I think they all go through the motions, but there is so much that goes unsaid

Really, like what

OTA3 Well, there was one psychiatrist that everyone seemed to dislike, but no one really stood up to him or spoke their mind, they just pulled him apart behind his back

Oh, really

OTA3 Well the social workers seemed quite happy to take on the doctors but the nurses didn't, well not the ward nurses. I must say that I would have ,liked to have had a placement in the community mental health team, the attitude with the staff seemed very different

In what way

OTA3 Well, they seemed to be more willing to take responsibility, take decisions, take risks. The ot on the team seemed to have a very different role to the ones we had in the hospital,

Like what

OTA3 Well they did much the same ans the social workers and nurses, acting as care coordinator, developing care plans,

So their roles were quite similar

OTA3 From what I saw in ward rounds and in meetings, yeh.

Would you say Paul, that you have a professional identity as an occupational therapist

OTA3 Um, that's an interesting one. Yes , I think I do feel like an ort now. I have had the opportunity to try our my skills and test some of the theory taught in uni

So it has been useful then after all, everything they have taught you at uni

OTA3 Well you don't think of it at first. You think you are just going along with your gut instinct, but when I discussed my work with my placement supervisor, she was linking it back to the theory and it was pretty clear then.

What have you been able to do then as an ot on your placement

OTA3 Well I have been able to work closely with peopled who are quite ill really, at their worst, to reduce their anxiety , loneliness and isolation, and for some, a sense of despair. I think I have helped some of my clients to raise their confidence and helped them to manage better or perhaps develop and practice coping strategies is better

How have you done that

OTA3 Well I've actually run an anxiety management group on my own, which was quite daunting but immensely rewarding.

You enjoyed that

OTA3 Oh yes, I have also been able to spend time with individual clients, 4 I worked with especially, building up relationships and assessing their needs

How did you do that

OTA3 Well, using the multi disciplinary assessment of need and risk assessment forms, care plans, mobility rating scales, that sort of thing

How did you fit into the team

OTA3 Well I was part of the ot department which was only ots and ot assistants and str workers, ex service users

So you didn't feel part of the wider team within the unit

OTA3 Well no, the ward staff are very separate, and all nurses or nursing assistants. The psychology department was totally separate and very distant and well. snotty it has to be said. As I said earlier, I think a community team placement would have been more enjoyable. I didn't really get a chance to work with other professionals

Do you think your approach or attitude towards clients has changed as a result of your placement experience

OTA3 Umm, i don't think so...i feel quite pleased with myself, I have come across some very disturbed clients which was difficult to cope with at first, but the staff team were supporting and helpful to each other. Um, yeah, i felt well supported.

That sounds a little like us and them, the staff and the clients

OTA3 Well it can be scary when someone is pacing around, giving you dirty looks and muttering under their breath, very unnerving, so you don't want to do the wrong thing,, unnerve them or make them worse, so you need to look to the qualified staff for a steer.

I see. Would that have been verbal or just watching what they did and using that as a model approach for the future

OTA3 Um, yes, i suppose the latter

Do you feel that the role of an ot in an inpatient setting has any power, in relation to clients

OTA3I um ..hadn't really thought about that. Power...i suppose so. well i don't know, the clients don't have to go along with what we say, although i suppose if they are keen to get out of hospital, they would do so quicker if we were able to report that they were doing well and making good progress.so i suppose....maybe

You have talked Paul about your experiences of working with the nurses, social workers and the psychiatrists and psychologists to an extent

OTA3 Yes

Do you think that this multi disciplinary work environment and the social engagement that you have had with colleagues has had any impact on how you perceive your identity

OTA3 (pause) I have liked what I saw with the ways that fellow ots operated, so I think I am happy to identify myself with the profession . yes, I suppose I feel like a student ot now, nut just a student

Wow, that's a good outcome from a placement, is it not?

OTA3I think i made the right choice

What about professional stereotypes- have any of the stereotypes you held of doctors, nurses, social workers and psychologists been challenged or reinforced during this placement

OTA3I think my perception of nurses has changed, they weren't the approachable, hands on nurses that i had imagined, much more distant, tougher, harder in some ways

Ok .what made you think that

OTA3 Just they way there were with clients, how they kept control of the ward and the way they maintained the routine I suppose

What about the other professional

OTA3 Um, i didn't really spend any time with the psychologists, just present in a few meetings with them, so i can't say that I know any more about them than i did before

Ok, and the social workers

OTA3 They seemed to be a tough bunch and all, but direct and helpful I think. There was one that was a right old moaner though. Always having a go at us for not doing this or that enough with her client.

Really

OTA3 Yeah, she was a bit of a pain

Have there been many opportunities for you to explore your strengths & skills and identify areas for development.

OTA3 Well I think the whole placement has done that. The things I thought of as strengths, building relationships with people and communicating, I was able to test out in some very challenging situations, and I was pleased with how I coped

any new skills you have become aware of

OTA3 Umm.....running groups, that was new to me and was much trickier than i thought. So much planning and preparation, and quite difficult to take the authoritative position of a leader of a group.

It is , indeed, but a new string to your bow

OTA3 Yes!

What about areas for development

OTA3 Um, I think I tend to ponder and listen too much sometimes, perhaps I need to be a bit more proactive

Has your placement experience afforded you the opportunity to practice, and perhaps begin to evaluate the core skills of assessment, report writing and intervention planning all the way through to closure and discharge.

OTA3 Um, yes, I took part in a number of assessments, and completed the paperwork with my supervisor. The writing in notes was quite straight forward, if not time consuming. The care planning paperwork was overwhelming!

Really?

OTA3 Oh yeah, there are only so many times you can repeat the same information over and over again- I got sick of writing my own name!

It can indeed take over the role. Did you see any clients through from admission to discharge

OTA3 Yeah, a few. They didn't come in ill and go home better though. They were just deemed well enough to go home with home treatment support or the usual community support team

Do you think your understanding of the various health and social care delivery systems has improved a s a result of the placement

OTA3 Oh yes, I understand the processes within the hospital and understand better the type of services that are in the community.

What about your course. Could you explain for me briefly what you think the overall culture and teaching style is like

OTA3 The uni course

Yes

OTA3 Well I think it is well organised, we have had a good balance of topics, we are treated like adults who have to take responsibility for our own learning

Could you give an example of that

OTA3 Well, if you don't turn up for a lecture or you are late getting an assignment in, they don't chase you to tell you off, you just fail or get marked down. There are consequences for your actions

What about informal academic or social support systems within their peer group. You mentioned last time that there are tutorials and informal study support groups that have arisen during the first half of the year. Are these still in place

OTA3 Um, we haven't got together really since we've been on placement.

Do you think these groups have influenced your professional socialization in any way

OTA3 What do you mean

Well has your identity as an ot been challenged ort strengthened by the support from these groups,

OTA3 No, I don't think so, not on my identity as an ot. It has influenced by choice of assignment partners or choice of group work colleagues though

I'll bet. It helps to find that out early on doesn't it

OTA3yes

My final question Paul you'll be pleased to know ids about role models. Have you identified any role models either at Uni or in the practice placement that you have been able to identify with

OTA3yes, my supervisor on placement was extremely competent and professional, I would hope to be as good as she is someday

that's excellent . what was it that you admired most about her professionalism and competence

OTA3well she was confident in dealing with difficult clients, she managed to persuade them to take part in things when they really weren't motivated to, and she was challenging but polite with staff from the wards.

Did you see behaviours that you would like to emulate or use in the future

OTA3 Yes...I think some, yes

Well that's been great Paul. I'll type all this up and send it to your for accuracy. I cannot thank you enough for your time and effort

OTA3 Will I see a copy of the final PhD

Oh yes, you can have a copy

Ruth 1
OTB1

Ruth, thanks so much for agreeing to be interviewed. It will last about an hour, and some of the questions you may well not be able to answer, and that's to be expected sop early on in your course

Ok

I'll kick off by asking why you want to become an OT? what are the motivating factors behind your choice.

OTB1 Um, I wanted to work with children with learning disabilities initially, um

Had you done that before

OTB1 My cousin has down syndrome and I've virtually grown up with her. It just comes naturally to me, working with special needs. Whilst I was at college I did 1 day per week work placement as a classroom assistant in a secondary school.

At what point then did you decide on OT as a career- when were you exposed to this

OTB1 Well I was going down the physio line, but my biology grades weren't up to it and someone suggested that OT was kind of similar, but you get a hell of a lot more opportunities , job wise. It kind of reflected what I was doing at college at the time, health and social care, so I thought, right I could go for that. I got a lot of info on OTs during my course, and so I applied to uni.

Did you choose this career, or has it chosen you

OTB1 Um, a bit of both I think

Had you considered any of the other health or social care roles other than physio - What about social work or nursing?

OTB1 We'll originally I wanted to be a radiographer (laugh)

Oh right, you've been through all the allied health care professions at some time..

OTB1 Yes, I settled on one. But never nursing of social work, no.

Where did you get your information on OT roles then.

OTB1 Umm I did a bit of research at college, we could do our assignments on the profession we wished to follow, so I did a lot on physios 'cos at that time it was what I was interested in. the rest I suppose was personal research on the internet.

Did you find it easy to find information OT

OTB1 No! definitely not. Not a lot of people know what we do, most people think its basket weaving and making tea! When I got to the open days at uni that's when things started falling into place. That's where I got the accurate information on the OT role from.

mm. it's a shame that was not more widely available

OTB1yeah.

What makes the OT role different/ preferable to the other professions

OTB1 With OT it's the range of job opportunities. You can work with mental health, children , older people, injury specific. There are always opportunities to work in many different situations. Nurses and physios have to specify which areas they want to work on and have to be based in hospitals or surgeries, basically.

So you felt that with the other professions you would have to make a choice on specialism early on

OTB1 Yes, where as with OT there are opportunities all the time to chop and change. If you fancy a change in job setting, and its easy to change, there are plenty of jobs

So you did your health & social care course at college. What were your hopes & expectations of the university course leading up to starting?

OTB1 That it would be a nice course and that I would be happy doing it.

What did you think you would learn, get out of it

OTB1 Um, hopefully along the mental health and learning disabilities line, ummm I think different ways OT can be used with people, and how it benefits. It will be personally rewarding to be able to see how you can help someone for the rest of their life

What about academically, assignments and stuff

OTB1I was offered a place at St Loyes as well as Coventry, and I chose Coventry because it wasn't as academic as St Loyes. St Loyes was very exam based, it was like school, you had to live on site, you couldn't live anywhere else, and they seemed to be.. well, quite……straight people. I went to look at Coventry and they were very much more relaxed and laid back. They were very nice about things. St Loyes was a 1 on 1 interview, where as Coventry was a group interview, and there were lots of opportunities to talk to OT students already on the course. With Coventry it was assignments and a final exam, St Loyes was exams, exams, exams. I don't want that kind of pressure

Have your expectations altered now that you have been on the course for 2/ 3 months

OTB1 No, the course is living up to my expectations, I'm enjoying the course

Ok, what would you say makes a good OT

OTB1 Um, you've got to be friendly and be good with people

Good interpersonal skills then

OTB1 Yes

What would you say then are the core skills of occupational therapists

OTB1 Umm, I think they are the same as the ones I just said, being a friendly person and being able to communicate well with people

Do you think these are unique to OT or are they shared amongst other health & social care professionals

OTB1 Umm I don't know but I would have thought that all jobs working with people would need these skills

What do you believe are the values , knowledge base & philosophy that provide the foundation of occupational therapy

OTB1 Umm…I don't know

Have you done any work in uni so far about the value base that guides and informs the work of OTs…. underpinning beliefs and approaches to the work

OTB1 Umm not really.

Cam I ask what your understanding of nursing may be

OTB1 Um, you specialise in a particular area such as general, mental health , learning disability or older people

Ok. Could you explain what they do

OTB1 Umm, no not really

Would you have any idea of what sk8ills may be required for nursing

OTB1 No, not at all

Or the values that underpin nursing

OTB1 No

Ok. What about social workers .Do you have any idea about their role and what they do

OTB1 Ummm, no (laugh), sorry

OTB1Any ideas about the skills they need or values & philosophies

OTB1 No idea, I'm sorry

That's Ok. What would you say Ruth are your own personal strengths & skills and areas for development

OTB1 Um I think academically I need to develop my academic skills, I don't know what is really expected at this level yet. I'd say I enjoy working with somebody, building up a relationship with somebody, I'm a people person so ..thats my strength.

Not a bad one to have. Looking at the wider picture Ruth, what is your understanding of the structure of mental health services in the global health setting

Umm, no

would you know what organisational structures are in place above or below hospital provision, or lines of accountability to the Department of Health

OTB1 Umm, no, I don't

Ok, do you have any understanding of the structures in social care, the lines of accountability, or who employs who, such as social workers

OTB1umm, no.

That's ok .What is your understanding of multi-disciplinary working.

OTB1 Um, lots of different people working with a person, from different organisations, like, um, a GP and a doctor in the hospital for instance

You have chosen mental health as a specialist area and you have a mental health placement this year. What is your understanding of mental health services

OTB1I don't have much of an understanding of mental health services. I haven't had my placement yet, although we have talked about mental health and learning disabilities at Uni. I have a little more knowledge about learning disability schools.

OK. Lets see what placement you get. When do you get to find out

OTB1 Soon, Hopefully.

Is there a specific group you would like to work with

OTB1 Children

OK. Putting yourself in the position of a young mental health service user, what would be your expectations of a OT

OTB1 Its hard for a child to tell who is who I would have thought, but I would want to know that this person was going to do their best to help me. Um they would want you to be a nice person

What difference do you expect to make to a users life

OTB1 Umm, to help someone to change their life for the better, to be able to learn ways of coping with their illness or disability

Is there anything else that you would like to add

OTB1 Umm, no I don't think so.

Thanks Ruth I'll contact you in a 3 months time if that's ok to arrange a further interview.

Ruth 2
OTB2

Hi Ruth, how's the course going

OTB2 Really well, thanks

Thanks for meeting up again. The interview will last about the same amount of time, about 1 hour. We will be revisiting some of the questions I asked in the last interview. Is that ok

OTB2 Yes, fine.

Lets start with what you think are the core skills of occupational therapists

OTB2 To be well organised, to be able to manage yourself and.. well, you have to be flexible, and you have to be able to work as part of a core team, as well as being able to work on your own

What about is your understanding now of the philosophy, core values and beliefs that provide a foundation for occupational therapy

OTB2 Umm. We have been taught it at uni, what is OT

And what are the values that underpin OT work

OTB2 To enable people to achieve independence in everyday life

What about philosophy

OTB2 Mmmmm, don't know sorry

Ok last time I asked about your understanding of the skills required for nursing. Has you knowledge or insight on their role changed at all since we last met

OTB2 Um, we are doing a module with nurses, social workers and physios. they help their patients, just in a different way to us. A nurse or physio is medical, we don't do anything medical like treatment.

Ok, so if you enable clients what do they do

OTB2 Umm (laugh) maintain physical health

what skills might they need to do that

OTB2 Knowledge of medical treatments, teaching skills and helping people to understand how to look after themselves

Ok. Do you have any idea what the values and philosophies may be that underpin nursing

OTB2 Um, maintaining health and life where possible, I think

Ok. What about social workers

OTB2 They maintain the social and environmental level.

In what way

OTB2 Maintaining the family environment and social situation, helping restore the status quo, the um balance

If that's the or underpinning philosophy and value base, then what might the skills be that they need

OTB2 The ability to work with people and their families, good people skills

Ok , could you tell me about the nature of any academic or social support systems within their peer groups that have evolved since you started the course

OTB2 Um, on the student side, there is little groups, but you feel that you can go into that group and you will be accepted. They aren't clicky. OTs seem to be really nice people who are very accepting of others. Um. On a student scale, people are willing to help you if you ask. I live with another trainee OT and we are always helping each other. Same with the tutors…… if they have time then they will help you

Have you fund any positive (or negative) role models within your tutors or lecturers

OTB2 Um, its hard with tutors at uni because they ***were*** OTs, you know what I mean? They are not in the therapy setting and more they are teaching therapy.

So do you think that when they are teaching how something should be done that they may be out of date, that it may not still be that way

OTB2 Yes, because it was their past, they are not bang up to date. When we have guest speakers and seminars from practitioners in the field, you know that what they are telling you about is bang up to date, it's what's really happening, they are doing it. We have had a lot of outside speakers come to tell us what they do.

Ruth, I know its early days, but do you feel that you have developed an identity as an OT yet

OTB2 Umm I don't know. I still feel like a student I suppose.

Ok. Has there been opportunity for you to explore your personal strengths and areas for development

OTB2 Yeah, I need to read more and gain more knowledge to write good assignments!

So for you the main learning need that's been highlighted for you over the last few months has been academic ability

OTB2 Yeah, well, we are all worried about passing assignments aren't we

How do you think this may link to your development as a professional

OTB2 Um, I need to develop my knowledge base, I just need more experience.

OK., Tell me about the role of the OT, what you have learned in uni over the past few months about the role you are training to do

OTB2 Well, my role is to.. teach or help someone learn new skills and abilities which they can practice and will help or benefit them for the rest of their lives. Like dressing practice, if I can do that with somebody so that they no longer need someone to come to their home to wash and dress them in a morning, then its helping them to maintain their independence further. You are giving people the opportunity to help themselves

Last time I asked you about your understanding of the various health and social care delivery systems . Has your awareness of knowledge of these changed since we last met

OTB2 Um in what way, can you remind me

Well, the structures above and below hospitals, who governs, who employs, lines of accountability, that sort of thing.

OTB2 Um, its not something we've covered really

That's ok. Have you talked about the different types of settings then in which you may work as OTs

OTB2 Well , we have talked about the role of OTs in hospital teams, yes

So whats your basic overview of teaching style on course and the syllabus content

OTB2 Well there is quite a lot of choice in the modules you can pick.

You do some with other professionals don't you

OTB2 Yes we are currently doing one with social workers, nurses and physios. The physios hate us

Who

OTB2OTs, they think they are better than us.

Why do you say that

OTB2 Well, in one recent lecture the OTs were sat on one side and the physios on another, and this physio picked her chair up and turned it away so her back was to us, and the teacher asked her to move when she came in and she said 'why do I have to move?'

Gosh, why is there this attitude

OTB2 Because you need better grades to get onto the physio course, and they think most of us are failed physio applicants. Its not just physios. Another time, we were doing a practical dressing session, helping someone to cope at home, and at the end of the session the speech and language students turned around and said, well is that all you do then

How odd. Well thats all my questions for now, thank you Ruth. Do you have anything to add

OTB2 When will you want to meet up again

Just after your placement in June if that's ok

OTB2 Yeah, fine.

Ruth 3
OTB3

Hi Ruth, thanks for agreeing to take part in this final interview, I appreciate you giving the time and your views.

OTB3 That's ok.

Same as previous interviews, there will be some questions that I have asked previously, and I just want to check learning and changes that may have taken place over the past year

OTB3 Ok

Can you tell me , what you believe to be the core skills of occupational therapy

OTB3 You have got to be able to work well as part of a team, whilst a the same time being a safe practitioner able to work on your own. You need to be well organised, and keep your managing skills on a level where you can manage caseload and paperwork, do it all in one go, you need to be able to juggle things. You need to be able to apply theory to practice, so academic skills are generic too. I think all skills are shared; looking for challenge, flexibility, being approachable. But these are skills needed in all professions working with people, they are not unique to occupational therapy.

Ok, What about the core values & philosophy of OT

OTB3 Well, it's to enable people to live as independently as possible and where you can enable people to make there own decisions about the levels they want to achieve. ……promoting autonomy.

What about the development of your value base and specialist knowledge

OTB3 Um, with regard to value base…the philosophy is about enabling people to live as independently as possible and where you can, help to encourage autonomy and independence and choice

Has your placement helped to clarify your purpose of role and OT approaches to clients

OTB3 Yes. A lot of the children here are non verbal, so you end up making assumptions based on little information, its really tricky. The children here will let you know if they don't want to be with you, they just walk off! If they can't tell you, they'll let you know in other ways.

That must be challenging

OTB3 You have to have such a great deal of respect for the client, because they can't communicate verbally you have to give them other powers. Such as this week I've been sitting in on art sessions as an observer, so I'll sit quietly and wait for a signal from the student to indicate that he or she wants me to join in or get involved, so they feel and element of giving me permission. I mean I feel much better, not imposing myself on them.

That's really interesting. So you just wait for them to want to engage with you

OTB3 Yes, the other day I was in a session with one girl I work with. She is verbal, but does not know my name, calls me lady. I was sat back observing and she turned to look at me and said 'lady do', so she was inviting me to join her.

So…you would say that you make best efforts to ensure that the client maintains control within therapy sessions

OTB3 Yeah, that's really important. Like when we are carrying out an activity session with them, we try to get them to indicate what equipment they would like to use, whether it's the projector, soft play cubes, whatever they indicate is of interest so that an activity is not being forced on them…. Working with the children on the severe end of the autistic spectrum, we have to use lots of different approaches to communication. One we use here is the pes system- picture exchange, so they use objects of reference. So there are three stages, mini models of the equipment, photographs, and them a symbol which is a line drawing with the word underneath so that they can progress on through the levels.

You've talked about control and giving power to the client. What power do you think clients perceive that you as a professional have

OTB3I think that clients find it hard to differentiate between nurses, OTs, teachers, physios. They see you as a worker, a professional that's there to help, but they don't know the differences between us and our approaches. I think the medical professions hold the most power if you want to call it that, as they are giving treatments and making diagnosis. We don't

That's really interesting. Now, with regard to the philosophy, core values and beliefs that provide a foundation for occupational therapy…. Do your colleagues encourage you to link theory to practice or do you make those links yourself as you encounter different situations

OTB3 Umm.. it depends. For instance, today we are using the communication room to work, as we are hoping to get some obs done. This placement here (children with mental health & learning difficulties) you have other theories such as neuro developmental, behavioural , social integration & psychological theories. It does depend where and who your'e working with as to which theory is pushed at you or not. Here they always have a reflective session afterwards, so we are constantly planning for the next session, constantly looking at how we can make things better, look at the problem from different angles.

Ok. You have mentioned the other disciplines you have been working alongside on placement. So has your understanding of the nurses role developed

OTB3 Um, I understand that nurses do basic medical procedures like obs, injections, blood testing, the basics before a doctor is involved

Do you have any further insight into the skills they may need, or the underpinning values and philosophies

OTB3 Um, I haven't had the opportunity to work along side them, just being in case planning meetings and reviews, and visiting children on their units where I have seen the nursing staff in action. I don't really have a view on them. Um..the nurses seem a little strict, hard at times , but perhaps that's unfair as they work with the children 24/ 7, they would know best how to approach the behavioural aspects. I think their philosophy is about looking after someones global needs, whether that be diet, sleep, personal care, etc at all times.

Ok.What about social work, what about the skills, underpinning values and philosophy

OTB3 They don't have to specialise, they work across the client groups. Their role is to help normalise things. Like with children the social worker would concentrate on returning the child to normal life.
So their philosophy is normalisation

OTB3 Well yes, helping people to live day to day with essential requirements such as housing, income, education, employment, well I'm not sure that they focus on employment actually

What kind of skills may they need to do this role

OTB3I think counselling skills, negotiating skills, dealing with families.

How long is the placement

OTB32 months. I'm here two months and then over in Kidderminster for 2 weeks with adults with learning disabilities as this place is closed for Easter. I get a longer mental health placement in my second year, 12 weeks

I didn't think all OTs have the opportunity to do mental health

OTB3 Yes, you have to do one physical and one mental health

Oh, I didn't know it was compulsory. Ruth, would you say at this point of your training that you are developing a professional identity as an OT

OTB3 Yeah, I think so. Initially on the course I was referred to as the student, introduced as the student. Now I'm introduced a the student OT, and yes I am, but I also feel that I have a part to play, something to offer. Like helping in the sessions. I feel more confident in the role. I feel that I know what to do now. As part of the team, we look at treatment scenario and plan strategies and approaches as a team

That's really positive. So, you have had the opportunity to work alongside professional OTs here as part of the team, but also alongside nursing and teaching staff. Do you think that you have been socialised in the ways of an OT.

OTB3 Um…I don't know , that's really difficult.

Have you felt like part of the OT team, picking up tricks of the trade, or learning better ways to do things other than what you learned in uni

OTB3 Well I suppose it's a really nice feeling , to be part of a particular staff team with specialist skills, and as I said earlier, being a student OT rather than just a student. I feel that I have a part to play. We have talked about different approaches and methods used by the unit staff (nurses & nursing assistants), and some of the shortcomings of teaching approaches, but on the whole everyone here appreciates the efforts of the other staff teams. And there are a lot of case planning meetings, so everyone is involved.

You mentioned discussions about nurses here and teachers. Are their any other professionals that you come into contact with

OTB3 Um yes, there is a psychology department, a couple of physios and sometimes a social worker, but they come from the childs home area.

Turning to your uni input, the teaching input and supporting syllabus content. Has it prepared you well for this placement

OTB3 Well the one module I am doing at the moment , it has two sessions a week, one is physical problems, such as arthritis, the other is mental health. We have covered things like personality disorder, depression, anxiety, schizophrenia, and I feel that I am gaining the knowledge in an easy to understand way. I feel more confident and comfortable because I'm beginning to understand the whole area,. There are optional modules as well, like learning disabilities

So you feel happy with the level of knowledge that you have gleaned from uni

OTB3 Yeah, I think that there are more opportunities to learn in a placement like this, probably because you can apply your knowledge, and …..tell people what you've learned basically. I mean before this placement I did modules on clinical reasoning, professional development, groupwork in OT

Is that how to run groups

OTB3 Yes. We have done assessments, standardised & non standardised, how they are used, what they measure, that's given us a bit of an insight into what goes on. We did one session where we had to assess our own living environment and then were given a case study where we had to assess how suitable that environment would be for them. I was living in a flat, and I had to assess how it would meet the needs of someone with down syndrome, umm and could that person live totally independently. We worked through things like identifying tripping hazards, etc. Overall I think the methods of teaching are good. You get your lectures, seminars and workshops, they get guest speakers to get other peoples insight, obviously there are different tutors.

The only thing I'd flag up as a negative is that the modular options aren't up to our expectations. I'm dong LD and secure settings. I thought we would learn about the different types of learning disabilities and how the OT approach can help, but what we have had is a stream of guest speakers talking about their specialist areas.

Will you be feeding that back

OTB3 Yeah. I will be doing option modules next year, but I don't know whether we have the same ones or whether we have to change, I don't know

OK. Last time we talked about the academic and social support systems within their peer group. You felt that both staff and other students were very supportive and approachable. Has that changed? Do you spend a lot of time outside of lectures and taught sessions with other students, and is it just OTs

OTB3 Um, I think we are all just more confident now, so don't need to rely on each other so much. I think the other students are supportive, but,. I don't know, we socialise more now I suppose, we know who we have things in common with and who we don't.

And is it mainly other students on the OT course that you would socialise with

OTB3yes

Have you identified any role models either at Uni or in the practice placement that they have been able to identify with

OTB3 At uni ,no, although some of the guest speakers have been quite impressive. I really admire the approaches of some of the OTs here. They are so kind, so nice and so genuine

So would it be fair to say that you have come across people who practice in a way that you think, yes, I would like to be like them

OTB3 Yes, I think so. Its about personality I think, and being genuine with the clients

That's positive. So whats your own level of confidence like in your own professional identity and ability to function independently in a md team

OTB3I understand what people are talking about now! As a new student I would wander what the second years were on about during some of their conversations, but having been on placement I now know the language and feel that I can understand professional speak a lot better.
My mom works in learning disabilities, and whenever I am at home now, we sit and chat about work, but my dad keeps butting in saying 'whats ADHD'' and things like that, yeah, I'm very confident with the terminology

So what about working with other professionals, do you feel confident with that

OTB3 You need to be able to work on your own in treatments scenarios, but work well as a member of the team, participating in the development of strategies and so on. I think in practice , it would get easier, the more knowledgeable you become

Has there been the opportunity for you to explore their personal & professional strengths & skills and identify areas for development.

OTB3 Yes, as a college student on placement, you can just turn up and watch basically, and ask a few questions. As a university student, you have to take responsibility for our own learning, its up to you what you get out of the placement, and you have to put your professional head on and act accordingly, think about the decisions you would make I these circumstances and the support you would want to receive. ……..um……I'm aware that you have to want to do this, otherwise if you qualify and just do a job without your heart being in it, the client won't get the benefit.

Has your placement experience afforded you the opportunity to practice and begin to evaluate the core skills of assessment, report writing and intervention planning through to closure and discharge.

OTB3 Yes……I have taken part in assessments, completed the paperwork and written reposts and therapy plans. No one has been discharged from here though, its a school, so most leave at 16. Skills wise, you have to be able to manage yourself and your time and your caseload, management at all levels is important to be able to do the job well . You need to be able to apply your theories that you have learned. I particularly love working with children, because you feel that whatever you teach them or help them with, it will benefit them for the rest of their lives. It's a great feeling, its like you have a reason for being here

Ruth, we discussed at one of your previous interviews your understanding of health and social care delivery systems . Has your knowledge base broadened on this in the light of your placement experience

OTB3 Mmm, It hasn't really , no. When you start working here, um, they gave me a structure chart, so I understand the different levels, up to trustees and the chief executive…. but I don't know anything else about other systems and structures

Ok, what about a community OT, do you know who they would be accountable to

OTB3 Umm, maybe social services, somebody like that, I don't know. I spent a short time in rheumatology this year, there was an OT room , separate from the ward and outpatients. The OTs were mainly rotational posts. They had their ward, and that's what they did. Other OTs had stroke patients and that's all they did.

In the community, what would the role entail.

OTB3 Um. They would visit the house, and assess whether the person has the skills and equipment to be able to live comfortably in that house…umm.

Would the team be based in the community

OTB3I'm not sure, I still think it could be like social services thing. Would it be a multi-disciplinary team. Um I really don't know.

Ok. Would you say that you have had opportunity now to consider the role of the occupational therapist and inter-agency working.

OTB3 Well with regard to multi-disciplinary working, its about one person having input from ots, physios, doctors, consultants, speech therapists, and they are doing their best for that client. It enables you to hear all different views, their opinion of the situation. The doctor with concentrate on the physiology of the body, where as the OT will look at how the body is functioning in everyday life, instead of concentrating on making the arm or leg better, we would look at making the lifestyle better for that person using their arm or leg. The different opinions should eventually form a treatment plan that will benefit the client overall.

So you have gleaned you multidisciplinary insights so far from one placement

OTB3 Yes, within this special school for children with mental health and learning disabilities. Apart from various messages form visiting lecturers describing their experiences and views, I have not been able to experience multi disciplinary working in a hospital or community health team yet.

Will you have a hospital based placement

OTB3 It depends, maybe not. It may be in a community team, either next year or the third

That concludes our last interview, thanks for all your help Ruth. I'll be in touch with the transcript

No Problem

Claire 1
OTC1

Hi Claire. Thanks for agreeing to take part in my study

OTC1 Oh thats ok.

I have a number of questions for our today, the interview should take about an hour if that's ok

OTC1 Yes, sure

Some of the questions I don't expect you to have the answers to as yet, as you have only just started your course, but it will allow me to track any changes throughout the year, is that ok

OTC1 Yes

Right, if we could start by discussing why you want to become an ot. Have there been any life experiences or other motivating factor that have influenced your choice

OTC1 Well, yes. I always wanted to be a nursery nurse, I loved children from a young age, so when I left school, I went to college to do a btec national in early years care

Oh. Did you enjoys the work

OTC1 Oh yes. I worked as a nanny for a while, then in a private day nursery. The money wasn't very good- it never is in childcare

No, I suppose the rates have to be affordable from a salary to make it worthwhile people going to work

OTC1 Yes. Anyway, my nan got ill with Alzheimer's disease

Oh, that was awful

OTC1 Yes, it was, she died within two years, from a heart attack thankfully, I mean it was quick

Yes, I understand what you mean

OTC1 But while she was having problems with her Alzheimer's, coping at home, she had help from a wonderful ot from the older peoples team. She was absolutely fabulous, helping nan learn ways of coping with her loss of memory, and really helping her come to terms with her illness

That's great to hear

OTC1 Yes, she was really supportive to my granddad, helping him look after nan, and my mom, and well, all of us really. I decided then that this was something I wanted to do

Wow, what a great reason to change career. Did you have to undertake any further study to enter the course

OTC1 No, I had the btec national from college which is a level standard, and I had also studies for an a level in biology at college, so it was automatic entry, well after the interview and police check

Is see. My next question is a bit redundant really, as I was going to ask whether you choose this career, or has it chosen you

OTC1 Well, I'd say it chose me , definitely. I just hope I can be good at it

Have you ever considered any of the other health or social care roles- for instance nursing or social work

OTC1 Umm, no , no

What do you think makes an ot different to those professions

OTC1 I don't know (giggle) I don't know what nurses and social workers do really. I saw a bit of what the nurses did when my nan was in hospital, but they didn't seem any where near as helpful as the ot was to my nan

Ok. Could you tell me what were your hopes & expectations leading up to the commencement of the course

OTC1 Umm, hopes and expectations

Yes, what were you hoping it would be like

OTC1 Umm, I don't know really, that there would be some nice people on the course, that I would be able to do cope with the assignments , um, that's it I think

Have these altered now that you have been on the course for 2 months

OTC1 Um no, I suppose I'm quite relived that there is a\ lot of help with it and study skills, and my personal tutor is really nice, so,,, yep, I'm happy

Ok, thanks . right, I'd like you , if you could, to explain to me what you think the core skills of an occupational therapist are

OTC1 Um, core skills. Well being an approachable person with a practical approach to problem solving . um, you've got to have common sense and be able to find workable solutions to problems with everyday loving.

Ok, so very practical skills

OTC1 Well yes, but also the ability to motivate people who are not really able or aware of what their limitations are

Do you think these skills are unique to OTs or are they shared amongst other health & social care professionals

OTC1 Umm, that's hard to say. Umm, I should think with most of them you need to be practical

Ok, what about nurses, what do you think the core skills might be for nurses

OTC1 Um, I really done know, being bale to help people with physical needs like… oh I don't know. Giving injections, enemas, dressing wounds, those sorts of things

Ok. What about the core skills of social workers

OTC1 Um, core skills of social workers… knowledge of I don't know, sorry

That's ok Claire, that's fine. Can I ask you what you believe are the values , philosophy and knowledge base that provide the foundation of occupational therapy

OTC1 Um, values would be a strong desire to help people.

ok

OTC1 Occupational therapists help people to cope with disabilities or problems that can be the result of physical or mental illness, an accident, or or just getting older and more frail.

What about philosophy

OTC1 Philosophy, i don't know the difference really

Ok what knowledge base might be needed

OTC1 Um, some very practical knowledge about services and equipment. For instance, if you need to providing specialist equipment such as a shower chair , a hoist to help a carer lift someone, or arranging adaptations such as a stair lift, then you need to know how you access those things, where they come from.

Ok. What about the values, philosophy and underpinning knowledge required for nursing

OTC1 Oh, I don't know at all. Something about caring for people? I don't know. Um knowledge of drugs and medicines

Ok. what about social work

OTC1 Don't know, sorry. I'd say… knowledge of benefits, the law, services that people are entitled to

Ok, thanks Claire. What are your own personal strengths & skills and areas for development

OTC1 Um, I think I'm a very patient, warm and profession al person which is a great strength in helping people. Areas for development really for me are knowledge of the specialist skills, particularly assessments tools, financial aspects of the services, um, knowledge of the health care system I suppose

Well that brings me nicely on to your understanding of the structure of mental health services in health and social care . what is your understanding at the moment

OTC1 Um, I only know what I know through my nans illness really

Ok

OTC1 I know that there are community teams that provide care for older people and younger people, and that there are nurses and ots in them…and psychiatrists. There ar memory clinics and outpatient clinics and um…wards in hospitals

What about social care

OTC1I don't know anything at all about social services. I know they fund some adaptations for people with disabilities, and provide alterations for the home, but that all

Ok Claire. What is your understanding of multi-disciplinary working.

OTC1 It's a team of people from different profession isn't it, like doctors, nurses and ots in one team

How do you think they may work together then

OTC1 Um, sharing out the work, allocating different case to different people

Ok, thanks. You have indicated that you want to specialise in mental health and you have asked for a mental health placement this year.

OTC1 Yes

What is your understanding of mental health services.

OTC1 Um, no different to what I described earlier really, about community teams and hospital wards. I really don't know any more

Ok. Putting yourself in the position of ma mental health service user, what would be your expectations of an OT

OTC1 Well, someone who can give practical help and advice on how to carry on day to day living at home. Someone who knows what tools and adaptations I need, and knows how to get them for me, quickly

What difference do you expect to make to a users life

OTC1 Well, I suppose the same again really, to have the specialist knowledge of what's available to them that can help them to stay living at home, to help their carers to look after them at home, and…, that's it really

Ok Claire, that's the end of my questions, thank you .Is there anything else that you would like to add

OTC1 No

Thanks very much for you time. I'll transcribe this interview and email it to you to check and agree if that's ok

OTC1 Ok, thanks

Claire 2
OTC2

Hi Claire, thanks for agreeing to meet with me again

OTC2
No its fine, it was really weird to read the last transcript, useful though, weird to read myself speaking

Yes, it is isn't it. well, thanks again. You are now 4 months into your course aren't you

OTC2
Yes, a ;little more, 18 weeks

Do you know where your placement is gong to be yet

OTC2
No, I'm really frustrated about that. I have said that I'm not bothered what service it is in as long a sits mental health, but it still hasn't been settled

Oh really. When are you supposed to be starting it

OTC2
Next month

Well lets hope they get it sorted for you. Ok. Some of the questions I will be asking you will be the same a s last time, and again I'm not expecting a right answer, just a gauge of your knowledge and perspective . is that ok

Mmmm

Ok. I'd like to start by asking you what you understand the core skills of occupational therapy to be

OTC2 Right. a sense of humour ,with good communication skills . you need patience, determination and a positive attitude to deal with people who may be very unmotivated

Why might the people you would deal with be less motivated that other people

OTC2 Well, any patients have conditions that is only going get worse over time, like dementia or multiple sclerosis, which means they gradually become less mobile and more disabled. Its really important to have a positive attitude and helping them to retain independence for as long a s is possible, and even then making sure that you enable them to make choices for themselves about how they want to be cared for.

In that respect Claire, what is different bout the core skills nurses may need

OTC2 Well I don't thin k they are doing the same job. They work with the illness, or condition, and administer treatments, so their skills are similar in a s much as they need to be good communicators and to be able to build up a good relationship with people, but its not about helping someone to function to their optimal level in day to day living tasks, its about treating an illness.

So any idea about what their required core skills may be, above communication skills and relationship building.

OTC2 Um, I don't know. Its more about knowledge to me, of being able to feel confident in leading someone's treatment, treatments and approaches to problems relating to illness

Ok, what about the core skills of social workers

OTC2 Umn, I'd say the basics as with nurses around relationship building, confidence and um good communication skills, but more specifically being able to challenge people on others behalf, like advocacy,

Challenge who- people or organisations

OTC2 Well, yes, people in organisations, the rent office, benefits agency, housing associations, any one that they need to settle problems with on behalf of the patient

Would you say, Claire that you have developed a professional identity yet as an ot

OTC2 Um , that's hard to say. When we have been in mixed lectures with other professionals, I suppose you feel that you are representing occupational therapy, that you should defend it somehow id it comes under fire. But I'm not an ot yet, I've got a long way to go.

Do the other trainees understand occupational therapy then

OTC2 No, they have the usual misunderstanding, like we do basket weaving and clay modelling, our that we just help people make cups of tea

Oh gosh, really

OTC2 Well those of the sort of things they say as jokes but I really don't think they appreciate the breadth of things that we do

Could you explain for me what the main professional roles of an ot are then

OTC2 Well, assessing peoples needs, , social and daily living skills, employment and work abilities and opportunities,um carrying out in depth assessments of peoples abilities regarding daily living, domestic skills and cognitive functioning.

Ok

OTC2 A large focus is on the physical such as mobility assessments, putting in adaptations is the home. But from the mental health aspect is can be things like encouraging someone suffering with depression to take up a new interest or rekindle something that they were good at I the past

Thanks, Claire, that's really useful Could you explain for me Claire, what your understanding is of the values, philosophy, and beliefs that provide a foundation for occupational therapy

OTC2 Um I think the overarching philosophy is enabling a person to live as independently as possible, was it values you asked for

Yes, values

OTC2 Well,, that we take a holistic approach to the whole person, including their aspirations, interests, and beliefs

Ok. **what about nursing, the values and philosophy**

OTC2 um I have to say I don't really know. But I would say something about helping people who cannot help themselves, saving lives, dignity and respect, something like that

ok. what about social work

OTC2 um, I'd say values are about preserving peoples rights and ensuring the y have equal access to services…um protecting vulnerable people perhaps

has your understanding of the health and social care delivery system developed at all since we last met

OTC2 um,I can't remember what it was last time we met

well you talked about how you knew the services through your nans health problems, and you described mental health community and hospital services

OTC2well I think I know a little more no about social services and how they operate. Um, they are separated into children's and adult services, and they provide assessments, but they also buy services for people from any type of service. I think I have heard a bit more about the general hospitals and the sort of roles that ots undertake in acute wards

ok, that's great. Has there been opportunity Claire for you to explore your personal strengths and areas for development

OTC2um, I don't think so specifically. …no. I'm sure my placement will reveal my developmental areas

are you looking forward to your placement, if they sort it out on time

OTC2oh ye, I can't wait. Its what its all about isn't it

ok. Could you give me a basic overview of the teaching style on the course and the syllabus

OTC2teaching style, well, we attend lectures, group tutorials, um, not much different really

what about assignments, what are they like

OTC2um, some written assignments, some group work, that's been good

have you had to do work with other professional students

OTC2yes, we had the opportunity to team up with other students on our module on health welfare and inequalities. We are also with other professions on our introduction to research module

what other modules will you have done this year

OTC2um foundations of occupational therapy I have just completed and I'm just doing two modules which are all about preparation for profession al practice and , well yes, they are quite good

you have mentioned group tutorials. Could you describe for my any other support structures that have been put in place for students on our course

OTC2well there are personal tutors that we can see if we make an appointment

what about the more informal arrangements. You mentioned group assignments or group work. How have the informal support systems been evolving.

OTC2I think they have been ok, the other students in my groups have been willing to do their fair share of the work, its been really interesting to work with students other than ot, um, yes , that's it I thin k really

Have you come across any role models , such as lecturers' or tutors

OTC2 Role models

Yes, someone who impressed you with their skill's, approaches so much that you might want to emulate them

OTC2 Um, no…no one has impressed me that much yet

Ok, thanks for that Claire. That concludes my questions you'll be glad to hear. I'll be in touch with this transcript for you to check for accuracy , by e-maul if that's ok

OTC2 Yes, of course

Rebecca 1
SWA1

Hi Rebecca, thanks for agreeing to take part in the interview. I'll be asking some questions that I won't expected you to know the answer to, but so that I can compare your answers across the year, if that's ok

SWA1ok

If I could start Rebecca by asking why you wanted to become a social worker? what were the motivating factors behind your choice

SWA1 Um, I looked into nursing and I looked into police work because I knew I wanted to work with the public and help people, um in deprived areas and social work just stood out to me.

Were there any life experiences that have persuaded you to wish to train as a sw

SWA1I had an average childhood , really from a working class family, but I think I'm quite streetwise really, but my partner grew up in children's homes so, perhaps that was part of my motivation.

So looked in to nursing as well as social work but chose sw.

SWA1 Mmm

Why did you think sw was more for you

SWA1 Because nursing, I liked the cpn area. I know this sounds silly, but I'm not into injections and drugs and stuff. So if that's a no no straight away, like much of the training is hospital based. I actually spoke to some one from college who had done their professional training, and I went away read some books and magazine articles and it just felt right. That's all I can describe it as, it felt right. I like the nitty gritty of it as well

Did you choose this career, or has it chosen you

SWA1I have got to have chosen it to a certain extent. My personality is that I need change day to day. I suppose ½ and ½ because my views on starting my access course and up until now have changed so much

You stated that you had considered nursing. did you considered any of the other health or social care roles?

SWA1 Um, no

Ok. So What do you think makes being a social worker preferable to the other professions

SWA1I suppose the engagement, working directly with people. My experience is in children & families. My experience was working for a voluntary organization called reentry which helps children get back into mainstream education, so my role was to befriend them and act as

a mentor. The relationships were strong, the bonds were strong so was something you could work with for months.

Do you think that kind of depth of engagement and working relationship something that you feel you are more likely to get in social work rather than some of the other professions

SWA1 Some areas, some not. It would depend on whether it is short term intervention or longer term. Is does depend on which area or team that you work in.

So did you do your access course immediately prior to starting the course.

SWA1I did it while I was working, yes prior to the course

Just before you started this course what were your hopes & expectations of the course

SWA1 Um to be honest is was quite nervous. The access course had been an eye opener for me, but the more I studied, the more it felt right for me.

So you felt that the access course prepared you well.

SWA1 Yes, definitely. I had a good idea of what the training was going to be like.

Have these altered now that you have been on the course for 2/ 3 months

SWA1 Yes. I've been impressed by the preparation we are getting.

So, what do you think makes a good sw

SWA1 Um…..Giving time to people, and helping where you can.

What would make a good nurse, and what would the skills be.

SWA1 You have to be caring, and have a good all round knowledge of different conditions and treatments.

What about ots, do you know much about them

SWA1 No, I don't.

Would you have an idea what the role is, and what skills they may need.

SWA1 Are they mental health workers?

No not specifically, it's a generic role but they can specialise in mental health. I'm sure you will come across them in you mental health placement.

SWA1 Oh, ok.

The skills you have talked about in social work, are these unique to SW or are they shared amongst other health & social care professionals.

SWA1I would say they are shared. The ability to understand different peoples needs is there in all health and social care roles. You still need the capacity to be able to bond with people.

Ok, thanks. What do you believe then are the values , knowledge base & philosophy that provide the foundation of social work

SWA1 Um, values…

What are the underpinning models and beliefs to social work practice, the basic driving force behind the approach.

SWA1 You have got to be able to want to help people from all walks of life with whatever their problem is. Wanting to help and befriend people and help them to keep independence wherever they can

Do you think these differ for nursing

SWA1I know their training is different, but we all work with the same people, so I think the values would be roughly the same

Ok. What do you think are your own personal strengths & skills and areas for development

SWA1I need to develop my understanding of the role of a social worker. I mean I do have an understanding, but I just need to get more experience basically in the different settings.

What do you think you are particularly good at

SWA1I think I am a good people person, I can talk easily with people and get on with them, I think I can put people at ease.

Do you feel that you have good interpersonal skills

SWA1I do feel very comfortable with people. I try to engage with people and learn from others, I know there are boundaries and professional issues, but I try not to have the I'm a worker and you're a service user attitude.

That's a healthy attitude to have. What is your understanding of the structure of mental health services in a) health and b) social care .lets look first at health, grass roots level.

SWA1 Um, community nurses and doctors liaise with the hospital. Um there are community teams with nurses and social workers. um. I know the organisation is called Wolverhampton pct.

Would you know who the pct reports to?

SWA1 No

Ok what about social care

SWA1 Well social workers report to managers who report to a director. I don't know who the director goes to…. The council. Um I dunno, mps or whatever they are

Do you know what bodies might be between the council and the government

SWA1 No.

That's ok, these are all things you will hopefully clarify during your training. Ok.What is your understanding of multi-disciplinary working.

SWA1 Services merging with other professionals, to be able to liaise with other professionals on issues. C & f work closely with education, etc.

If I was a members of the public and said 'why would you all need to work together' perhaps, what would you say.

SWA1 We all have different skills and we are all there for the general public. All roles offer a different service. Social workers are there…to do social work.

Putting yourself in the position of a mental health service user, what would be your expectations of a sw

SWA1I suppose , its hard.

Imagine yourself as a service user meeting a social worker for the first time. As regard to approaches, and values and interventions, what would you expect

SWA1I want someone to listen to be able to help me sort out problems with practical issues. People tend to go to the doctor with help for illness and medication. People go to social workers about bills and housing problems. You have to be able to say what you can do and what you can't and point them in the right direction. I would want a social worker to guide me.

Ok Rebecca, this brings me to my last question, which is what difference do you expect to make to a users life

SWA1 When I did my statement, I put that if I could make a difference to just one persons life, than my job would have been worthwhile. i always remember it.um. I originally wanted only to work with children, and try to make their life experiences better, but I would like to help people with mental health problems to cope with life themselves.

That's great, thanks very much. I'll transcribe tis interview and e-mail it yto you for checking and approval in the next couple of weeks.

SWA1OK

Rebecca 2
SWA2

Hi Rebecca, how are you since we last met

SWA2 I'm fine thanks, really enjoying the course

That's great. thanks for coming to this second session. Just to warn you that some if the question sin this interview will be similar to the ones I asked you in the first interview, but it will enable me to identify any changes over the course of your first year

SWA2 Ok.

Could you tell me what you think the unique core skills of sw are:

SWA2 Umm, to have the knowledge to be able to help people access the help and services they need. To view people as individuals…… and to not make judgements bout people and their ways of life

Ok, and nursing, has your knowledge or insight into the skills a nurse may require changed since we last met

SWA2I don't know I can't remember what I said last time, umm…. Being caring and sensitive …… and warm and helpful I suppose

Ok, and have you had any opportunity to learn more about the ot role we talked about last time

SWA2 Um, no

Ok. How would you describe , then, the philosophy, core values and beliefs that provide a foundation for social work

SWA2 Um, respect for choice……. treating people with respect, and enabling people to make choices.

And how are these different to the philosophy and values of other healthcare professionals

SWA2 Well, I think that nurses have very wide ranging skills and abilities, mainly focused on ill health and disease. Doctors are more specialised and take on leadership roles. I don't know much about any other healthcare roles, um , nursing assistants maybe.

Ok. Do you think there been opportunity for you to explore your personal strengths and areas for development over the last 5 months on your course
SWA2 Yeah, I think some of the groupwork in class helps us explore the skills we have and how we need to develop. We are learning to reflect on our views, and experiences and how they impact on our work.

And how do you think these may link to your development as a professional

SWA2I hope we continue to evaluate our strengths and weaknesses throughout the course- it will help us to get feedback from each other, and recognise where we are getting better. I think a good social worker is someone who is aware of how they come across to other people.

Ok thanks. Could you tell me whether there are any social support systems or informal groups that have developed within your student group

SWA2 Well there is a small group of us that get on well, we have lunch together and regularly meet up to work in assignments. They have been really supportive

Right. Are there any lecturers or tutors that have inspired you so far, and good role models?

SWA2 Um, no not really.

Do you see them as social workers

SWA2 No, I know they have been though….probably

Do you feel Rebecca that you have a professional identity yet– do you feel like a social worker

SWA2I don't feel like a social worker, no. I feel like a university student

So you are beginning to feel like a social worker, identifying yourself with the professional role

SWA2I think that we are learning the core skills, well the theory behind the social work role. We have been given information and booklets on professional standards of behaviour, and what will be expected of us out there on placement, that's been really helpful. I don't feel like a social worker yet though

Ok. What is your understanding of the role of the sw and inter-agency working within the various health and social care delivery systems

SWA2 Well I don't think health and social care work that well together, we have looked at national health and social care policy though, they seem far apart. I don't know what it is like at a local level, not yet

Ok, thanks Rebecca. My last question is about your view on the overall course content and syllabus content and the teaching style, now 5 months in. Has it given you information at the right level, or are there things that you would change

SWA2we have been really well prepared for when we go out on placement, I think that's really good

Really. What kind of preparation have you had, what form has it taken

SWA2well if your going into a statutory placement, they give you information on the social worker role and stuff like that. They also give you booklets to work through on the particular area that you are going to work in.um we also had a health and safety test

That’s sounds like good preparation

SWA2 Yeah. Really good. they were asking about our personal experience and taking us through different case studies, asking us what we would do.

We are the guinea pig students, because we are the first year of the degree so we will be the first sw degree students out of the patch. They listen to our feedback and make alterations for future years.

Oh, does that feel strange to you

SWA2 Yes, it has not been tried and tested.

Ok. Thanks for your time, I’ll be in touch soon.

Rebecca 3
SWA3

Thanks for agreeing to meet for this final interview Rebecca

SWA3 No problem

I'd like, if we can, to start by discussing how you perceive that your professional identity has developed since the beginning of the course , since you have now been on your placement. If you could think about your value base and your role.

SWA3 Through my experience I now feel like a professional, as I have developed a professional manner.

So you feel confident now in understanding what the role of the social worker is

SWA3 Um, I don't know about that. I have been on placement in a mental health day centre, here at xxxxxxxxxx . so , there aren't many social workers, qualified ones on the day support and outreach teams. The cmht is part of the overall service here t the centre thought, and there are social workers, well ASWs in that team.

Right. Have you had a chance to spend time with those social workers

SWA3 Yes, I have shadowed them and been on visits. My placement supervisor thought it would be important to see the job from both angles, really

So, are you saying that you feel like a social worker now, or like a mental health professional

SWA3 Umm, I don't know, probably a professional Mental health worker. I'm not sure how different the roles all are really.

Ok. What impact has this placement had on your understanding of the philosophy and core values that provide a foundation for social work

SWA3 Umm when you say social work, do you mean the social care perspective? The core values are the same, enabling and assisting service users to achieve their potential, maintain independence, that sort of thing.

What about nursing. Do you have further I sight into the skills required by nurses

SWA3I think so, I've had quite a lot of opportunities to see what they do, and they have to have a lot of skills around treatments, different types, and putting care plans together, trying to bring together other workers who are involved, and sort of organising things really

Did the social workers and ots not take on these roles too wit the care programme approach

SWA3 Yes, I suppose so

Ok, what about the values and philosophy that underpins nursing, have your views changed at all

SWA3 Um, I think they focus a lot more on recovery and getting people better and keeping them well, to a level that they are happy functioning at, rather than quick fixes. Does that make sense

I think so, are you saying that they don't work towards a cure, but more around management of symptoms and working at the clients pace

SWA3I think so, I thought it would be more short term focussed, you know.

Ok. What about OTs, did you get a chance to spend time with them

SWA3 Um, they were in the team, , I just didn't see much of them. There was an ot, xxxxxxx, but I can't say that I saw what she did.

Did you come into contact with her in meetings or care programme meetings

SWA3 In the weekly cmht meeting, yes she was there. She seemed very nice, but I can't say I worked out what she did

So you wouldn't be able to tell me what skills an ot needs, or the values and philosophies underpinning OT

SWA3NO, not at all

What impact do you think that working in a multi disciplinary team, well indeed the wider multi disciplinary service that you have been working in, has had on your perceptions of other professions, maybe any stereotypes that you may have held

SWA3 Umm, I have spent my time trying to find who does what, what the processes are, what service are available, and I don't think that it has felt like different profession to me, just different processes and systems. I suppose when in the cmht allocation meetings the nurses came across as I expected them to, focussing on medication and diagnosis.

Really, was it that obvious

SWA3 Yes, and I sat in a couple of cpa reviews and out patient appointments, and the doctors were definitely in charge, controlling and running things

Right, so within your own team, the day support and outreach team, you didn't see these roles/

SWA3 No, the staff weren't social workers, well, some of them were, but most were…um counsellors I think, day centre officers they were called.

So has this placement given you an insight into the roles of other health and social care professionals within multi-disciplinary mental health teams.

SWA3 I think so. I mean…..nurses follow the medical model and social workers follow the social model. Nurses need to have a good understanding of illness and medication, to work with the doctors, where as social workers look at all aspects of a persons life, day time activities, employment, housing etc. the two roles to work together hand in hand. Social

worker need to know the law, although nurses working in mental health would need to have some understanding.

Ok, thanks. How confident would you say you are now in your own professional identity and ability to function independently in a md team

SWA3 I think I have a good understanding of the role and I feel confident with theoretical underpinning models, but I am a little apprehensive about putting it into practice. Next I will have a caseload on placement, so although a student, I will feel like a social worker…I hope! This placement just wasn't long enough to get my teeth into.
I felt comfortable doing this. I have found it really interesting here, developing the skills I am going to need as a social worker, the people skills, the assessment skills
Yeah I think so, I know the different services in Wolverhampton. I would be able to search and find out about the most appropriate services and their availability.
Yeah,….. I mean when I hear about a new service I always make a visit or ring up to get as much info as i can about the service and who it may benefit. When I started on placement here I put myself around trying to get a flavour of the service available, getting a grasp of what everyone else does.

I suppose that's the difference between having a placement on the provider side, as a qualified social worker you will probably be working as a commissioner, making assessments and putting support packages together to commission

SWA3 Yes, most students ask for statutory sw placements, but I think as a provider you are more insight into services available. Also its important to look at the voluntary sector.

Do you think the overall style of delivery on your course has facilitated you're your development as a social worker

SWA3 Well TOPPS have a large influence on the outcomes, there is a lot of integrating theory into practice , we've had whole modules on that. We have studied case studies, different approaches such as cbt and person centred therapy. It is very informative, law modules, human rights act, all important acts have to be integrated in to all of our assignments where appropriate. I think the portfolio is perhaps the most useful though, having to gather evidence and link it back to theory myself, its harder than writing an assignment.

So you feel that the portfolio is the most useful assessment method regards enabling you do assess you own development

SWA3 Yes, I do.

What about the informal social support systems within your student group. Have there been any

SWA3 There are a few of us who have kept in contact over the placement, mainly to catch up with coursework and to compare notes, but I haven't spent anymore time at uni than I have needed to.

Have there been any role models either at Uni or in the practice placement that you have identified

SWA3 Um..i think there were elements of practice and approaches in quite a number of people in this placement that I would like to take on board, but no one specific person

Ok. Do you think there has been the opportunity for you to explore your personal & professional strengths & skills and identify areas for development.

SWA3 What I do know is that you have to be able to manage your time! That's one thing I have found out, time management is important. ... Being able to adapt your approach to different individuals is a strength that I think I have . um being able to work within the requirements of the law, my knowledge of law is a weakness in need to work on.

Right, I'm sure all social work students would say the same thing! Has your placement experience afforded you the opportunity to practice and begin to evaluate the core skills of assessment, report writing and intervention planning through to closure and discharge.

SWA3 Um, the placement hasn't given me that many opportunities on the commissioning side, although the level 2 assessments i have been involved with, purchasing outreach. I have shadowed quite a few assessments with the crisis team, and I have done a couple myself, but they were quite challenging, as people are so ill.

So experience of the exciting work and the more mundane day to day work then

SWA3 I have had lots of experience of keeping notes, and the processes required to keep good notes. I have seen a number of clients moving through the service from beginning of treatment to discharge, um, one or two have been on the team a couple of times throughout the placement.

Ok. My last question Rebecca relates to whether this placement has improved your understanding of the various health and social care delivery systems and your understanding of the role of the sw within this context.

SWA3 Right,. Um…I have a good understanding now of mental health services in the community. I have come across recovery based models in the recovery house, the specialist teams such as home treatment, assertive outreach and early intervention. Um health and social care work together within the resource centres where the community mental health teams are housed.

Right, so what about how these teams work together

SWA3 Um, I think I now understand better how the nurses and doctors in the community teams relate to the wards, and how the social workers in the community teams don't seem to work that closely with other social work team. They are part of the health team, if you know what I mean.

Yes, they are seconded across aren't they.

SWA3I think the social workers work closely with the nurses, outreach workers and doctors, although there are still many hierarchies and games being played. The clients can play individual team members off against each other which is not helpful, not in this kind of service.

Ok, thanks so much for your time, and for meeting up with me for the three interviews. I really appreciate this Rebecca. I'll send you the transcript of the interview as soon as I get it typed up.

Kam 1
SWB1

Thanks for agreeing to be interviewed Kam.

SWB1 That's ok

The interview today should take about an hour, and I will be asking some questions that you may well not know the answer to. That's to be expected, and it will help me track your learning over the course of the three interviews. Is that ok

SWB1 Yep

I'd like to start by asking why you want to become a social worker, where there any motivating factors behind your choice

SWB1 Well I was in care for much of my childhood, I had my mom and dad, I love them very much, but they just couldn't cope.

Oh, that must have been very difficult for you.

SWB1 No, not really, the people who looked after me in care were, well mostly really great to me. I feel that I want to repay them…the system for looking after me so well. I want to be a social worker and make a difference to peoples lives.

So would you say that you choose this career, or has it chosen you

SWB1I think social work has chosen me, and I know I will work in childrens services at some point, to repay my debt, but I am really interested in mental health

Have you considered any of the other health or social care roles

SWB1 Erm, no, not really

Do you know anything about other professions within mental health services

SWB1 Yeah, there are nurses, psychiatric nurses, psychologists, psychiatrists, all very medical!

What do you think makes social work different, or even preferable to the other professions

SWB1 Well I think its about seeing people as a whole person, you know, all of their needs, ; love, housing, money, education, the things that all of us need

How is that different to the other professions

SWB1 Well, they focus on illness and specific problems that need treatment, not the whole person

Ok. What were your hopes & expectations of the course throughout the past year leading up to the commencement of the course

SWB1 Well I've been really excited. I've done voluntary work for a childrens charity, and I completed my access course with my little girl being as young as she is

How old is that

SWB1 She's 5

Goodness, that's young. You have done well to juggle education, work and childcare

SWB1 Its been hard, but I've been looking forward to it

Have these hopes and expectations altered now that you have been on the course for 2/ 3 months

SWB1 Um, no. the work is how I was expecting it to be. I'm a bit worried about the coursework, but I think everyone is. The people on the course, the other students I mean, are really nice

What would you say makes a good social worker

SWB1 Someone who is non judgemental, who does not impose their values and views on other people, but who really wants to enable people to improve their lives

Ok so what are the core skills needed to be a good social worker

SWB1 Um, well ; knowing the law, knowing peoples rights, what they are entitled to, ; knowing what services people can access

So you would say its knowledge rather than skills

SWB1 Well you need the knowledge along with a non judgemental approach- it's an approach, an open way of thinking.

Do you think this approach or way of thinking is unique to SW or is it shared amongst other health & social care professionals

SWB1 Um, I think anyone working with people should understand peoples rights, but I think people look to social workers to know what people are entitled to, especially in the way of benefits an housing and such.

What skills do you think a nurse might need

SWB1 I would say people skills, putting people at ease, not being squeamish or tickle stomached when dealing with vomit and blood.

Ok, you mentioned a few of the common mental health professions earlier, but not occupational therapists. Do you know anything about that role

SWB1 I've heard of physiotherapists

No, this is a different role

SWB1 No, I haven't come across those

Ok. Could you describe for me what you believe are the values , knowledge base & philosophy that provide the foundation of social work

SWB1 Um, the values are around being non judgemental, enabling people to realise their own potential, empowering people , preserving rights.

What about the knowledge base

SWB1 Um, like I said earlier, knowing rights, what peoples are entitles to, knowing what services are out there for people

Ok, what about nursing. Would you be able to describe what the value base and philosophy might be that underpins nursing

SWB1 I dunno, looking after people, keeping them free from pain, making sure they have access to treatments.

Ok, thanks Kam. What would you say are your own personal strengths & skills and areas for development

SWB1 Well……I am a confident person who cares about people and wants to make a difference, particularly to those who are struggling. I can communicate with people on different levels. Development wise, well i need to know more about services, um creating care packages,

What is your understanding of the structure of mental health services in a)health

SWB1 I have no idea. Well…theres new cross hospital and primary care services

Do you know who the bodies are that they report to

SWB1no

and b) social care

SWB1well social services is a directorate of the council, that's Wolverhampton city council

ok, thanks. What about the term multi-disciplinary working- what does it mean to you.

SWB1 Well, people from different backgrounds, from different professions working together as part of a care team, to get the best services for a person.

Ok. You said that you are interested in mental health and you hope to have a mental health placement this year. What is your understanding of mental health services

SWB1 Well, apart from hospital wards where people get admitted to, and sectioning, I know there are day centres that social services run, and community nursing teams, where there are social workers as well.

Are the social workers part of the nursing teams

SWB1 Yeah, I think so

You talked earlier about the service you received from social services during your childhood. Bearing that experience in mind, and perhaps thinking about the situations people experiencing a range of mental health problems may be in, what would be your expectations of a SW

SWB1 Well, to see me as whole person, not as someone with mental illness, to be non judgemental, to be able to help me get the support and services that I need, support my family…to realise that I am more than a person with an illness, much more

So what difference do you hope to make to a users life

SWB1 To enable them to access things that they would find difficult to do themselves, as vulnerable people such as children in care or people with mental illness- to enable them to make choices for themselves

OK Thanks Kam, thanks very much for your time today. I'll type up this interview and send it across to you so that you can check it for accuracy and agree its an accurate record.

Kam 2
SWB2

Kam, thanks very much for coming to this interview

SWB2 That's ok.

Kam, some of the questions I will ask in this interview will be similar to last time, but its just to enable me to compare your responses across the year, is that ok

SWB2 Yes

OK. Could you start by describing for me what the unique core skills of a social worker are

SWB2 Having a non judgemental approach to individuals, knowing peoples entitlement to support and help and services and being able to help them to access it., um. Being able to get alongside someone, good interpersonal skills.

Could you tell me Kam, what your understanding is of the philosophy and core values that provide a foundation for social work

SWB2 The belief that someone has the right to live the lifestyle of their choice, and should be enabled to make choices that enable them to do that.

Ok. What about the values that underpin social work

SWB2…um core values are non judgemental approach, unconditional positive regard for people, and equal opportunities for all irrespective of race, gender, culture, religion, etc

What about your understanding of other health and social care professionals

SWB2 Well, I haven't had anything to do with other professionals. I don't go on my placement until next month, its going to be in a mental health resource centre. There are community mental health teams there

That's great, that you've managed to get the placement that you wanted

SWB2 Yeah, I'm really pleased, really looking forward to it.

Have your views about the skills required for nursing changed at all since we last met

SWB2 No, I haven't learned anything about the nursing roles

What about the values and philosophies that underpin nursing

SWB2I suppose when talking about social work values and philosophies you start to think that they probably apply across all of the helping professions, you know? They are probably the same as social work in nursing

Ok. We mentioned occupational therapists in the last interview. Is that a role that you have come across at all at uni

SWB2 No

Ok thanks. Could you tell me Kam, are there academic or social support systems within your student group

SWB2 Well there are some really nice people on the course, but they often go out drinking and to clubs, but I've got xxxxxxxxx to look after, so I go straight home. It's a shame really, but I don't think I'm missing out- done that already!

What about academic support

SWB2 Well I've been appointed a personal tutor, we have met once and she seems really nice. There is lots of support and information to help us with assignments, so I'm feeling a lot more comfortable about that now. I have to submit two by next week!

Are these your first assignments

SWB2 Yeah, first real ones

Would you say that you have identified any role models in your lecturers or tutors

SWB2 Not really, the lecturers seem to know their stuff, although some are a bit boring in the way they present their lectures. I think some are just lazy as well, sending us of to do our own 'self guided study' (interviewee uses fingers to demote exclamation marks)

Would you say that you have a professional identity, as a social worker

SWB2I think that I am a student social worker, and i have a long way to go before I can say I'm confident as a social worker- I have a lot to learn

Ok, thanks. Would you say that there been opportunity for you to explore your personal strengths and areas for development

SWB2 Um, my personal tutor asked me to identify areas for development, and I find it hard to do, because I need to get out there to practice to find out what I am not good at doing you know what I mean?

Yes, I do.

SWB2I don't know what I am good at yet, apart from being confident and communicating well with people from all walks of life

So do you have a professional identity at the moment, as a social worker

SWB2 No, I see myself as more of a student at the moment, I hope that during my placement I'll feel more like a social worker

Ok. Since e last met, has your understanding of the role of the social worker in the various health and social care delivery systems developed

SWB2 Um, we have talked about commissioning care packages, and the need to liaise with other agencies , such as hospital staff, gps , care homes, etc. We have talked about the structure of primary care trusts and how these related to the hospital trusts and primary care, but that's as much as I know

Thanks Kam. My last question relates to the overall teaching style on the course, what is it like?

SWB2 Well the modules so far have been well structured, there are lectures we go to, the assignment details are given to us well in advance, and we are told where we can get help if we need it. There is a lot of help with IT and core learning skills at the moment, they are really keen to get our assignment writing skills up to scratch!

Thanks great Kam, thanks again, I'll be in touch next week.

Kam 3
SWB3

Thanks for coming to the final interview Kam, I'm really grateful.

That's ok

You have just finished your placement haven't you

SWB3 Yep, just done 6 weeks in a CMHT within a resource centre. Finished Friday.

Kam, if I could start by asking whether you think you have developed a professional identity as a social worker since we last met

SWB3 Oohh, not sure…professional identity. I feel more comfortable with my knowledge of the role of a social worker and my ability to carry out the role. Is that what you mean

Well, do you feel that you belong to that profession, that you are now part if it

SWB3 Well yes, I am still a student social worker, but I feel that the role is much broader in the mental health setting, all of the roles are

So could you articulate what the purpose of role of the social worker is in a cmht

SWB3 Um, the role is to assess needs, arrange or purchase care to fulfil those needs, to provide ongoing support to people with a range of mental health problems with day to day issues. Um, there is the specialist stuff that only the ASWs do, like mental health assessments and vulnerable adults assessments.

Ok. What is the value base that underpins this work and what are the approaches used

SWB3 Values…well, the code of practice for social workers spells out the underpinning values. I can't remember all of them, but for me the main focus is on promoting independence and respecting the rights of service users, whilst protecting them and other people from harm. Ummm…empowerment of individuals and anti-oppressive practice are key.

Ok. What approaches are used in social work, in mental health

SWB3 Approaches used in social work…um we provide a mixture of practical interventions and well, counselling really, coming from a humanistic approach rather than a treatment or illness approach

Right. Would you be able to explain the philosophy and beliefs that provide a foundation for social work

SWB3 Philosophy….ummm..we see the individual as social beings which are a product of their environment - including family, friends, income and housing, employment and health. I think the fundamental belief is that we should respect the service users views and its not our place to be judgmental.

Do you believe there are core skills unique to social work

SWB3 Erm, I think it's a skill to be able to reflect on your values and be aware of your prejudices, being open and honest with yourself and constantly being aware of how these may impact on your practice.

But is this unique to social work

SWB3 Well I think that some of the other professions have very specific interventions, treatments, models, that I think they slot people into very easily. We as social workers don't have diagnostic tools, specific questionnaires and measures like the psychologists, or medication to prescribe. I think its harder to stand back and take the time to get to know a person and the world that they inhabit, before establishing how you can best help them , on their terms.

You refer to some of the other professions within the team. Do you think that the experience that you have had working alongside them has had an impact on your attitude towards them or any stereotypes you may have held

SWB3 Um, I think working alongside people helps to dispel stereotypes as you get to know the people and realise that it's the person, the individual that matters, not the profession they trained in. you know, there are good nurses and bad nurses, the same goes for social workers.

Was there an ot on the team

SWB3 Yes,xxxx

Did you have the opportunity to find out about their role

SWB3 Um, I shadowed her doing a couple of assessments, and sat in on a couple of cpa meetings she ran. Um she seemed to be a very capable worker, but I would struggle to say she did anything different to the social workers.

Would you be able to say what skills an ot needs

SWB3 I think the people skills required to enable you to carry out an assessment of someone's mental health problems and their abilities and needs

Ok. What about the values and philosophies that underpin occupational therapy

SWB3 Oh I don't know about that, no I would be presuming

You discussed nurses. What are the skills you think they may need to carry out their role

SWB3 I think the confidence to apply treatments and approached without really knowing someone, without having had the time to build up a relationship and know that it is something you have chosen, its like the medication . Thing is, they are happy to give it whether a client wants it or not, just because its been prescribed by a doctor.

So this is more of a value base or underpinning philosophy issue, isn't it

SWB3 Um I suppose so, it's a we know best philosophy. Not client knows best

Do you think most nurses would be wiling to enforce treatments that clients are unhappy to receive

SWB3 I think so yes, if they are satisfied that I is in the overall best interests of the clients health, but I think most of the time they do not have that foresight

Has your understanding of the role of the social worker in various health and social care delivery systems developed as a result of the placement.

SWB3 Um, I think so. I have a good idea now of mental health services, cmhts, the way health and social care work together, and hospital based services. I sat in on ward rounds, wow, they were interesting!

Really, good or bad

SWB3 Well, we spent a lot of time on the ward, but the environment is not good, nit good at all.

Ok. Did the placement experience afforded you the opportunity to practice and begin to evaluate the core skills of assessment, report writing and intervention planning through to closure and discharge.

SWB3 Yes. I've shadowed loads of assessments, and written up the paperwork, completed some level 2 assessments, um shadowed sessions and sat in on anxiety management groups, lost really. I have a good insight into care management and particularly the role of the cpa co-ordinator.

Ok. I'd like to ask you to give me an overview of the course delivery style and whether it has helped you

SWB3 Um, I'm not sure what you mean

Well…have you been given the information, support and preparation that you needed to perform well during your placement

SWB3 Oh yeah, I think the course has been designed really well. We have done groupwork, case studies, not on metal health, but to help us focus on our core values and approaches. We had packs on the role of the social worker in a cmht, and guidance on professional behaviour and conduct, that was useful.

Have any informal social support systems developed within your student group.

SWB3 Not that I am aware of, no. m mean, there have been a few nights out, but nothing to do with the course or placements

Have you identified any role models either at uni or on the practice placement?

SWB3 Role models….i think there were a number of staff on the cmht who had good attitudes and seemed to know what they were doing, I'm not sure they would e role models though. There was one that I would definitely never want to be anything like!

Who was that then

SWB3 An old cpn who was near retirement and should go as soon as possible. His attitude was really bad, so judgmental, so patronizing.. and sexist!

Do you feel confident in your own professional identity and ability to function independently in a multi disciplinary team

SWB3 Well, I think I could find my way around the role in any new team, I know what my limits and abilities are, I've a lot to learn though, I wouldn't call myself a social worker yet!

Thanks Kam. My final question is whether you feel you have had the opportunity to explore your personal & professional strengths & skills and identify areas for development whilst on placement.

SWB3 Um, I think I have. I have reflected on my placement experiences and pulled together items for my portfolio and I think they highlight what I've done well, and where I need to improve my knowledge.

That's great, thanks for your time Kam.

Lynne 1
SWC1

Hi Lynne, thanks so much for agreeing to take part in these interviews

That's ok

This interview will take about an hour, and I will be asking a number of questions that you may find difficult to answer, but I'm not expecting you to know the answers . It will help me track your learning over the course of the year

SWC1 Ok

If I could start by asking you why you want to become a social worker? what are the motivating factors behind your choice

SWC1 Well I've always wanted to work with people in a helping capacity. I have worked in a residential home for people with a learning disability for a couple of years and I wanted to get qualified – I feel that I can help people more if I have more knowledge.

Right, so you already have experience of working with people with learning disabilities within social care setting

SWC1 Yes. I have done some agency work with older people as well.

Oh, right. Are there any life experiences that have persuaded you to wish to train as a social worker

SWC1 Um, no. I have experienced a lot of life, moved away from home at 16 ,lived in London, travelled. I think I have seen the world a bit and I am an open minded, understanding person.

So.., would you say that you choose this career, or has it chosen you

SWC1 I've chosen social work specifically. I have pursued other careers, I completed almost 2 years of a psychology degree at uni a few years ago

2 years? Would you mind telling me why you left?

SWC1 um, just personal circumstances at the time, I needed to work and earn money. I bitterly regret it now, of course. I'd love to go back and finish that year

I'm sure its something that is possible

SWC1 Yeah, maybe, when I've completed this course!

You said that you have done agency work with older people. Was this as a nurse or in social care

SWC1 With nursing agency

Have you considered nursing as a profession, or any of the other health roles such as occupational therapy

SWC1 Um, not really. I feel that social work addresses all people from all sections of society and empowers and enables people to make choices. A lot of the health care professions are very hierarchical, and the medical model does not empower people to make decision for themselves

Right. Is it the enabling, non hierarchical approach that makes a social worker different, or even preferable to the other professions

SWC1 Well, the medical profession specifically I think ,yes. Its not imposing a treatment or making a judgement, its enabling people to make decisions for themselves

Could you tell me what the role of a nurse is, do you think

SWC1 We'll its to carry out treatments and procedures on people, treating illness and working more under the direction of a doctor.

Ok, would that count for mental health and learning disabilities as well

SWC1 Well yes, I think so. The structures are a little different, but people are still treated as ill and needing to be cured, rather than taking into account social and political situations

Could you tell me what skills you think a nurse might need to carry out their role

SWC1 Technical skills of applying treatments, being able to empathise and talk to people, those kinds of skills I would have thought

Would you be able to say what you think the underlying value base or philosophy of nursing is

SWC1 …..I think its to treat people where you can, save lives, keep people free form pain, and protect people from themselves

How might they do that

SWC1 I mean in the case of suicidal people, keeping them under close supervision

Ok. What about occupational therapists?

SWC1 I've heard of them, aren't very similar to physiotherapists, but they also work in psychiatric hospitals doing basket weaving and clay modelling, those kind of activities

Well, they are increasingly becoming core members of multi-disciplinary mental health teams, so you will definitely have the opportunity to find out more about them during your course, I would have thought

SWC1 Oh.

Would you be able to state what you think the skills might be that they would need

SWC1 I would have thought that they need practical and artistic skills to engage people in those kinds of activities

What about the values and philosophies of occupational therapy, what might they be

SWC1 Umm, that meaningful occupation is useful to distract people from their illness, that learning new skills can help people cope in other areas of their lives

Ok, thanks. Your'e a few weeks into your course

SWC1 Yep.

What were your hopes & expectations of the course throughout the past year leading up to the commencement of the course

SWC1 Um, I hoped to be challenged, having already studied at this level, I'm not too worried about assignments and stuff. I want to learn, and I want to be challenged, that's what I hope for

Have these altered now that you have been on the course for 2/ 3 months

SWC1 No, we are getting a lot of good theoretical input and lots of insights from different angles, its good

That's excellent. Do you think, bearing in mind your previous experience and input from the course to date, that you could tell me what makes a good social worker

SWC1 Um, someone that is knowledgeable about the services and resources out there that are on offer to help someone, yes, you need to have knowledge of what you can access. And um… being non judgmental, definitely no snobby middle class people pretending to understand someone's situation that lives in a council flat with 6 children and no income!

Can I ask you then, what you think the core skills are that are needed for social work

SWC1 mm. core skills…. Empathy, being bale to help someone to make a decision or choice about the direction they want to go in, and I think like I said before, knowledge of the services and options available

Are these unique to SW or are they shared amongst other health & social care professionals

SWC1 I think the medical professions and the skills they need focus more on giving a treatment and working with illness, rather than enabling people to choose how they want to be helped. I think the skills of enabling people to make choices lie within social care and voluntary sector services.

What do you believe are the values , knowledge base & philosophy that provide the foundation of social work

SWC1 Umm, value base is around protection of human rights, equal access for all, non discriminatory , anti oppressive approaches to people. Justice and equality. Um, what was after values sorry?

Knowledge base and philosophy

SWC1 Um, the knowledge base is around peoples rights, models of understanding people, development, how they cope with life and the impact this can have on their abilities. Um….understanding of the influence that poverty, education, illness, wellbeing and family relationships can have on an individual. Umm.. I think that's all i can think of for the moment, sorry

No that's fine. What would you say are your own personal strengths & skills and areas for development

SWC1 Um, strengths…...i think as I said before, I have life experience, living in London, experiences of relationships, I know my way around the system and I am a confident person, so they are my strengths. i need to work up my academic knowledge of social models of understanding. I don't know about the legal system much, I know that its key to being a useful social worker. I know some of the services around here as I grew up here and know it well, but I don't k now the ins and outs to accessing services and what they all provide.
Umm. I need to know more about different therapeutic approaches to mental health problems.

Ok, thanks. You say that you know this area well, and you have worked in social care before

SWC1 Yep

What is your understanding of the structure of mental health services in health and social care .lets take health first

SWC1 Um. Well, the mental health care trust here provide services in hospital and in community teams .

Right. What about social care

SWC1 Social services, which are part of Wolverhampton council have a duty to provide services for those most in need, such as home care for the elderly, day services for people with learning disabilities , mental health, older people. Um. Childrens' services, such as foster care are with them also, but they are all part of the overall council.

Ok, thanks Lynn. If I could move on now to ask you what your understanding is of multi-disciplinary working, what is it?

SWC1 Well its people from different professions working together to achieve a common goal, to provide the best care for a person.

Do you mean in the same team?

SWC1 No, not necessarily, multi disciplinary working can be across teams.

OK. You have indicated that you would like to work in mental health and you will hopefully have a mental health placement this year. What is your understanding of mental health services

SWC1 Urm, do you mean in the council?

No, very broadly, across health, social care, voluntary sector.

SWC1 Well, I think that health services provide diagnosis, treatment and hospital based help for people with mental health problems. Both social services and voluntary organisations provide services that, um help to support people living in the community with mental health problems

Like what specifically?

SWC1 Um, helping them to get the right sort of accommodation, benefits advice, hep with day to day stuff like paying bills and shopping, um, going to college, access to jobs…that sort of thing

Ok, thanks. If I could ask you to put yourself in the position of a mental health service user, what would be your expectations of a social worker?

SWC1 I would expect a social worker to be impartial, impact in my best interests, to enable and support me to make choices about what I want to do in life, help me get the benefits I am entitled to. I would definitely expect them to respect my decisions and not force their own opinion on me

Ok thanks. What difference then do you expect to make to a users life

SWC1 Well I hope I can do what I just said, help people with specialist knowledge and advice of their entitlements and act in a non judgemental way to hep them live the type of life ……..that they want to lead.

Thanks Lynn. That concludes my interview for this session, Is there anything else that you would like to add ?

SWC1 Umm, no I don't think so

Well thank you very much for your time, I'll be transcribing this interview and sending it to you for checking in the next couple of weeks.

Lynne 2
SWC2

Ok Lynne, thanks for meeting up with me again for this

SWC2 No problem

Now, some of the questions I will be asking you in this interview will be very similar to last time, its so that I can try to identify any changes that occur in your thoughts and descriptions over time- is that ok?

SWC2 Yep, no worries

Now I'd like to start, if I may by asking what you think the unique core skills of sw are:

SWC2 Um, I would say that social work is a systemic approach, and the theories that underpin it are based within the social model and its focus on
Equality regarding race, gender, sexuality…and so on

Ok, so that's the theoretical perspective of the social work approach. What skills does an individual need to carry out social work, that are not required by say, nurses or occupational therapists in the same way

SWC2 Oh, ok. Um, the ability to focus on the individual person, and work with them in a non judgemental way to achieve their own goals, I would say that nurses and ots don't use that approach as they are focussed on implementing plans and treatment approaches

Right, so what skills do you have that would help you to do that

SWC2 Um, I'm not afraid to meet people where they' re coming from. I'm not shocked by anything, and I don't feel the need to transfer my values to someone else, how they live their life is fine by me. I would also say I can build a rapport with someone quite quickly, on a professional level

Ok, we discussed your understanding of nursing last time. Have your perceptions or understanding of their roles changed over the last few months

SWC2 No not really. I suppose I have a better understanding of what makes us different to nurses. Our approach is about the person, their family, their carer, the environment and how the whole system impacts on that individual, not just on the drugs they're taking or the history of the illness in their family.

What about the skills they might need

SWC2 No. I think they need to know their treatments, they need to know manual handling, how to communicate with people and keep paperwork up top date, like everyone else

Ok, what about the role of occupational therapists and the skills they might need

SWC2 I suppose their pretty similar, but , no that's unfair. I don't know for sure what they do, no more than when you last asked me

Now I think you answered this earlier in regard to social work, when I asked you about core skills of social work. What is your understanding of the philosophy, core values and beliefs that provide a foundation for social work

SWC2 Yes, I think I talked about the social model and the systemic approach

Yes,. So do you think you would be able to tell me what the underpin philosophy and values are that underpin nursing

SWC2 Not really. My experience of nurses having worked alongside them during agency work is that the philosophy is to care for people, which means doing things to them or helping them, hands on, physically to do things that they cannot do themselves. I think the problems with that is with many disabled people or mentally ill people, they cannot tell you what they want, so the nursing approach has to make assumptions, you know , about what is best for someone.

So would that mean that the philosophy of nursing is to do what is best for someone

SWC2 Um, yes. To do your best to keep them comfortable, well, whatever

Similarly, would you be able to explain what the underpinning philosophy and values of occupational therapy are

SWC2 No, only guessing that its about occupation, and keeping people busy, giving them something to do to distract them from their problem or their illness

Ok, thanks Lynne. Could you tell me what the academic support is like at uni

SWC2 Um, its ok. Um,..anyone that's struggling can access help, and we all have a personal tutor.

Have you taken up any of the support on offer

SWC2 No, haven't needed to.

Ok, what about your fellow students. Do you feel that you get much support from other students, are there groups outside of lectures that you socialise in

SWC2 Not really, some of the group like to go to the students union, quite a few live in student accommodation near to each other so they see a lot of each other. I'm living with my boyfriend so I don't mix with them much

Oh, I see

SWC2 I like most of them, they're alright, I just don't want to spend my own time with them. I've already got a life

Have you adjusted to student life though Lynne. You mentioned last time that you had been a student before for nearly two years, is it something that you have slipped back into easily

SWC2 Um, yes I suppose, although I'm a lot older now. I don' feel the need to go out drinking every night and be one of the gang, you know?

Yes, I do. Are there any good role models on the teaching or tutor team?

SWC2 Um, I'm not quite sure what you mean

Well, are there any of the lecturers on the course that have inspired you, that you have thought must be a good social worker in practice, or even the opposite, that you have thought they are bad role models

SWC2 I don't see them as social workers to be honest. I mean, I know , well I presume they have been at some time during their lives, but they are just taking us through theory and approaches, we don't get to see them in practice

Ok , thanks. So you do not see them in a professional sense.

SWC2 No, not really

How about yourself? Do you se yourself as a social worker

SWC2 No not yet, I'm a student social worker. I don't mean I haven't go the skills to be one, I just haven't practiced as one yet

Do you feel that you have started to develop a professional identity yet

SWC2 Well if you were to ask whether I see myself as a social worker in comparison to other jobs like nurses, then I would say yes, I have an identity- as a social worker

Ok thanks. Has there been opportunity for you to explore ,Lynne, your personal strengths and any areas that you would like to develop

SWC2 Not really, no. I think that will come in my practice placement, which I'm really looking forward to.

Really, do you know where you are going yet?

SWC2 No, but its looking like I should get a placement with the community mental health team or mental health day services.

That's great, fingers crossed eh. So could you tell me how do you think your strengths and potential areas for development may link to your development as a professional

SWC2 I am a good communicator, and I build rapport well with people. I think this will be a strength not just in social work practice, but especially in mental health, where the relationships are more long term and the importance of good communication skills is key.

Ok, what about your areas for development

SWC2 Well I need to know more about how I can empower and enable people as a social worker in mental health, I haven't had experience of that, and its something that I will only gain from experience. The brokerage role, arranging packages of care, I don't know how

,much freedom there is to be creative, to work with the person designing their package of carte. I want to learn all of that. Its knowledge I don't have yet

Ok .that sort of leads me on to the next questions, which is about your understanding of the various health and social care delivery systems and consideration the role of the sw and inter-agency working within this context. You mentioned the brokerage role, what do you perceive that to be in mental health

SWC2 Well as I said, I don't really know until I get out there in the real world to see how it works, but, I know that once you make an assessment of someones' needs, there may be a list of support that they could benefit from, such as help with benefits, help with finding employment or getting back into education, moving accommodation, those sort of things. As a social worker, to be effective, I would need to know all of those agencies that provide those services, whether I can buy them and what the procedures are.

So when you talk about other services, do you see these as mental health specific services or general service provided by say, the council or voluntary agencies

SWC2 Well I don't know, not yet

Would you see yourself as working closely with other mental health professionals

SWC2 Um, in relation to the persons illness or as part of the package yes. I don't know really, until get out there.

Ok Lynne, thanks for that. Well my final question id about the teaching style on course and the syllabus content. Could you tell me a little about it

SWC2 Um, what specifically, all of the modules

No, start with the style. Is it face to face teaching all of the time, do you do a lot of groupwork, or self directed learning?

SWC2 Oh, I see. There is a mix really. We have lectures, but they are not too dry, we usually have to break up into groups to consider case studies and the like. There are preparation packs for each module available, so you can prepare for the work in advance if you want to, and get an understanding of the subject.

Is there any self directed learning

SWC2 Yeah, a fair bit. I'm just going to start a law module, which requires a lot of work on my own, in the library and on the internet. I think we have to do self directed learning all along, for instance, the values and ethics module focussed us on understanding our own prejudices, values and beliefs and how they could impact on our approach to others. You can do case studies and write assignments till you are blue in the face, but until you spend time reflecting on your self in everyday life, you cannot get a full understanding of how you tick. And that's so important, understanding how your own values may affect the way you treat other people.

Ok Lynne, thanks so much for the interview, I'll be in touch with the transcript in the next couple of weeks.

SWC2 No problem.

Lynne 3
SWC3

Thanks for agreeing to the final interview Lynne

SWC3 That's ok

You have just finished your placement haven't you

SWC3 Yes, I've been with the south east cmht in xxxxxxxxxx. for 6 weeks, its gone so quickly!

That was the placement you wanted wasn't it, in a cmht?

SWC3 Yes, mind you, it's a bit of a crazy team!

Really? In what way

SWC3 Well, some of the characters, I mean, I was surprised at how they behaved towards each other.

Was is good, or bad

SWC3 Some of the staff really didn't get along. In fact, one or two seemed to hate each other

And how did that affect the team

SWC3 Well, the team didn't feel like that much of a team, but the clients got a fairly good service

.**Tell me a bit about your views and perceptions of your role whilst on placement.**

SWC3 Well I've been attached to an asw who is very experienced. Not so much as an asw, but as a social worker. He is really caring about the clients and tries his best to do a good job.

So what was your role

SWC3 Well I shadowed his work, and the other members of the team in the first couple of weeks

Who were the other team members

SWC3 Well the team consisted of 4 cpns, 3 asws , 1 ot , 1 psychologist, although I never seemed to see her, and two psychiatrists

Were there any support workers

SWC3 Oh yes, an str worker and a nursing assistant

What kind of work related activities did you do

SWC3 Well I worked with 2 clients who were new referrals as I joined the team. I shadowed the assessment and the completion of the level 2 paperwork

Whats that

SWC3 Um, the care package purchasing agreement with the local authority

Ok. Did you just shadow work for the 6 weeks

SWC3 No, once xxxxxx was happy that I knew what I was doing, he asked me to visit two clients twice weekly on my own., they had specific isues that I was able to work with them on. One was having difficulty getting out of the house due to his isolation and needed help accessing employment, the other was having financial problems as she had been off sick from work for 12 months so her income had stopped, but she had a mortgage and loads of other bills, so I was working closely to a plan with them, reporting back to xxxxxxx.

So did you just engage in social work tasks

SWC3 I don't think those are just social work tasks. All of the team carried out that type of work with their clients, in fact everyone carried out screening assessments which surprised me

Why

SWC3 I don't know, I thought the referrals would be centrally assessed and allocated, but the whole team took part in that. The assessment form was generic, so it had medical , social and psychological aspects within it.

So do you feel that your professional identity as a social worker has developed as a result of being on placement

SWC3 Well I think I have a good idea what social workers do in a cmht, but I think the roles of the team are pretty similar, apart from the very specialist social work responsibilities

What were these

SWC3 Um, mental health act assessments, vulnerable adult assessments and some other things relating to the mental health act processes

Has your knowledge increased as a result

SWC3 Well, there is a lot that I now feel that I don't know! To be honest, I visited one of xxxxxxxx clients with him who he later had to section, and I was really quite scared. I was surprised to find out how much of the sectioning process , the responsibility I mean, lies with the social worker. That's quite scary

What did you find scary, the responsibility

SWC3 Yes. no, the power that the social worker has over someones' life. Those decisions are life changing. And there are some people on my course that quite frankly, well it scares me to think that they will have that power one day

Yes it is quite scary. I just need to refer back to the question Lynne, as its a long one……ok, what about your own value base- has that changed as a result of your placement experiences?

SWC3 Mmmm..not quite sure what you mean

Ok, during your exchanges and experiences with clients on this placement, have your values been challenged in any way

SWC3 Well, there were a few clients that were a pain in the arse I mean, very stroppy and difficult and I found my patience ran out with them fairly early on

Really? What kind of difficulties were they experiencing

SWC3 Well one had a personality disorder and she ended up running us all around in circles, threatening suicide, trying to get admitted, getting vulnerable adult referrals through to us via the police on a weekly basis, its easy to see why some workers get fed up with some clients, you can only do your best

Yes, this client group can present quite challenging behaviour.

SWC3 Another client kept cancelling appointments, not turning up for things I arranged with outreach and day care and, well, I just ended up very frustrated, not getting anywhere

In what way do you think these experiences challenged your value base

SWC3 Well I've always maintained that the client is the expert and a social worker should be there to assist them in making choices and help them to achieve their goals. But some of these people didn't want to be helped.

It sounds as if this frustrated you

SWC3 It did, on several occasions

This takes us nicely into the next question Lynne

SWC3 Ok

I'd like to revisit, in your own words, your understanding of the philosophy, core values and beliefs that provide a foundation for social work

SWC3 Based on a sociological perspective, mental health social workers assist people experiencing socio political and environmental stressors to develop and adapt coping strategies and support mechanisms.

Wow, that's impressive

SWC3 I've just written up an assignment last night, that's why! (laughter)

Do you think, based on your recent placement experiences that the social workers practiced that philosophy

SWC3 Yes I do

As social workers or a mental health team workers

SWC3 I think that the three social workers in that team had a very strong identity. They didn't draw the same boundaries around their skills as the nurses did. I didn't hear one of the social workers refuse to work with someone

Who did you hear refuse to work with someone

SWC3 A few times, during the weekly allocation meetings, there were little arguments where people wanted to avoid taking new referrals

Was that about people wanting to keep their caseloads down

SWC3 Probably. It seemed more than that, a couple of the nurses stated that the person needed a social worker and that there was no apparent medical problem

Right. From these experiences, have your perspectives changed in the core skills you think are unique to social work

SWC3 um, I can't remember what I've said before

don't worry. Just tell me whether you think there are any skills that are unique to social work , above the other professions

SWC3 well I would have said care management, putting care packages together, but I think that all members of the team do that. They are all CPA care co-ordinators, and I didn't know that they could all complete purchasing paperwork for the council services

were there limits to what they could purchase

SWC3 mmm…not sure, but most were arranging day care and outreach, and employment pathways support.

So what skills are unique to social workers

SWC3 Um. I don't know. Mental health act work, giving a non medical perspective……understanding of someones emotional distress that is not a mental illness or problem.

Has your placement experience afforded you the opportunity to practice the core skills of assessment, report writing and intervention planning through to closure and discharge.

SWC3 Um, I'd say yes. I have completed assessments, done all of the paperwork, written in the notes. I haven't discharged anyone, but I wasn't there long enough.

Ok, Lynne thanks. Um..i'm going to ask about professional stereotypes now. Do you think that your work placement had any effect on your perceptions of the stereotypes of roles within the team

SWC3 I think the psychiatrist definitely lived up to theirs (laughter)

In what way

SWC3 They were arrogant, quirky, bossy, dismissive, everything I expected

Oh dear. What about the other team members

SWC3 Well, the nurses were nursey, but I was quite surprised at their adaptability, they did see beyond the medical model, although they talked about medication all of the time.

Any changes in your views on their skills

SWC3 Yes, i think they do very broad assessments of anybody and everybody, so they are quite good at assessing levels of risk. They also did a lot more therapeutic stuff like group work and anxiety management programmes, that sort of thing.

What about the ot, you said there was one.

SWC3 Well, she was good, but I can't really see what was different in her role to the social workers, other than the fact she did not do the mental health act stuff or vulnerable adults.

So the role didn't seem too distinct then

SWC3 No, her role was quite similar to ours.

Any different views on the skills she needed to function in her role

SWC3 I suppose similar to the nurses in some ways, assessment risk assessment, i think her role was less trouble shooting or risk management though, more developing programmes to work towards employment or meaningful activity.

Do you feel that you know what nursing and occupational therapy entails now, what values and philosophies underpin the approaches

SWC3 No, but I think if I were to do my 70 day placement in that team, it would make a difference. If I were there for longer, I would gain more insight into what it is they do, what the differences are

What impact would you say that working in a multi disciplinary team like that one has on the understanding of professional roles within the team

SWC3 Um, I don't know, I was there for such a short time, it whizzed by

How confident do you feel now in your own professional identity as a social worker, would you know your role and function within a multi disciplinary team

SWC3 Um…I think I would know what I am supposed to do, but I would not have the confidence to challenge other professionals regarding their role, as I don't understand it enough. I would challenge unethical or bad practice , of course

Have you come across any role models, people whose practice you would like to emulate either at Uni or in the practice placement,

SWC3 Yes, I think xxxxxxxxxxxxxxxxxxx is a fantastic social worker, and as lovely human being. If I turn out like him it will be a good thing

That's nice to hear

SWC3 Well, there were things that he said to people, approaches that he used that impressed me, and I think I will use them myself in the future.

Have you had any contact with your student colleagues during the placement

SWC3 no

Ok, Lynne. That brings me to my last question, which is about your understanding of the various health and social care delivery systems in Wolverhampton. Have you had the opportunity on this placement to expand your knowledge

SWC3 oh yea, I've gained some knowledge of the agencies around that provide different services, I visited a few. Access to some of them is still a mystery, but I definitely understand what goes on in the psychiatric hospital now, I've spent a fait amount of time on the wards, the acute admission wards anyway.

Ok, , that's all I have, thanks for your time, you have been so helpful. As before, I'll send you the transcript for your perusal.

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