

An investigation of Black Minority Ethnic service users' perception of their needs within a North London Mental Health NHS Trust: A Phenomenological Qualitative Study

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This study was conducted to find out from service users from a black and minority ethnic background (BME) how they perceive their needs were being met when being cared for in a Mental Health Trust. The participants were drawn from the black ethnic group including Black African, Black Caribbean, Black British and Black Mixed Race.

The study was a descriptive phenomenological study whereby the participants were interviewed using a semi structured interview via the use of a topic guide. The study was informed by the mental health trust' priorities under the Race Equality Scheme to meet the needs of the diverse group which it serves.

The interviews were tape recorded and the data collated was transcribed verbatim. Six themes and subsequent sub-themes were identified following thematic analysis of the data. The findings from this research study suggest that BME service users did not express any negative

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views about the care they received by the mental health trust. Some of the BME participants however stated that they had to wait varying lengths on time before they received specialist psychological services. The participants expressed that they experienced stigma and discrimination by the police, criminal justice system, employment and the wider public.

A number of recommendations were proposed including the development of a 5-day training programme to support the police and other social, welfare and charitable services in enhancing their knowledge and skill about mental illness. Mental health professionals to continue to challenge discrimination through social media campaigns, video and publications. There was also a recommendation made regarding the 6Cs - Care, Communication, Compassion, Courage, Competence and Commitment. In that the term 'Consistency' should be added to make a 7th C. Other Implications for best practice were also noted.

Key Words: BME service users, needs, mental illness, support, service user experience.

Introduction

A comprehensive plan for eliminating discrimination and achieving equality in mental health care for all people of Black and Minority Ethnic status (BME) was put forward by Department of Health, (Department of Health, 2005a). The publication of this document was a significant change in supporting the work within Mental Health Trusts when considering the needs of service users (SU) from a BME background. This was fully supported by the Equality Act (2010) which made it a legal requirement under the Act, that NHS Trusts publish an annual report on their performance in the delivery of fair and equitable services, promoting equal opportunities and fostering good relationships between the different groups of SUs and NHS Mental Health Nursing staff.

A review commissioned by the former Prime Minister Teresa May in 2017 was conducted in 2018. The report noted with concern the disproportionate number of people from black and minority ethnicities detained under the Mental Health Act 1983 (Department of Health, 1983). Whilst experiences vary across different ethnic minority groups, the report highlighted

that the reviewers were “*particularly concerned by the excessively poorer experiences and outcomes of individuals from black African and Caribbean communities,*” (Department of Health, 2018, p. 58). In seeking reasons why this is so the report emphasised that research has evidently aligned health inequalities to racism as well as socioeconomic factors (such as inequalities in housing, local neighbourhoods, education and employment), (Department of Health, 2018, p. 163). Similar evidence has been found by authors such as (CQC, 2020; 2018; Department of Health, 2018; Memon *et al.* 2016; Brui & Singh, 2004; Bhui & Bhugra, 2002a), that people from a BME background encounter difficulties in accessing and using mental health services.

Ethnicity or ethnic group has been defined as a group of people whose members identify with each other through a common heritage, often consisting of a common language, common culture (which can include a religion) and or an ideology which stresses a common ancestry, (Institute of Race Relations, 2019). Culture is a social construct which is characterised by the behaviour and attitudes of a social group (Fernando, 1991). In a similar vein, Radcliffe, (2004, p. 28), suggested that “*the precise nature of ethnicity is highly contested as the term tends to be used loosely to imply commonalities of language, religion, identity, national origin and or even skin colour*”.

Notwithstanding, Bhopal suggested that:

ethnicity is a multi-faceted quality that refers to the group to which people belong, and/or are perceived to belong, as a result of certain shared characteristics, including geographical and ancestral origins, but particularly cultural traditions and languages (2003, p. 441).

Ethnicity varies from race, nationality, religion, and migrant status, sometimes in subtle ways, but may include aspects of these other concepts (Bhopal, 2003). While race and ethnicity are different, they are overlapping concepts that are often used synonymously (Nittle, 2020; McKenzie & Crowcroft, 1994). Notwithstanding Bunglawala (2019) observed that there were different acronyms used to describe people from ethnic minority background. Whilst acronyms are very ‘*catchy*’ and ‘*convenient*’ they are not always well thought through, have

negative connotations or are hurtful to people (Bunglawala, 2019). Okolosie, *et al.* (2015) highlighted advantages and disadvantages on the use of the acronyms and pondered on the fact that if the acronyms are scrapped what would they be replaced with.

Millar *et al.* (2015) noted that the history of SU involvement in mental health bestrides at least five decades. In 1983, the Griffiths Report spoke about the difficulties in hearing the authentic voice of the ultimate consumer of psychiatric services and suggested that health care should be measured by how it is perceived by users. In 1985 patients' councils in psychiatric services and mental health advocacy projects began to develop in the United Kingdom (UK), adopting an approach which broadly aimed to change mental health services dialogue and discussion, (Millar *et al.* 2015; Peck & Barker, 1997, p. 269). In that same year, '*survivors speak out*' (British Mental Health SUs' group), was formed which took a more campaigning stance (Peck and Barker, 1997). This approach brought to light the personal stories of mental health SUs in a wider political context. To this end, it could be argued that the emphasis of user involvement in decisions about their care has arisen from a number of factors: the perceived remoteness and unresponsiveness of services to the needs and wishes of users, an increasing diverse and discerning public and the demands of various groups, (Sharma *et al.*, 2016).

User involvement defines the process whereby individuals become actively involved in their health care, rather than be passive recipients of such services, (Neech *et al.*, 2018). Notwithstanding, Gee, Mcgarty and Babfield (2016), identified systemic barriers to user and carer participation. However, the concept of working in partnership with SUs is well established in health policy. To this end, the NHS Constitution pledged to patients that NHS staff will "*work in partnership with you, your family, carers and representatives*", (Department of Health, 2015, section 7).

In a qualitative study conducted by Lwembe *et al.* (2016) they found that the use of co-production helped to overcome barriers to accessing mental health services. The study highlighted an alternative model that could lead to delivery of patient-centred services to improve access and patient experience within mental health services, particularly for BME

communities. Lwembe *et al.* (2016) also found in their UK study that stigma and fear of disclosure, were acting concurrently with an apparent suspicion of the service during the initial assessment session, to provide a substantial barrier to engagement.

Nonetheless, Wright, Williams and Wilkinson (1998) purported that needs in health care is generally defined as the capacity to benefit. If health needs are to be identified, then an effective intervention should be offered to meet these needs and improve health. Notwithstanding, Clarke *et al.* (2019) proposed that a health intervention is:

a combination of activities or strategies designed to assess, improve, maintain, promote, or modify health among individuals or an entire population. Interventions can include educational or care programmes, policy changes, environmental improvements, or health promotion campaigns (Clarke et al., 2019, p.1).

Indeed, Thompson (2014) concluded that health needs assessment is used to set the policy agenda, plan services and target resources effectively to result in maximum health benefit for both individuals and populations

Mental health needs include broad domains of health and social functioning, which are necessary to survive and prosper in the community. Needs can be assessed from different perspectives, including staff, patient or carer, and have been differentiated into unmet needs and met needs (Phelan *et al.* 1995). A consensus emerged across Europe and Australasia that mental healthcare should be provided on the basis of need, with an intended goal of improving subjective quality of life (Department of Health, 2011; Lasalvia *et al.*, 2000).

Background to the research

This study was conducted to enquire from SUs from a BME background on their perception of what their needs were and their experience of whether those needs were being met when being cared for in the NLMHT (Flood, 2021). The Trust recognised that it served a multi-

cultural population and identified the following priorities under the Race Equality Scheme to meet the needs of this diverse group:

- Improving information about the mental health needs of a diverse population which the Trust serves.
- Improving quality and cultural capability of inpatient care.
- Forming a partnership with local agencies to develop stronger links with the community.
- Continuing to enhance the early intervention and prevention services and improving access to the range of services that people need.

Several authors, (Halvorsrud *et al.* 2018; Brui & Singh, 2004; Bhui and Bhugra, 2002b; Keating *et al.* 2002), have expressed concern that SUs from a BME background encounter barriers both in accessing and using mental health services. Therefore, the aim of this descriptive phenomenological study was to provide an in-depth description of the BME SUs perception of their needs when being cared for by the Community Mental Health Teams in the NLMHT (Flood, 2021).

Hence, it is hoped that the information drawn from the study will give further insights into the needs of this specific group and address ways in which those needs could be met. The research question derived from practice and the literature, underpinning the study was:

Research Question:

Do service users from a BME background perceive that their needs are being met within the Mental Health Trust?

Methodology

This study used a qualitative methodology. It has been suggested that there is a closer fit between the practice of nursing and qualitative research than any other methodological approach (Gullick & West, 2012; Miller, 2010). That is because subjective human feelings and emotions are difficult (or impossible) to quantify, (Holloway and Galvin, 2016; Forster, 2001). Therefore, in this study, a descriptive phenomenological approach was chosen as it helped to discuss the lived experience of the service users from a BME background.

Method

A search through databases such as MEDLINE, PsycINFO and CINAHL revealed that much has been written about SUs being treated less favourably when accessing and using mental health services. For the purposes of this study the acronym 'BME' was used to identify the participants who took part in the study. The author in this study enquired from the participants what they perceived their needs to be and how those needs were being met within the North London Mental Health Trust (NLMHT) (Flood, 2021). This was done via the use of semi structured interviews.

As suggested by Qu and Dumay (2011), the interview guide ensures that the same thematic approach is applied during the interview. Therefore, below are the themes that made up the interview schedule for the research study:

- Needs for individual Care Planning.
- Ethnicity and equality.
- Access to information.
- Meeting needs in a crisis.
- Needs for timely treatment and support with mental distress.
- Need for ordinary living and long-term support.
- Need for personal growth and development.

Ethical issues

Prior to conducting this study, the proposal was sent to the North Central London Research Consortium (NoCLoR) (a Trust funded research advisory body) for peer review. Ethical clearance was obtained at the National Research Ethics Service (NRES) 12/LO/1377. Written consent was sought from senior managers of the inpatient and community services to gain access to the participants. Once permission was granted the Care Co-ordinators (CCs) were approached via Community Mental Health Team Managers to agree the suitability of the SUs due to their vulnerability. Each of the participants gave their consent on the basis of information and knowledge about the research.

Seale *et al.* (2004) stated that research subjects have the right to know that they are being researched, the right to be informed about the nature of the research and the right to withdraw at any time (respect for their autonomy). Participants were informed that their participation was voluntary, and that the researcher follows the rules of confidentiality and anonymity, (Flood, 2021). For that reason, pseudonyms were used and identifiable names such as the name of the organisation was anonymised to further protect confidentiality of the participants under study.

Sampling and data collection strategies

A purposive sample of twenty-four SUs from a BME background with a diagnosed mental illness. The criteria for the study were that the participants would need to have been in receipt of services from the NLMHT for 1 year or more as an inpatient or in the community. That they had been selected following discussion with their CCs on their suitability (due to their vulnerability) to take part in the study. They needed to be either Black British, Black African, Black Mixed race or Black Caribbean. This was determined following peer review by NoCLoR.

The CCs from 6 Community Mental Health Teams (CMHTs) identified participants from their caseload who met the criteria. Those SUs were asked by their CCs if they were willing to take part in the study. The sample included both male and female SUs between the ages of 21 -61.

Reed and Procter (1996) suggested that sample sizes in qualitative research are often small and the sampling is often purposive rather than focused on statistical principles such as randomisation.

The data was collected using a semi structured interview schedule. The duration of the interviews were 30 to 45 minutes and occurred in a room within the CMHT bases; however, 3 participants were not able to attend at the CMHT base therefore the interviews were conducted at their homes.

Piloting the research instruments

Once completed the interview schedule was sent to the manager of one of the local SU groups to give her comment. Also, the interview schedule was sent to the Lead Nurse for the acute service for her comment. Both reported that the structure and the questions in the interview schedule were appropriate.

Analysis

Each of the tape recordings were listened to in their entirety. The tapes were listened to again to ensure the essence of what the participant had said was captured. To maintain accuracy the tapes were replayed at certain points during transcription.

The transcribed interviews notes were read to make sense of the data using Giorgi (2009, 1985) systematic method. At that point words and phrases were being highlighted with the premise to group similar words and phrases to begin the process of identifying emerging themes

Results

The next stage includes consideration of the results of the study. The analysis including identification of sub-themes and then linking them to major themes identified as seen in Table 1.

Themes	Subthemes
<p>BME Service users require support from mental health services</p>	<p>The need for suitable housing.</p> <p>The need for specialist services</p> <p>BME Participants had to wait for varying periods of time before accessing specialist services-Timelines.</p> <p>Involvement in care plan:</p> <p>Support from the Care Coordinator and/or the Mental Health Team.</p> <p>Information about illness and treatment options</p>
<p>Participants from a BME background would like to find gainful employment</p>	<p>BME participants experienced being stigmatised in their attempts to find work.</p> <p>BME participants require extra support in returning to work.</p>
<p>Recognising signs of relapse</p>	<p>BME participants established some trigger factors that can cause them to relapse.</p> <p>Learning from previous experience of being unwell.</p>
<p>The need for help with taking medication and medication concordance</p>	<p>BME participants link taking medication as a major part of their recovery.</p> <p>BME participants highlighted the negative effects of prescribed medication.</p> <p>Some BME participants experience weight gain as a side effect of medication.</p>
<p>Service users from a BME background experience stigma</p>	<p>Some BME participants linked the stigma they experienced as coming from the wider society.</p>

Hope	Service users from a BME background demonstrate resilience. Spirituality
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Table 1: Breakdown of major themes and sub-themes following data analysis.

Figure 1 (below) gives a breakdown of how the coded text were grouped together to form the major theme—BME services users require support from Mental Health Services as seen in table 1 on page 11.

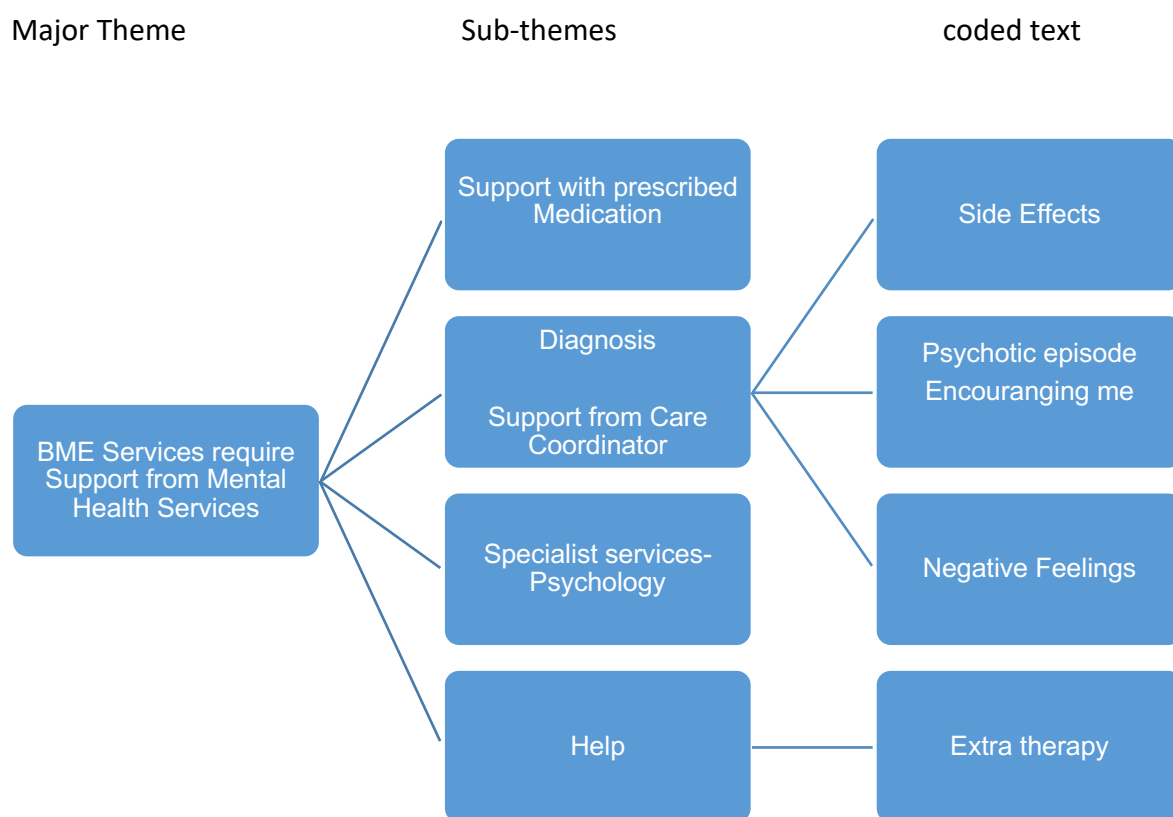


Figure 1: Breakdown of coded text

Figure 2 below reflects the type of mental health diagnosis and the number of participants per diagnosis. 15 participants had a diagnosis of Schizophrenia, 5 participants were diagnosed as Paranoid Schizophrenia. 1 participant was diagnosed as Paranoia, 2 participants were diagnosed as schizoaffective disorder and 1 participant was diagnosed as Bipolar Affective Disorder.

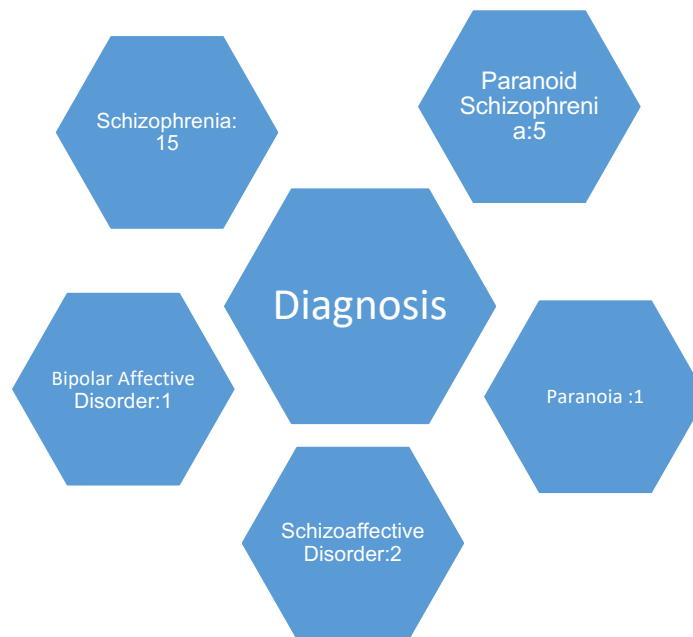


Figure 2: Participant diagnosis

The main themes derived from the participant data are outlined and discussed below:

Theme One: BME Service Users require support from mental health services

In this study when the participants were asked about their main needs, several of the participants had a resounding response - 'support'. Notwithstanding, whilst the term 'support' could be quite broad, each of the participants were specific in the type of support they required. This theme comprised 6 subthemes:

The Need for Housing

When asked about their main needs some of the participants cited housing as one of their main needs. Nathan stated:

I used to live in supported accommodation but now I have got my own flat, so I don't need to get that much support anymore. I just come for blood test and stick to appointments that's it really (Nathan, 29yrs, male, schizoaffective disorder).

Mary had a similar view and cited housing and benefits as her main needs. Mary said:

Just things like housing and benefits just things like housing and benefits really (Mary, 29yrs, female, Schizophrenia).

Some of the participants including Robert wanted help with his housing situation but had not received it.

Robert stated:

Both mental health/physical. I need support with my request. I need support with housing...when I requested to move, I did not receive it, instead they start giving me medication. So, I didn't receive what I asked for. I was concern about where I was living, they allocated me to a doctor. They say it would take a long time... I am talking to social services. I am still in the same place I am still waiting (Robert, 43yrs, male, Schizophrenia).

The concept of 'social isolation' was discussed by some of the participants in this study. Ali talked about being lonely and agreed for others to move into his flat. The impact of his actions related directly on his housing situation, his mental health and personal safety. Ali stated:

Obviously I have issues to deal with drugs because I'm on drugs as well but I have come off drugs... I have lost my accommodation and because basically I was letting the drug dealers in. Yes, because I was lonely, so I have let them in and I'm Muslim been doing drugs, but I have not taken any drugs for the past week (Ali, 49yrs, male, Schizophrenia).

The Need for Specialist Services

Some of the participants in this study identified specialist services such as psychology and the drug and alcohol service as an area of need. In thinking about this Andrew commented:

... yeah psychology and drug and alcohol awareness if I start using again they promptly tell me to come to (xxxx-drug and alcohol service) ... because when I talk about things ... I feel like I don't have to carry a weight. So...you know what I mean, to get over their mental health and the stress of day-to-day life people passing and things in the family and then when I go to psychology all of that sort itself out, I can let it all out you know what I mean yeah those are the main things. (Andrew, 31yrs, male, Schizophrenia).

BME Participants had to wait for varying periods of time before accessing specialist services-Timelines.

It appears some BME SUs had to wait a considerable amount of time before getting help from psychological services. Luke stated:

It's more psychodynamic so it's more talking therapy and it's the first time I have had it on a one-to-one and I find that it is helping... going through a lot of things that have affected me in the past. ... I have not managed to deal or to get through some issues, so I think not only me but that a lot of people... don't know what services are out there. I think the more people that get this help... being in hospital some people never ever get out of that loop...(Luke, 34yrs, male, schizoaffective disorder).

The participant above highlighted the help he is now receiving from psychology. There seemed to be a suggestion that talking through issues with a psychologist helped tremendously.

Involvement in care plan

Collaborative working is essential in the care planning process as it ensures that the BME SU recognises, that they are involved in the process. Engaging in such a collaborative process will allow SU needs to be identified and be provided by Mental Health Services. Some of the responses from the BME participants seem to suggest that the participants were not participating fully in their care planning. Gloria described her experience of attending her care plan meeting and said:

There is a lot of talking to you and it's a lot of talking at you and if you try to express yourself it's like you are being confrontational, but you're not, you are just trying to explain yourself with what you are going through and how you feel (Gloria, 43yrs, female, paranoid schizophrenia).

However, Grace stated:

When I keep well, I realise is the consistency with how the NHS has structured my care because... I tend to feel better ... when my Care Coordinator visit or like the therapy, I am getting now on a weekly basis...but I find like if it's not there for long time, I just feel like I am going down! (Grace, 51yrs, paranoid schizophrenia).

With specific reference to participants' experiences concerning the use of mental health services in the Trust, all the participants were happy with the care that they received. Nonetheless, some of the participants seem to link any discrimination/stigma to come from external agencies such as the Police, Criminal Justice System, Employment and the wider society. Paula felt wronged by the police, because a record of an offence was registered on the Disclosure Barring Service check (DBS). This meant that checks show that she has a record of an offence. She felt that as she was given a caution it should not have been placed on her record, as it impacted negatively on job applications. Her exact words were:

They say they will call you back and they never do (Paula, 47yrs, female, Schizophrenia).

Charles stated:

So as a black man I think I have not experienced any racism, I think they are fair (Charles, 42yrs, male, Paranoid Schizophrenia).

Notwithstanding, in this study most of participants were able to articulate what their needs were and how they were being met, even though not all participants felt their main needs were that of support.

Support from the Care Coordinator and/or the Mental Health Team

All the BME participants placed great emphasis on meeting with their CC and recognised that the CC was central to their care as they can call upon the CC to help them manage a range of situations. Grace said:

In general, my mental health but because over the years I have had a lot of side effects from the medications like mood and sometimes do still get depressed I get support from my care coordinator (Grace, 51yrs, female, paranoid schizophrenia).

George stated:

My main needs were to sort of get a recovery plan of getting better, yes a recovery plan, recovery plan getting better (George, 36yrs, male, Schizophrenia).

Information about illness and treatment

Most of the participants were able to articulate what their diagnosis was and what information they were given about their illness. However, the participants displayed different

levels of understanding of what the term schizophrenia meant. Some of the participants identified with the term as it is portrayed in the media. Paula stated:

They were not very clear, but I also read the letter that was written about me that said I had a condition, because I have been suffering from a condition for ten years now because every time I came in it's a different diagnosis. When I was here last time, they said that I am suffering from Schizophrenia or something like that (Paula, 47yrs, female, Schizophrenia).

Paul explained:

Well the doctor explained to me, that I have a condition, that I am schizophrenic and that I will be on medication, they gave me a pack telling me what the medication does what it will do and how to take it and explain to me my rights and stuff (Paul, 38yrs, male, Schizophrenia).

The information from the BME participants suggest that they were aware of their diagnosis, but some needed further clarification in understanding how the illness presents in terms of symptoms and treatment options.

Theme Two: Participants from a BME background would like to find gainful employment.

When asked about their main needs some of the BME participants identified being employed as a need. A number of the BME participants talked about the negative experiences they encountered in their attempt to gain employment. Others felt that they required extra support to return to work. Those two areas have been broken down into subthemes

BME participants experienced being stigmatised in their attempts to find work.

Paul used to be in employment on a part-time basis. He said:

Is that aspiration to get back to work... also in catering I have done level 2 supervisory role. A lot of people they go into hospital they started wondering why nothing is going

right for them but they don't realise, so my support team encourage me that I could do things for myself, If I can one day support my family I want to get a move (Paul, 38yrs, male, Schizophrenia).

Another participant spoke about her experience in a sheltered work area when she did catering. She was concerned that the lady who taught the group did not follow proper procedure. The participant linked that behaviour to the negative views of people who have a mental illness. She described the teacher's attitude as 'slapdash'. Gloria stated:

I feel as though they don't put their whole heart into it, they just want to give people a slapdash course. To me...if you're working in a different environment you would have to wear the hair net because if any hair went in the customers food you would be in trouble (Gloria, 43yrs, female, paranoid schizophrenia).

The participants above experienced stigma in their efforts to find work. This has no doubt impacted on them in several ways including social, financial, and psychologically. The experience has hindered their progress in reaching a place of fulfilment.

BME participants require extra support in returning to work.

A number of the BME participants spoke about their desire to return to work but also recognised that they needed extra support in returning to work. In particular, some participants cited a less intense environment to enable them to adjust after a period of sickness. Some participants felt that engaging in leisure activities such as playing the guitar or going to the gym gave them structure which allows them to build their confidence in preparation to return to work. Ryan stated:

I will say that she is a role model, she encourages me to participate in things like for instance... my last job was two years ago and since then I have been unwell three or four times and so I just wanted to get back to work, but right now I am not in the right place... and it's my Care Coordinator that really showed me that I have to focus and concentrate in my mind re-educating my mind. Find hobbies, find interest first... I have just got to look at it from my perspective (Ryan, 40yrs, male, paranoid schizophrenia).

Grace, one of the BME participants placed a huge emphasis on the need to be employed. However, she felt that for those who have attempted to find work they faced certain challenges and described the SUs as “going around in circles”.

Those participants who had been employed contended that they could not always be at work due to the frequency of their relapse. This meant that they had to take time off work. Luke stated:

...at the time I was working at HMV records service I would lose sleep I would have strange ideas, there are times I needed to take time off work because I... used to get this really bad feeling at times (Luke, 34yrs, male, schizoaffective disorder).

Theme Three: Recognising signs of relapse

The BME participants were asked about their needs when they experienced a crisis in their mental health condition. Some of the participants talked about factors that caused them to relapse and also areas of learning which they felt has helped them in the management of their illness.

Trigger factors that can cause them to relapse

A number of the participants were able to recognise signs of relapse. There were those who remembered what happened when they first became unwell. A few causes were cited including drug induced psychosis. Guy said:

I normally suffer from schizophrenia and paranoia and that the crisis is that I get anxious and paranoid... yeah but when I'm taking the tablets yeah, I notice and sometimes getting panic attacks, ... I noticed when that happens, but the tablet is really umm. Before I did not think that the tablets were helping I used to think it was my own self but now I realise when I don't take it I get those kinds of feelings and now when I take it everything just seems alright so it's more manageable (Guy, 23yrs, male, Schizophrenia).

Paul stated:

Because the reason I was unwell is because I was taking drugs...after all it was the drugs I was taking. When I take the drugs, I got paranoid, ... that's when things starts going wrong, and not being able to sit down with my mum and tell her this was what was going on.... (Paul, 38yrs, male, Schizophrenia).

You see before I was on heroin...that was what used to trigger my symptoms so I'm off heroin now so that's why I think I have been so well (Charles, 42yrs, male, Paranoid Schizophrenia).

Learning from previous experience of being unwell.

It can be suggested that the service user is best placed to recognise their relapse indicators either by learning or by observational skills of the mental health staff, family and friends.

Jacob had to contend with anxiety attacks and spoke about ways to alleviate it when the anxiety attack happens. In thinking about the question on recognising relapse signature

Jacob said:

When I'm having an anxiety attack, I usually just have a warm shower or listen to music or anything to put my mind at ease (Jacob, 24yrs, male, Schizoaffective Disorder).

Paul also talked about what triggered the symptoms of his illness and stated:

If that happens, I can always ring my care support team they will always help me, or I can make my way to hospital...so it does not go too far where they come and pick you up and take you instead you take yourself (Paul, 38yrs, male, Schizophrenia).

Another participant (Andrew) from a BME background, had a fifteen-year history of being involved with the mental health service. He narrated his views on drug misuse and recognised this as his relapse signs. He had several admissions into hospital following periods of substance misuse.

I'll be honest with you I use a bit of drugs now, but I don't relapse, obviously I'm a bit older now so when you're younger your mind is not as strong... now as you get older you much

more in control. I'm more mature now am 31... I understand how people say they used drugs in order to get away... but obviously I don't use it to that extent where I cannot handle myself...It's just like having a drink, a bottle of wine with your dinner that's how I look at it (Andrew, 31yrs, male, Schizophrenia).

Participants from a BME background discussed their learning from the experience of being unwell. They used that experience to inform how to manage their mental health.

Theme Four: The need for help with taking medication and medication concordance.

The use of medication is a process that have been used over many years to treat the symptoms of a diagnosed mental condition. The participants from a BME background identified taking medication as one of their main needs.

BME participants link taking medication as a major part of their recovery.

Support while taking medication was cited as an area of need by most of the participants. There was also a recognition by the BME participants that medication had a major part to play in their recovery.

Paula talked about the calming effect the medication had on her and said:

I must say medication is the first thing because it help to calm me down and it help me to relax and made me aware that I am unwell and that I need to take it but also looking positively into life because I don't want to look at it as if it is something that is stigma around mental health (Paula, 47yrs, female, Schizophrenia).

Emma had a similar view and said:

Taking my medication and then I will not become sick. That is if I don't take my medication then I would be sick yeah (Emma, 31yrs, female, Schizophrenia).

The above participants noted the benefits of taking prescribed medication and linked it to their recovery and ongoing optimism.

The BME participants highlighted the negative effects of prescribed medication.

One reason for poor compliance with medication was the belief that “nothing is wrong with me”. Paul explained that as he was well all his life, it was difficult to comprehend how could something like mental illness happen to him. However, he got to a place of acceptance and belief that the medication he was taking had a role to play in keeping him well.

I have been fit all my life so I didn't really realise that it could happen to me so when it first started, I wasn't really like taking the medication... so I was a bit in denial ... but over the years I have come to realise that it is an illness and it can be treated and with the right medication. I found ... the best thing is to take your medication and get on with your life like my mum she is diabetic so for her all of her life she has to take medication but... I did not believe that thing could happen to me and stuff like that and I did not really like this side of being unwell (Paul, 38yrs, male, Schizophrenia).

Harry linked the cessation of the negative symptoms he experienced with taking medication. He said:

When I do become unwell, I disappear you see but it stopped 12 years ago maybe the disappearing has stopped it may come back, again I don't know if I stop taking my medication (Harry, 61yrs, male, Schizophrenia).

Dominic talked about the side effects he experienced while taking prescribed medication and said:

... I have been having side effects, that's awful I feel drowsy in the morning...they are looking into (Dominic, 30yrs, male, Schizophrenia).

Roger who was diagnosed with Bipolar Affective Disorder described what it was like when he was in the depressive cycle of the illness. He explained that he would rather ‘rough it out’ rather than take prescribed medication.

They say it's when I stop taking the medication, because many times I have tried stopped taking the medication rough it out sort of thing, because I try to wean myself off medication (Roger, 41yrs, male, Bipolar Affective Disorder).

Another participant experienced side effects of taking psychotropic medication. He also had a view on what he thought was causing his mental illness.

Robert stated:

At the same time, they send me to hospital. I am an African man I see a woman in my flat, those things disturbing they say they can stop it by giving medication... I am worried about my weight, I was sleeping a lot, my heart is beating from me. If it is witchcraft medication won't get rid of it. It is not a sicknes (Robert, 43yrs, male, Schizophrenia).

The above participants discussed how experiencing side effects of medication impacted on their daily living. However, there was a tone of joint working with the professionals in finding the medication regime that suited each individual participant.

BME participants experience weight gain as a side effect of medication

Several of the BME participants expressed reasons why they stopped taking their medication. Some suggested that they experience severe debilitating side effect effects from medication. There were descriptions of physical effects such as weight gain, feeling drowsy and stiffness in joints which made walking difficult.

Luke highlighted that he stopped taking his medicines due to the many side effects he experienced. Luke said:

...I was working as well in a part-time job...they were giving me tablets and I was not aware what effect they were having on me. The first one was making my tongue hung out ... I could not breathe and other times I was on olanzapine it made me put on a lot of weight

on my face blew up, I could not feel anything emotionally... and I did not know what was going on (Luke, 34yrs, male, schizoaffective disorder).

Similar to Luke, Grace cited one of the side effects of medication as weight gain. She said:

I think I use to be able to do things but since my illness I find that I am not able to do it anymore. That gets me down I think it's the medication. I am slowed down, and my life is totally..., so that gets me down. I think it's to do with the medication. Because of the medication ... I gained about 8 stone..., I lose it and then I end up putting it back on, really, it's a struggle (Grace, 51yrs, female, paranoid schizophrenia).

The participants above struggled to maintain a healthy weight which was a result of taking psychotropic medication. This would suggest an area of need for the BME participants to maintain a healthy weight.

Theme Five: Service Users from a BME background experience Stigma

The participants drew a parallel between those who work in mental health and those who live in the wider society. The participants suggested that those who work in mental health understood the illness, therefore they did not feel stigmatised by mental health workers.

BME participants linked the stigma they experienced as coming from the wider society.

The participants explained that the stigma they encountered came from the wider society as there was a misunderstanding of mental illness. The participant felt that the stigma they experienced was compounded as mental illness has been portrayed negatively in the media.

Paula described how stigma of mental illness has affected her and said:

I don't talk about my mental health to anybody unless it is the medical profession or somebody who need to know because of certain law or something cause I..., don't feel comfortable that they would keep it as secret as I don't think they will understand that somebody can have mental health and still work or still do anything productive. It is like they are sort of doomed and they are people who have no use in society, so I have that

feeling in me, but I don't speak about it to my friends or colleagues or anybody (Paula, 47yrs, female, Schizophrenia).

Luke talked about his experience as a black man and felt that the stigma he faced was not from the mental health service but in the community.

...and I don't think it's really an issue personally... but I think when you are out and you're trying to get back in the community, even sport because anything that young people did when you first become mentally ill the worst thing is you lose your love of things; you lose your passion because you think that you cannot do anything (Luke, 34yrs, male, schizoaffective disorder).

Ali had a strong belief in his faith however he stated that he did not attend a place of worship as he felt his misuse of drugs made him not worthy of being with fellow believers.

Yes, I am Muslim but that sometimes because of the situation I have been in I wasn't stopped physically from going but it was just the company I was keeping stopped me from going so I have not been going (Ali, 48yrs, male, Schizophrenia).

Another participant Gloria linked the voices that she experienced as an invasion of her body and saw it as a stigma.

Theme Six: BME Participants had Hope for the future.

The participants discussed their journey of recovery and expressed how hopeful they were for the future. Whilst hope was the major theme, the following are the corresponding subthemes.

Service Users from a BME background demonstrate resilience

The participants who were from a BME background talked about how their illness had affected them and how they saw their future. Some talked about personal strength, others talked about religion, and others talked about family and friends.

Paul contended that a weight was lifted from him when he was able to speak to his mother about how his illness was affecting him and said:

especially black people you know, black people don't like saying it in front of their mums you know, you know it's like a stigma... but when you finally know the truth or telling the truth your life suddenly become better it is like something lifted. Yes, the medication does help but staying off drugs and doing the right thing you know. Things such as I want to settle down, and I think I don't want to go back to taking drugs I just want to be independent (Paul, 38yrs, male, Schizophrenia).

Equally, Charles attributed mental illness and as being a stigma that he wanted to leave behind and focus on his hope for a positive future. Charles stated:

You see ... mental illness, yes I was ill once but I don't accept that I am ill now... I think you can get better... I am as best as I can be. I am not going to go back to the old me before I got ill, I am the new man now (Charles, 42yrs, male, Paranoid Schizophrenia).

Leo expressed his belief and said:

There is Hope. Faith and Hope this is about my Christianity, that's worth holding onto that isn't it? (Leo, 41yrs, male, Schizophrenia).

Despite what the above BME participants are going through they demonstrated resilience with the hope of getting better.

Spirituality

The narratives offered by the BME participants suggested that spirituality played an important role in their wellbeing. That having a religious belief gave them comfort to know that all will be well if they only believe and have an acceptance in the good that has occurred in their lives.

Roger had a strong belief in his faith and felt that was more beneficial than taking medication.

He stated:

Actually, in my own opinion the drugs don't really do it for me, it's when I go for prayers and that...I just go to a Pentecostal church now and then (Roger, 41yrs, male, Bipolar Affective Disorder).

One of the main features of the recovery approach is instilling hope in the lives of those who have a mental health problem. The BME participants talked about how their illness has affected them and about their future. Some talked about personal strength, others talked about religion, and others talked about family and friends. When asked about what has kept him well, Ali was able to make links with his faith. Ali stated:

Obviously when I went into hospital, I was ill so I would not say that the medication I received was totally responsible for getting me better...I think it's not just the medication that keeps you well, I think it's time as well... and obviously I am a Muslim, so my Lord use me as well. He has already told me that in the dream ... whenever you need healing as long as you make an effort, he's my Lord. He created me and you also. (Ali, 48yrs, male, Schizophrenia).

Paula also talked about her Christian walk and how she was conflicted about the mix between medication and prayers.

Paula stated:

Also being a Christian because I am a born again Christian and I read the bible most of the time so that helps me a lot, so I am always just there just hoping. I don't want to get ill again you know because I thought I would just leave the medication and just get well by myself by just praying but it didn't work for me... I took my medication and since 2011... I have been well, so I see it works so I don't want to feel like I am under pressure to leave any medication or anything (Paula, 47yrs, female, Schizophrenia).

Hannah in answering the same question was adamant that she had not benefited under the mental health system and stated:

Well Hinduism and Buddhism, I've been to the Hari Krishna Temple in Tottenham Court Road... (Hannah, 43yrs, female, Schizophrenia).

The above narratives suggest that the participants spirituality played an important role in their wellbeing. That having a religious belief gave them comfort to know that all will be well if they only believe and have an acceptance in the good that has occurred in their lives.

Summary of Results

The participants were able to identify their areas of need and also expressed the negative impact of their illness on their lives. That included the side effects of the medication, the lack of opportunity to be employed and the stigma they faced in the wider community. The participants demonstrated their appreciation for the role of their CC and the help they received from the mental health service. The participants showed an awareness of how mental illness can be portrayed negatively in the media. By association, one of the participants did not talk openly about her illness as she feared reprisals by the wider community/public. Nevertheless, the participants were able to demonstrate that with the right support they were able to make plans for a better future.

Discussion

Six themes and sixteen subsequent sub themes were identified in this study and will guide the discussion. Theme one was centred on BME participants need for support from mental health services. In terms of support the findings highlighted that housing was one of the main needs of the BME participants. It has been suggested that persistent poor housing problems can lead to poor mental health, (Pevalin *et al.*, 2017).

Ali (pseudonym) talked about being lonely and allowed others to stay in his flat. Unfortunately, those who stayed in his flat were dealing in illicit drugs rendering him to feel unsafe in his own home. He was able to alert his CC regarding what was going on who ensured that he was moved to more suitable accommodation.

Holt-Lunstad *et al.* (2015, p. 227), theorised that living alone, having limited social network ties, and having occasional social contact are all indicators of social isolation. Whereas social isolation can be an objectively quantifiable variable, loneliness is a subjective emotional state. Loneliness is the awareness of social isolation or the subjective experience of being lonely and thus encompasses subjective measurement.

The need for specialist services in particular psychology and drug and alcohol services were cited by the participants as another main need. Specific interventions typically offered in early intervention psychosis (EIP) include individual cognitive behavioural therapy (CBT), family therapy and carer interventions, medication in the form of a low-dose antipsychotic regime and social support around education, employment, and housing. Interventions such as these are recommended in the guidance for schizophrenia published by the National Institute for Health and Clinical Excellence, (NICE; 2014, 2010).

Memon *et al.* (2016) conducted a research study with BME SUs to establish perceived barriers in accessing the mental health service and how the services can be improved. Participants identified two broad themes that influenced access to mental health services. First, personal and environmental factors included inability to recognise and accept mental health problems, positive impact of social networks, reluctance to discuss psychological distress and seek help among men, cultural identity, negative perception of and social stigma against mental health and financial factors.

Second, factors affecting the relationship between SUs and healthcare provider included the impact of long waiting times for initial assessment, language barriers, poor communication between SUs and providers, inadequate recognition or response to mental health needs, imbalance of power and authority between SUs and providers, cultural naivety, insensitivity

and discrimination towards the needs of BME SUs and lack of awareness of different services among SUs and providers, (Memon *et al.*, 2016, p. 3).

Since the inception of the Care Programme Approach in 1990, the CC has been identified as having a pivotal role in managing the care of SUs with mental health problems. Whilst much has been written about the role of the CC, SUs themselves rely on that individual to offer the support they require in their journey through mental health service.

Patient participation has been viewed as a means to enhance self-determination and empowerment of the SU. The notion of shared decision-making (SDM) as discussed by De las Cuevas *et al.* (2012) is a clinical model that promotes an interactive communication process where healthcare professionals offer their evidence-based technical knowledge, established on population averages, while patients provide information about their own preferences, values and concerns with respect to the available diagnostic or treatment options to reach a consensus on the decision (Deegan and Drake, 2006).

The term stigma has been described as ‘a severe social disapproval due to believed or actual individual characteristics, beliefs or behaviours that are against norms, be they economic, political, cultural or social,’ (Lauber, 2008). The basis of which seem to be a lack of knowledge about mental health, fear, prejudice and discrimination. Stigma in mental health has been a long-standing issue. More recently an attempt to raise awareness by the ‘young royals’ Prince Harry, Prince William, and Kate Middleton helped to inform the public through their ‘*Heads Together*’ campaign about mental illness.

The evidence in this study showed that most of the participants had difficulty in finding work. Two reasons were given: firstly, the lack of understanding about mental health issues in the workplace, and secondly discrimination against those who had a mental illness, (Flood, 2021). Cartwright *et al.* (2017) inferred that people with SMI are disproportionately unemployed. This was also found to be the case by Bond and Drake (2008). One BME participant Gloria (pseudonym) experienced such stigma while attending a sheltered workshop. She felt that the teaching was ‘*slapdash*’ and linked it to negative views of people with mental illness.

Due to the stigma the participants encountered some felt unable to tell their employers or other work colleagues that they had a mental illness. The experiences of the participants in this study were upheld by Thornicroft (2006a, 2006b) who found that there was strong indication that those with mental health problems find it difficult to gain access to and retain employment. It has been suggested that people with SMI in the United Kingdom have an unemployment rate of 61-73%.

Theme three concentrated on participants recognising their relapse signature. The SU is best placed to recognise their relapse indicators. This occurs either through their own learning from their experiences when unwell, or by observation of mental health staff, family, and friends. However, Eisner *et al.* (2018) noted that basic symptoms may be potent predictors of relapse that clinicians miss and contended that, the best way of identifying pre-relapse basic symptoms was a verbal checklist asking specifically about these experiences.

The authors noted that the use of a basic symptoms' checklist in clinical practice, in conjunction with an existing checklist of conventional early signs, may yield a richer relapse signature. It was interesting when the researcher asked: how do you describe a mental health crisis and what action is taken when that happens? The BME participants were able to articulate answers such as '*crying, don't want to do anything, I stopped taking medication, hears voices, tell my mum and my brother*'. One participant stated, '*people see the changes in my mood*'.

Richards *et al.* (2013) postulated that we need to accept that expertise in health and illness lies outside as much as inside medical circles and that working alongside patients, their families, local communities, civil society organisations, and experts in other sectors is essential to improve health.

Substance misuse was also found to contribute to at least six of the SUs experiencing a relapse. Substance misuse among psychiatric spectrum disorders is widespread (Di Forti *et al.* 2019; NICE, 2016). It was estimated that in the United Kingdom a third of patients with SMI have an active substance use disorder including schizophrenia, mood, dissociative, and personality syndromes (Das-Munshi *et al.*,. 2020; Department of Health, 2006).

One of the BME participants, Paul (pseudonym), recognised that he became unwell because he took drugs. He described that he got paranoid after taking drugs which usually led to hospital admission. It was interesting to hear how another participant Andrew (pseudonym), described his understanding of substance misuse, and compared the effects on his mind as not being strong when he was younger, but now fifteen years older he feels more in control.

Much research has been done in the use of medication resulting in the formulation of newer drugs which profess to have less side effects making them more tolerable for the SU . However, several BME participants expressed reasons why they stopped taking their medication. Some suggested that they experience severe debilitating side effects from medication. There were descriptions of physical effects such as weight gain, feeling drowsy and stiffness in joints which made walking difficult. There were also descriptions of psychological effects from taking medication. (Mwebe, Volante & Weaver, 2020, p. 3).

Accordingly, people who use mental health services need help with managing their diet and food intake. A mixture of diet and exercise would be key in supporting SUs in their mental health journey. Charlton (2015) explained malnutrition and mental health disorders as a chicken and egg scenario. Does the presence of mental illness influence eating behaviours and result in an insufficient intake, or conversely, does a poor nutritional status impair mental function and lead to worsening of symptoms? The overwhelming body of evidence suggest that malnutrition predicts adverse clinical outcomes (Slattery *et al.* 2015; Jan-Magnus *et al.* 2011) and requires innovative strategies to address this problem in practice.

Theme five concentrated on the BME participants experiences in using the mental health services in the Trust; particularly if they felt discriminated in anyway. All the participants stated that they did not experience discrimination in the care they received in the Trust. They seemed to link any discrimination/stigma as originating from external agencies such as the Criminal Justice System, Police, Employment, and the Wider Society. That was the experience for (Paula) who was given a police caution several years earlier as it hampered her ability to find employment.

Theme six highlighted that whilst there have been some negative experiences namely, stigma and discrimination the participants were filled with hope for the future. Going through a major illness such as mental illness enables the individual to build resilience. This is the substance of how well one adjusts to the devastating effects that come with such an illness including loss of employment, breakdown in relationships, financial concerns, housing issues.

In this study the BME participants identified with a number of different factors which were aligned to the concept of hope. Some talked about personal strength, others about religion and others family and friends. It was clear that they all felt the intangible sense of knowing that these areas played a major role in keeping them well. Paul (pseudonym) discussed how he hid his substance misuse habit from his mother. He described it as being a stigma in the black community. However, when he was open with his mother he felt like a *'weight'* had been lifted from him. This seems to suggest that a positive mental attitude towards one's illness enhances their chance of recovery (Sagan, 2015).

Ali (pseudonym), who was of the Muslim faith felt that his substance misuse habit was not in keeping with his faith. Whilst he had a strong belief, he did not attend a place of worship, as he felt the misuse of drugs made him unworthy of being with fellow believers. Ali (pseudonym) felt shame and embarrassed about his substance misuse behaviour. Other participants talked about their Christian belief in their journey to keeping well. However there was a recognition by the participants that it was a joint effort with medication and their faith that had worked.

The findings showed that the needs of the BME participants were met to some extent. For example, all the participants emphasised the value in meeting with their CC. However, on issues such as housing, specialist services and medication the BME participants stated that they needed further support. Similar findings have been put forward by Islam, Rabiee & Singh (2015).

The participants understood the term CPA, but not all participants believed that they were involved in the process. However, the BME participants also believed that their spiritual belief and medication needed to go side by side as they placed equal importance in both. Research

has shown that culturally spiritual beliefs feature quite highly within the BME community (Tuffour, 2020; Hays and Aranda, 2016; Keefe *et al.*, 2016).

Limitations

A limitation in this study was the concept of 'insider researcher' (Berkovic, 2020; Tuffour, 2018, p. 3) which came to the fore, as I was in a senior role in the Trust and was mindful of the fact that I had to follow all the appropriate steps to carry out this study, from accessing SUs as participants to conducting the semi structured interviews. In addition, as an employee and a mental health nurse (MHN) the participants could have viewed me as a CC rather than a researcher. That was evident when one of the participants asked whether my meeting with him would be a regularly occurrence. I explained what my role was as part of the research study.

Whilst the objective of the research study was to elucidate information from BME SUs about their experience, I was mindful that the participants could have viewed me as part of '*the system*' and felt obliged to say what they thought was appropriate especially on sensitive issues such as race and culture. Equally, it would have been useful to hear the views of staff and carers in meeting the needs of the BME SUs, however as the remit of this study did not include the views of staff or carers, it is suggested that further research is necessary as both are integral in providing and managing the care and support that the BME SU requires.

Conclusion

The results of this study showed that concepts such as needs, user involvement, ethnicity and race were explored. The results also highlighted the vulnerability of SUs in mental health. A discussion regarding the participants' views on their perception as to whether their needs were being met occurred within the study. In terms of support, the results highlighted that housing was one of the main needs of the BME participants. The need for specialist services in particular psychology and drug and alcohol service were cited by the participants as their main needs.

Other areas highlighted in this study was the need for support from the CC and BME participants requiring information about their illness and treatment options. Additionally, the findings showed that the BME participants required extra support in returning to work. Notably, medication concordance was a subject of discussion in this study. The results highlighted that BME participants viewed medication as a means of support. The participants noted that they experienced side effects from the prescribed medication.

The results also indicated that the BME participants faced discrimination from the police, criminal justice system, employers, and the public at large. The implications for practice and the need for further research, were key aspects in the findings as they are relevant to Mental Health Staff, policy makers, stakeholders, voluntary and spiritual organisations. This would ensure a well-coordinated programme of care within mental health services in meeting the needs of the BME SU.

Recommendations:

The following recommendations are grounded in and derived from the evidence and results of this study:

- Training programme for the police and other social care and mental health professionals to enhance skills when dealing with someone with a SMI.
- Mental Health Professionals to continue to challenge discrimination through social media campaigns, video, and publication.
- Recommendation to the Chief Nursing Officer and the Nursing and Midwifery Council regarding implementation of 'Consistency' as the 7th C.
- Transformative approach in the negotiation and regular review of the Care planning process.

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Exploring The Practice Of Thesis Construction Via The Lens Of The Life Career And Paradox

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‘The way into the underland is through the riven trunk of an old ash tree ...’

(MacFarlane 2020: backcover).

This paper explores the hidden depths of reflective journeys through a professional doctorate programme.

Literature Review. *The Higher Education Policy Institute (2020) report presents a decline in the attraction of Professional Doctorate Education, one that seeks to address the attrition and length of time of completion of traditional doctorates, yet rests on an undertheorised notion of practice. This paper examines the meaning construction at play in the force and form of expression on professional doctorate programmes and the implications it has for the practice of Doctoral Education.*

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Methodology: *Using a case-study methodology, this paper examines a deep auto-ethnographic work, to illuminate and shine a light on reflective and reflexive encounters across the life career, to challenge the natural attitude of career (equating work and progress) so prevalent within HE employability discourse.*

Findings: *The case provides insight into how such a perspective upon career evokes overarching paradoxes within the reflexive story telling of thesis construction, how the strand of thesis construction begins long before engaging with the doctoral process, interconnecting with multiple strands constituting the life career, from childhood onwards, shaping the final linear story that is pronounced to fit a credentialised framing.*

Conclusion: *The paper thus challenges the dominant narrative of a linear development of Doctoral Education, to a practice much more akin to rhizomatic learning (Deleuze & Guattari, 1987) or constellation learning (Benjamin, 1999) to inform future doctoral policy and practice.*

Keywords: career, paradox, autoethnography, case-study.

Introduction

'The term 'professional doctorate' can mean many different things, and there are many different forms and structures for a professional doctorate programme' (Fulton *et al* 2013: 1). The stages of 'doctoral study' are outlined by Fulton *et al.* (2013), prioritising the choice of topic, that is fits within your own professional context, is a 'project' and is approached as a journey for personal transformation. Identity, literature, methodology, supervisory relationships, and dissemination from the guide rails for a doctoral project.

When asked 'why did you choose to study on a professional doctorate programme?', initial motivations for undertaking this course of study coalesce around salient points of 'for a sense of personal achievement' and 'for professional/subject interest'. The outcomes of having studied a professional doctorate are to think more critically, to deepen subject/professional issues, to use reflective practice, and to make a difference to practice (Fulton *et al.*, 2013: 8).

The Professional Doctorate Programme has been designed for those working in the academy, professional, public and social services to producing knowledge and developing practice. Candidates complete a research project alongside other candidates from a range of professional settings. This provides a stimulating multi-agency learning environment, which enriches the personal, intellectual and academic abilities of candidates and will help to develop best practice. Many established approaches to advanced study have focused solely upon academic training. The Professional Doctorate, however, utilises a practical approach, linking work-based problems to personal and professional development. The Professional Doctorate is a research-based qualification with the same academic standing as a PhD, but it has been specifically designed to meet the needs of those working in a range of demanding roles.

The guiding principle of the multi-disciplinary Professional Doctorate is to support the development of research that generates new knowledge and the application of that knowledge within professional domains in order to advance the field. It provides the opportunity to develop and apply knowledge and is becoming increasingly relevant as a doctoral route of choice for industry professionals. At the core, to be relevant, professional doctorates must be located / focused in the industry they represent. The Professional Doctorate provides a common course framework with a structured sequence of common 'modules'. The doctorate usually takes four to eight years to complete on a part-time basis. The primary purpose for candidates undertaking this route is the opportunity to bring real business / industry challenges into the academic domain, to develop new solutions that contribute to advancing and applying knowledge within specialist fields. These awards also open higher-level opportunities for lifelong learning and continual professional development, theory and practice, within relevant subject areas.

The Professional Doctorate provides space for practice-led research, at doctorate level, concerned with advancing the knowledge of our discipline areas. It is expected that the research topic will have direct relevance to the candidate's own professional interest, working life, or that of his / her organisation.

The Professional Doctorate is interdisciplinary and would enhance and coalesce existing research groups and centres. It would harness existing research ideas for early career researchers (ECR) and new colleagues, develop innovative partnerships such as nursing, social work and paramedicine. Fulton *et al.* (2012) have argued that professional doctorates produce Mode 2 types of knowledge (which specifically focuses on the generation, adaptation and implementation of knowledge within the practice setting), an increasing professionalisation of knowledge production and enabling transcendence of professional boundaries to enhance and develop practice. Mode 3 types of knowledge production are increasingly focused on autoethnographic, first-person, narrative, case-study accounts.

The underpinning philosophy of professional doctorates vacillate between many poles on a spectrum from realism to constructivism, direct access to truth and construction of truth, ontologies and the nature of reality, epistemology and how we know that reality, pragmatism and theory, materialism and idealism, realism and perception, interpretivism and positivism. From this plethora of concepts how can we arrive at the necessary conditions for conducting a professional doctorate. One avenue that presents itself is praxis.

Praxis is the act of engaging, applying, exercising or practicing ideas. It is a unity of thinking, making and doing. Praxis in research is the democratising of emancipatory research. It is a democratised process of inquiry that is characterised by negotiation, reciprocity and empowerment (Lather, 1986). A distinction between 'praxis' as the and practice. Praxis is 'the contingent *unfolding* of events' (Nexus) and practice as 'bundles of non-verbal and verbal activities' (Alkemyer & Buschmann, 2017). Praxis has a rich heritage in a Marxist lexicon as a sensuous human activity and a revitalised resonance in 'Practice' theories (Shove, Pantzar & Watson, 2012; Hui, Schatzki & Shove 2017). For these purposes, praxis in research explores singular moments of praxis as case-studies, and the expression of experiences as autoethnography. Praxis is seen in professionalism of nursing, education, research and

reflection. It is theorised by a host of authors from Wittgenstein and the flow of praxis, Heidegger as a source of language and meaning and Bourdieu as theorizing *habitus* but the fully explicated and unified theory of praxis waits fulsome discussion but praxis links the individual with the collective and the field of professional practice.

Methodology

A case-study methodology utilises auto-ethnographical work to illuminate the reflective and reflexive encounters of the life career. Case-studies have a long history and growing impact on 'new' types of knowledge generation. Case-studies fit well with a focused approach to work-based learning, practice-based investigations and allow for an in-depth understanding of real world and applied research. They enable a wide range of research methodologies and methodological approaches.

Yin (1984, p. 24) defines a case-study as, 'An empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between the phenomenon and context are not clearly evident; and in which multiple sources of evidence are used'.

The doyen of the case-study, Robert Yin (2011; 2013), has written extensively on the use of case-studies as a methodological approach with the largely positivist approach, with the assumption that there is a reality which the researcher is attempting to explore and uncover or unearth to share with a wider, grateful audience. The case-study formulated in this perspective, has strengths: dealing with the practicalities of everyday life; the unpicking of ambiguities; requiring several data sources; and theoretical exploration that goes beyond the superficial (Hayes 2019, p. 174). It gathers a richness of data and applying theory can generate new hypothesis or new theory, covering inductive and deductive reasoning moving from theory (deductive) to developing theoretical ideas from practical situations (inductive).

Case-study research is firmly placed in constructionism and interpretivism as an epistemological standpoint that acknowledges and celebrates subjectivity (beyond objectivity), examines meaning making (not observable phenomena), and generates meaningful data (not empirically measured). The defining feature of the case-study is the contested, conflicting and multiple realities that are social constructed, interpreted and the making of meaning. Meaning is derived from the expressed meaning of participants, the projection of meaning by the participant and the capacity of interpretation by the researcher to translate and articulate meaning in a systematic and analytical approach.

Yin (1984) has a slightly different focus.

- *descriptive case-studies* where a case is described usually in some detail.
- *interpretative case-studies* in which the case is analysed, and inferences drawn
- *evaluative case-studies* in which detailed evaluations are made.

Stake (1995) identifies three case-studies

- *Intrinsic case-studies* where a researcher attempts to examine and understand a particular case with a view to addressing difficult theoretical issues, concerns and

problems (e.g. a hospital ward or school because they are using a new or novel approach or are of interest).

- *Instrumental case-studies* where a researcher attempts to use a case as an exemplar and draw inferences which can be applied to a wider range of cases, often across different sites.
- *Collective case-studies* in which more than one case is studied explored across sites.

To this we could add contextual, situational and relationship based.

- *Contextual* where the social, cultural and political milieu of a particular case is explored to provide a 'rich and thick' description (Geertz, 1994) similar to Bourdieu's (1992) habitus or Bronfenbrenner's (2009) socio-ecological model.
- *Situational* where the specific geographical and material aspects alongside the emotive and feelings aroused constitute the case.
- *Relationship-based* where the relationship-based nature of action in a given situation or context is the focus of this case.

Case-studies enable the circulation and airing of different types of knowledge(s) beyond the simple type one and two distinction to an emergent third space knowledge. This 'third space' of knowledge is characterised by expressed and self-narrated knowledge claims. Autoethnography is an emerging methodology in research and has become an increasingly popular method of inquiry (Duncan, 2004).

Autoethnography is a form of qualitative research in which an author uses self-reflection and writing to explore their personal experience and connect this autobiographical story to wider cultural, political, and social meanings and understandings. Autoethnography is a self-reflective form of writing used across various disciplines such as communication studies, performance studies, education, English literature, anthropology, social work, sociology, history, psychology, marketing, business and educational administration, arts education and physiotherapy.

Ellis (2011) suggests Autoethnography is an approach to research and writing that seeks to describe and systematically analyse personal experience in order to understand cultural experience. This approach challenges canonical ways of doing research and representing others and treats research as a political, socially-just and socially-conscious act. A researcher uses tenets of autobiography and ethnography to do and write autoethnography. Thus, as a method, autoethnography is both process and product.

'Autoethnography shows struggle, passion, embodied life, and the collaborative creation of sense-making in situations in which people have to cope with dire circumstances and loss of meaning. Autoethnography wants the reader to care, to feel, to empathize, and to do something, to act. It needs the researcher to be vulnerable and intimate. Intimacy is a way of being, a mode of caring, and it shouldn't be used as a vehicle to produce distanced theorizing. What are we giving to the people with whom we are intimate, if our higher purpose is to use our joint experiences to produce theoretical abstractions published on the pages of scholarly journals?' (Ellis & Bochner, 2006, p. 6).

Maréchal (2010, p. 43) suggests 'autoethnography is a form or method for research that involves self-observation and reflexive investigation in the context of ethnographic field work and writing'. He continues these methods have been criticised for 'their validity on the grounds of being unrepresentative and lacking objectivity' and 'for being biased, navel-gazing, self-absorbed, or emotionally incontinent, and for high jacking traditional, ethnographic purposes and scholarly contributions' (Maréchal, 2010, p. 45).

Clough (2000, p. 290) argues autoethnography can serve as a vehicle for thinking 'new sociological subjects' and forming 'new parameters of the social' giving new ways to explore subjectivity, experience, memory and identity. Bochner (2000, p. 271) argues 'good personal narratives should contribute to positive social change and move us to action'.

Autoethnography is a rigorous methodology that has value and benefit in the contribution to wider health and social care practice, teaching and research communities. It is a democratic process that can illuminate the relationship of power within the field of health and social care and education. Haynes and Fulton (2015) argue autoethnography can structure and guide the research process, by providing structure to the process of reflexivity. They go on to suggest autoethnography provides a factually accurate and comprehensive overview of the professional doctorate candidate's career trajectory. It should act as a driver of self-explication for the professional doctorate student thus providing a degree of both catalytic and educative authenticity and provide an insight for the reader of the professional doctoral thesis.

Chang (2016) states 'autoethnography is gaining acceptance as a legitimate research method in health science research' and a growing volume of published autoethnographies is indicative of this trend. However, the dominantly descriptive and evocative illness self-narratives that may evoke emotionally compelling responses from readers but offer insufficient sociocultural insights about the illness phenomenon. To identify a "desirable" autoethnography that provides not only a "thick description" of personal experiences but also a sociocultural interpretation of such experiences, Chang (2016) recommends both creators and consumers of autoethnography to ask five evaluative questions: (1) Does the autoethnography use authentic and trustworthy data?; (2) Does the autoethnography follow a reliable research process and show the process clearly?; (3) Does the autoethnography follow ethical steps to protect the rights of self and others presented and implicated in the autoethnography?; (4) Does the autoethnography analyse and interpret the sociocultural meaning of the author's personal experiences?; and (5) Does the autoethnography attempt to make a scholarly contribution with its conclusion and engagement of the existing literature?' Autoethnography carries the traces of 'inquiry, as a kind of seeking, must be guided beforehand by what is sought' (Heidegger, 1962, p. 25).

Traced reflections

The case study under investigation explores the doctoral journey of the second author. The process of completing the professional doctorate was traced via a reflexive log that was completed throughout the programme, and such a tracing was then summarised via the writing and submission of a 5000-word summative reflective account (Gee 2019). This section

of the paper will account for the writing of this document, as well as providing extracts, to consider how the reflective account emerged and the part it and reflection played in the doctoral process. It illustrates and advocates how reflection is a fluid and rhizomatic process, how this particular reflection was framed via broad notions of career as 'any social strand in a person's life' (Goffman, 1961, p. 127) significant activity traced via reflexive articulation that connects to a broader sense of life articulation (Gee, 2017, p.183). Such broad activity was then placed under a deconstructive reading informed by a range of dualities, where duality is to be considered as a 'conceptualisation of reality that provides a paradoxical relationship between opposing yet entwining entities' (Gee, 2017, p. 187). The argument being put forward here is that the dualities - self and other; being and becoming; agency and structure - bring into focus paradoxes within the text (Gee, 2019). Such 'moments' provide insightful readings and connections, to consider how a range of action, as well as inaction, presences and that which is perceived as not present, trace thesis invention, an invention that is both a 'finding' as well as a 'construction' (Derrida, 2007).

The Reflective account of the professional doctorate undertaken provided an opportunity to discuss reflections on the research process and their importance of reflexivity and the how the 'self' is an important aspect of the research process and how the self-unfolds during the process of the project. Considering the construction of a linear narrative to trace reflexivity throughout the project, which is likely to bring into play reflections before the process brings to the fore important questions of framing, as highlighted in the reflective account.

So it begs the first reflexive question as to the purpose of such endeavours? An opportunity to provide a demonstration of my reflexive skills so important to any social researcher? To prove my reflexive credentials? To 'reveal' how knowledge is constructed? To provide some sort of reflexive story of the project? The story 'behind' the story? Underneath the story? To the side? Above? A look behind the doctoral curtain of construction? In this case Deconstruction? Or, from a Foucauldian perspective, a form of modern confession, with my tempted response to assert to the reader 'mind your own business! (Gee, 2019, p. 1).

Already within the reflection process one is to account for its stance, its perspective, where reflection is not only a matter of considering space, but also time, the unfolding of phenomena, when and where should the reflection start and who is the trace of reflection for and its purpose? This brings into play the importance of the context of reflection, that reflection and in this case autoethnography, or autobiography is not an apolitical act that occurs within a vacuum (Gee & Barnard, 2020).

When considering context, notions of time and place come into play, when should the reflection start and what strand(s) of 'career' should be focused upon? Should thesis construction be considered as occurring solely within the strand of the 'student'? What of other interconnecting strands, family, work, creative, leisure? What of strands that occur before the emergence of the doctoral strand? In what ways does the thesis construction connect with the 'self'? What of strands of other people that interconnect with the doctoral thesis, supervisors or theorists? In the case of the reflective account the consideration of the

influence of Derrida – the most influential thinker upon the philosophical architecture of the project – was a starting point of contemplation, why Derrida? Not an easy question and one that involved a consideration of the researcher’s past and varied interconnecting strands, hinged upon an overriding paradox within the text belonging whilst not belonging: a position at intersecting borders. These intersecting borders are considered in the lengthy extract below.

“My mother very often talks and reflects on the romantic meeting of her parents in what was at the time called Palestine, back in the mid-1940s. My mother’s mother, a Sephardic Jew, met my Grandfather, a Bermondsey boy from South London, a non-Jew, who managed to find himself in Palestine as part of the Military Police. It was very much a love affair that crossed many borders, physical, religious, national and political boundaries. This is not the only crossing of boundaries that occurs when thinking of my genealogical roots, my father was an Ashkenazic Jew, making me an unusual mixture of Jewish ethnicity, both Ashkenazic and Sephardic Jew, as well as part English non-Jew. My mother born in newly crowned Israel in 1948, was moved to London soon after her birth to be brought up by a London Transport bus conductor father and her mother, a full-time carer of children as well as an unofficial lone provider. My mother is very much considered working class, growing up as the only Jew in rough inner-city London schools with dark complexion and having to fight such difference in the playground. My mother, although an intelligent woman, left school with few qualifications and barely being able to read and write due to the many disruptions she experienced having to defend her Jewish identity. Leaving school at 15 my mother became a hairdresser. My father on the other hand - a middle class son of a father that owned his own legitimate loan company and his mother a secretary - was an academically bright man that enjoyed school leaving with good qualifications to train to become an actuary in an insurance firm. My mother and father’s love, as was the case for my mother’s parents, crossed boundaries, in this case Jewish ethnicity and class difference. Such a story is reliant upon my mother’s telling, in particular as my father died of cancer when I was one and half years old, I have no living memory of my father. What becomes apparent of such a story is how the stories before my own provide interesting conceptual considerations. This story provides the crossing of boundaries, in-betweenness, and a sense of absence, all important aspects of the doctoral thesis I have produced. This is perpetuated whilst growing up Jewish without a Jewish father, similar in some ways to my mother. As my mother’s father was not Jewish she did not learn much of the Jewish customs and religious beliefs, however as mentioned before, due to being different at school and this being marked by the label of Jew, my mother had to fight to protect such an identity, an identity that became inscribed and loved yet without a full knowledge of what being Jewish entails. Therefore, my mother did not have such knowledge to pass on and as my father had passed away this left another void. However, I was still marked as being Jewish and attending a state school in North London within a predominant Jewish community there were many Jewish children present at my school. This provided a pass into their community. I was able to interact with such a group with ease where I noticed that non-Jews struggled to gain access, this was particularly important in the teenage years and when one starts to become interested in romantic relationships. Though I had access I did not share the same values and knowledge, I belonged but only to a certain degree. I was also friends with many non-Jews. As a result, I was able to witness discriminatory practices that occurred within such groupings toward the other. When with the Jewish children I would

hear words such as 'Yok' and 'Goyim' being used to slander the non-Jews. Likewise, when hanging around with my non-Jewish friends I would hear the slurs of 'Yid', sometimes even when I was present and when I would speak up of such slurs I was informed, 'it's ok you're not really one of them'.

I appreciate that such reflections at first glance appear very distant from the doctoral process, however, when considering the question of 'why have I an interest in Derrida' suddenly there appears to be connection. On coming to know Derrida's own biography I became aware that he also has a Jewish heritage, he liked football as a youngster, as do I, and his family experienced a death which Derrida had no direct memory of, the death of his eldest brother a year before he was born. I acknowledge that part of my introduction to Derrida was by one of my supervisors, however there were other theorists I was introduced to, yet Derrida appeared to gravitate toward me for some reason, even before hearing of his biography. The reading of chapters of his book '*The Margins of Philosophy*' provided much interest, as though I was reading someone that felt similar about the world they inhabit. Margins being a poignant word here, as illustrated before, my biography and history is littered with boundary considerations, where I felt I belonged whilst not belonging. Being placed in such a liminal position also made me question things, in effect deconstruct what I saw and learnt. The void and absence of my biological father provided a curiosity of philosophical questions from an early age, why had he gone? Where? How? Absence became a strong presence for enactment and still is" (Gee, 2019, pp. 3-4).

The lengthy extract above provides an insight into the fluid nature of thesis construction, how the self becomes pulled toward, or moves toward, certain interconnections, in this case Derrida as opposed to other theorists. The self here is considered as emergent, temporal, with significant marked and memorialised changes as well as acknowledged continuity, a self that 'finds' and traces such a journey, whilst acknowledging its part in interpretation, the influence of other, time and place and interaction. This is not to over romanticise the drawing toward Derrida, other theorists could have been chosen to focus the architecture announced, and if the circumstances had of been different then the possibility of another theorist, or no theorist at all, might have emerged. The argument here is how the deconstructive reading, focused upon duality and paradox provides a rich temporal and rhizomatic reading to occur one avoiding the symmetric geometry of reflective frameworks often promoted within practice (Gee & Barnard, 2020).

Taking into account context from a more macro position also highlights forces that may appear distant from thesis construction have their perceived part to play if focused upon. This is where the duality of agency and structure can come more into play a contemplation, in this case, of how social policy has its part to play in determining whether a person has an opportunity to be in a position to construct a thesis in the first place as highlighted in the next extract.

Widening of participation – a structural consideration

Whilst much of the reflections that occur here come from a supposed agentic view it is worth noting that economy and social structures come into play. 'My mother's desire was that my

brother and I were destined to go to university, a promise she had made to my father, although clever enough to go to university he never did. With such a promise it provided me with little choice as to 'career' trajectory. I studied a Civil Engineering Degree at the University of Surrey – a far cry from 'career' and Sociology which I now teach and research. I hated the course and knew that studying tangible objects was not for me. After graduating and working for two years I decided to study for a Diploma in Career Guidance. I always had a desire to want to venture back to the academy and be a lecturer. I was lucky that at the time of looking to become a lecturer, 2005, it was before the economic crash, it was during the New Labour Administration which came to power upon the mantra of 'Education, Education, and Education'. With this being the case widening participation policy was at its zenith, not only in terms of attracting non-traditional students but also non-traditional staff. As a result, I was provided with an opportunity to apply as a lecturer and not having a Masters, let alone a PhD, did not provide an overbearing obstacle. Having been within the academy for over 10 years, surviving the crash of 2008 on a short term contract, and seeing the many changes that have occurred with the continual marketisation of education, I am fully aware of the barriers that now prevent those working at the academy and I am aware that a change in economic climate can have big influences on opportunity. Such knowledge of social structures and my engagement with social theory once joining the university as lecturer made me determined to consider the duality of agency and structure in my research and pedagogy' (Gee 2019: 6).

The reflection above takes into account different strands of the enacted career, how past emerges toward the ever slipping and multiple presents, other, their multiple strands, action, inaction, taste, the shaping of taste, certain presences and acknowledgement of that which is not present and its influence akin to negative space 'within' a sculpture, how that which is not there still marks its presence via absence.

Previous professional doctorates have demanded a reflective journey, including some theory, to give voice to the trials and tribulations of doctoral education. It has taken the form of a love affair, deeply personal journeys, addressing absences, creating muses, professional reflection, and narrating a journey of scaling heights, traversing low-lands and points of arrival and departure. Feelings of inferiority, loss of self, have all been reported in courageous acts of self-definition through reflective investigation. Self-validation, addressing atrocity stories, respondign to critical incidents, professional development, lifelong learning and retirement projects form the context of completing doctoral work. Mindfulness, curiosity, imagination, cultural sensitivity, lifelong learning and intellectual engagement and development underpin the process.

Rhizomatic learning derives from Deleuze's (2004; 1994) work and Guattari (1972; 2000; 2011) that culminated in Deleuze and Guattari (1987; 1983) and where rhizomatic learning is 'movements in diverse directions instead of a single path, multiplying its own lines and establishing the plurality of unpredictable connections in the open-ended smooth space of its growth' (Semetsky, 2008, p. xv). The unification of there diverse directions and unpredictable connections are caught in the case-study of autoethnographic accounts and the smooth space of its growth. This challenge to linear development adds to the tendrils and rhizomes of thought and new knowledge production on professional doctorates. These stems, shoots, tubers, corms of thought take place under a crystalline sky. Constellation

learning is drawn from Benjamin. Benjamin's (1999) *Arcades Project* or *Passagen-Werk* is a fragmentary, unfinished mediation and exploration on the topography, history and humanity of Paris forming a constellation or galaxy, where 'the individual stars of which he drew together over more than a decade, collecting notes, quotations, aphorisms, stories and reflections on dozens of dossiers that he called *Konvolute* – 'convolutes' in English, meaning 'coils', 'twists', 'enfoldments' – each of which was identified by a letter' (MacFarlane, 2020, p. 133). Rather than a linear history of Paris, Benjamin created a kaleidoscope, the crystals of which fall into fresh patterns with each new reader. This arduous journey is to honour the memory of anonymous beings that are emerging through case-studies of autoethnography. The coils, twists and enfoldments of doctoral journeys are the gathering of many of rhizomatic thought and constellation thinking.

The personal reflective account gives value to new methodologies focusing on autoethnography, first person accounts and case-studies. The intricacies of personal journey's on doctoral degrees add to informing policy and practice that needs to extend the linear narratives of research processes to include. The personal is reflective.

Conclusion.

There is a limitation in reflective accounts that verge on the descriptive and lack a critical insight in the reflections. A critical autoethnography would be more fully expounded with a recognition of the context as important in influencing the reflective accounts and the structuring dynamic of social, political and cultural factors that influence individuals and groups reflecting autobiographically.

The practice of professional doctorates presents a challenge to traditional doctorates in the scope, reach, breadth, depth, complexity and situated of knowledge generation.

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The Introduction of Work-Based Learning to Higher Education in the UK

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Work-Based Learning (WBL) in higher education is a field of study established in the UK that has developed since the early 1990s. The term WBL was first coined in the USA although not initially in higher education. Notably the Council for Adult and Experiential Learning (CAEL) which aims to improve education-to-career pathways for adult learners promoted work-based experiential learning. WBL was then developed further in UK higher education institutions (HEIs), taking the learning to higher education level but keeping some of the principles from the USA CAEL model. Some key principles were basing learning in the individual's work environment, accessing and improving abilities, and reflecting on experiential learning.

The possibility for this development came when several universities across the UK were awarded a grant in 1992, from the then Department for Employment, to develop learning from work, in the curriculum. At Middlesex University it was called the 'Curriculum in the workplace' project and it took as the starting point, workers themselves rather than students going out into the workplace as part of their HEI course. It was the work of these projects, and the subsequent networking enabled by the Universities Association for Continuing Education (now known as Universities Association for Lifelong Learning), that launched WBL in higher education in the UK.

The 1992 government funding had the intention of providing a curriculum model for people working full time and studying part time and to form partnerships with organisations as well as students who worked part time or had placement opportunities. It started in some universities by using the model of 'Independent Learning Studies' (Osborne et al 1998) and Adult Learning. The development of university accreditation services supported the development of the WBL curriculum by providing the facility to recognise prior experiential learning (RPL) at the individual level but also learning from high level external courses e.g.,

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in-company programmes. The Learning from Experience Trust and Higher Education for Capability (HEC) movement informed the development of the WBL curriculum.

A transdisciplinary (TD) approach was taken by those universities who instituted WBL as a field in its own right. The ability afforded to those with experiential learning to gain university level credit through learning from work enabled many people to access higher education, many of whom were the first in their family to receive a university level award. WBL was soon taken up by many UK universities and the term WBL began to develop new meanings (see Definitions paper).

Middlesex University who had a leading role in establishing WBL in UK HEIs (Queens Anniversary Prize, 1996) and the University of Portsmouth both developed WBL centres and initially led developments in the WBL curriculum area introducing stand-alone awards in WBL. Middlesex was recognised with the award of a Queens Anniversary Prize for innovation and excellence in 1996, for this work. UK universities then also engaged with WBL programmes, for example, the Universities of Teesside, Glasgow Caledonian and Chester. These HEIs had whole programmes based on this approach whilst some universities chose to develop modules and other elements of WBL in their programmes. An example is the university of Lincoln and Humberside, now the university of Lincoln that had taken a similar approach but had a central unit for WBL that connected to subject discipline areas across the university where subject disciplines wanted elements of WBL to be part of their awards. More recently, since WBL means more than a curriculum designed for the workplace to meet the needs of workers studying part-time, the University of Warwick for example has developed WBL modules and other WBL features in almost every subject across the university.

Independent Study and Adult Learning

Independent study can be thought of as a process, a method and a philosophy of education (Forster,1972; p ii). It has its pedagogical roots in Adult Learning (Freire 1972; Knowles, 1990; Mezirow 1991) which also had a significant influence on the development of WBL.

Independent study is a process, a method and a philosophy of education;

- in which a student acquires knowledge by his or her own efforts and develops the ability for inquiry and critical evaluation,
- it includes freedom of choice in determining those objectives, within the limits of a given project or program and with the aid of a faculty adviser,
- it requires freedom of process to carry out the objectives,
- it places increased educational responsibility on the student for the achieving of objectives and for the value of the goals

(Forster, 1972, p. ii)

Many of the universities that had taken part in the 1992 funded project developed an approach to knowledge in the field that drew upon and developed modules used by independent study – especially learning agreements and negotiated shell modules - and combined them with *Accreditation of Prior and Experiential Learning* (known as APEL, APL or RPL) and WBL project modules.

Experiential learning

The WBL movement was greatly informed by the various approaches to RPL especially as it was informed by the *Learning from Experience Trust* which in turn had worked with the Council for Adult and Experiential Learning (CAEL) <http://www.cael.org/>. CAEL started in the USA, 1974 and used the term Prior Learning Assessment (PLA). In the UK the SEEC organisation <https://www.uall.ac.uk/public/networks/seec> is a network that has developed opportunities to provide mobility between and access to HEIs through the use of credit. The SEEC Credit Level Descriptors provide a detailed set of measurements for assessing levels of academic learning.

Capability

The Higher Education for Capability (HEC) movement was popularised through the *Royal Society for Arts' Education for Capability* project. There was a growing need for professionals to move beyond discipline-specific expertise and engage with, what Schön (1987:3) terms, the "swampy lowland" of practice. The Capability journal is now archived with Advance HE. See the HEC archive; <https://www.advance-he.ac.uk/knowledge-hub/higher-education-capability-archive-heca>

Lester's 2014 paper discusses the Capability approach as "*taking account of things that characterise the working environments of many professions such as emergent contexts, evolving and contested practices and the need for intelligent judgement and lived ethical practice*" p.7

Universities Association for Continuing Education

In 1992, a new WBL network was set up with the then, Universities Association for Continuing Education (UACE) UACE later became the Universities Association for Lifelong Learning (UALL) and the network changed its name to Work and Learning in order to incorporate the wider interests that universities had developed in relation to learning for, in and through work. The network has been convened by Middlesex University from the outset and remains a thriving network of UALL, <https://www.workandlearningnetwork.org/>

Transdisciplinarity

Most work roles involve abilities that cut across the wider curriculum in higher education. Middlesex, Chester and Teesside are examples of universities that developed a pedagogical model of transdisciplinarity drawn from theorists such as Nicolescu, Gibbons and Nowotny.

Despite this happening at about the time of the *First World Congress of Transdisciplinarity* (1994) where the charter of transdisciplinarity was adopted, a transdisciplinary (TD) approach to curriculum was not well known or well understood. The TD curriculum model did not stem from the research movement in the first instance, it gradually developed as a curriculum area that took its areas of knowledge from work. Transdisciplinarity at that time was considered by the research councils as a contested concept. David Boud's chapter in the now classic book, *Work-based Learning: A New Higher Education?* (Boud and Solomon, 2001) brings to light the place of transdisciplinarity in WBL and discusses how assessing work-based learning would need a TD approach. Since then, more scholarly articles have made the case for transdisciplinarity and it is now a recognised term in many different fields but especially where curricular are related in some way to work situations.

Universities such as Glasgow Caledonian, Middlesex and Teesside have used the same TD approach to WBL whilst other colleagues across the UK, who run programmes of WBL, blend subject discipline areas with the more TD approaches of WBL in a variety of different ways.

The tendency for WBL to follow a TD curriculum has much in common with the ethos of the international TD research movement. However, WBL has developed a pedagogical approach in these instances rather than a purely research approach. The WBL direction in transdisciplinarity is not towards large scale research projects but as a pedagogy that supports the unity of knowledge in work situations (paid and unpaid) that lies both beyond disciplines and between and across the disciplines. The goal is the understanding of the present world in the context of work, of which one of the imperatives is the overarching unity of knowledge in work-related communities of practice. Examples of where WBL is defined and discussed as TD include Boud (2001), Gibbs and Costley (2006), Costley and Armsby (2006), Gibbs and Garnett (2007).

Curriculum Development

WBL as a validated field of study is engaged heavily in curriculum and pedagogy and has award titles that span from Foundation level to Doctorate level and there are also possibilities for certificates of credit being gained by students that can have currency towards an award at the same or other institution. The Bachelors and Master in WBL that was developed in many universities across the UK was the basis for the development of the Doctor of Professional Studies in 1997, a highly successful transdisciplinary (TD) doctorate now practiced by universities across the UK. A TD approach to educational knowledge in work-based and professional studies is therefore now practiced at all higher education levels from Foundation to Doctorate. An early publication in the field (Portwood and Costley, 2000) set out the curriculum areas, modules and factors relating to a WBL curriculum. More recently, Helyer and Garnett, (2016) wrote a chapter explaining how WBL fits into higher education demonstrating the TD nature of WBL. A paper (Costley and Pizzolato 2017) discusses transdisciplinarity in the Doctor of Professional Studies.

WBL did not emerge from a subject discipline; rather, from the outset, it emerged and developed according to the needs of learners in work-situated settings. It did use methodologies drawn from the Social Sciences and Humanities to guide practitioners in

their approach to their practice-based projects. Methodologies have since broadened with a wide range of practitioner-researcher enquiry approaches with the 'Researching Professional' having become a familiar term.

The approaches to research used by academics engaged with the learning and teaching in WBL taught degrees and the Doctorate in Professional Studies, in relation to their own research, can vary according to the nature of the research being undertaken which could be curriculum development, pedagogical research, evaluative research, philosophical research etc. Academics who engage in pedagogical research, may be researching the underlying philosophies and theories supporting the curriculum area and/or policy-related research, in which case their research is not about developing a work-situated project and is not necessarily TD. This causes WBL to be unlike subject disciplines in this respect, where the academics are undertaking research interests that are in line with their research students. The WBL curriculum area does not bring about such a relationship.

The WBL movement led to further publications in more organisational learning and business areas but always had an 'education' focus with publications about WBL mainly being published in Education journals and submissions of scholars in the field being entered in the Research Excellence Framework (the system for assessing the quality of research in UK higher education institutions) going into the Education unit of assessment. The WBL network continues to straddle these two more general areas in approaches to curriculum development and to research. In the UK WBL underpins much of the curriculum design for degree apprenticeships (Garnett 2020).

WBL in higher education partnerships

With the influences of Independent Learning, Adult Learning, experiential learning (known as APEL, APL or RPL) and the Capability movement, the pioneers of WBL gained experience of working with organisations. They soon developed partnership models (Garnett 2001, Garnett et al 2001), that included accrediting company courses, developing learning agreements with organisations in every professional area and further development of work-based methodologies and work-based projects.

Summary

WBL in higher education stems from developing a curriculum model for people in work contexts that has its roots in Independent Studies, experiential learning and the Capability movement in the 1990s. At that time, it was intended for people in work who were studying part time and for placements and other experiential work activities for full time students. The curriculum was designed to engage the work situation itself as a focus of the studies. Most models of WBL in higher education entail a pedagogical approach to both curriculum and research, are embedded in practice, and have been designed by educationalists whose main focus has been learning and teaching in higher education. Since the early 1990s the term WBL has been used in some countries including the UK to mean work experience of any kind including placements etc. but other terms have since been developed. This has led to a conflation of the terms used e.g., Work Integrated learning, Work-Related Learning to

mean the same thing. The knowledge and subsequent learning and teaching that takes place in work situations has become a key focus in most countries over the last 30 years and the developments in WBL have been significant in informing a whole range of work-related initiatives in HEIs. Many scholars recognise a TD situation in work environments. There is more scholarly work to do in explaining how subject discipline knowledge coupled with the more TD knowledge of work situations can be wholistically presented in programmes of study. WBL ideas have been incorporated into the employability agenda and the current focus upon graduate skills in relation to Bachelor's degrees. The more focussed aspect of WBL continues to develop the pedagogy and curriculum content that is appropriate for people learning for and from work.

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How Compliant Are Physiotherapists Affiliated To Occupational Health Services With Clinical Audit Practice?

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The purpose of this project was to determine the extent to which physiotherapists affiliated to occupational health services undertake the full clinical audit cycle. A sample of convenience was used to select physiotherapists that were in attendance over two conference days. Those who verbally consented to take part were asked to complete a survey and place it in an envelope which was immediately sealed to maintain confidentiality of responses. The majority of physiotherapists undertook clinical audit practice (94%). The common frequency of clinical audits was annually (77%). Most physiotherapists did not contribute their clinical audit outcomes into any quality improvement initiatives (42%). Occupational health services should encourage physiotherapists affiliated to them to identify and link their outcomes into broader quality improvement initiatives so that the full audit cycle can be completed.

Keywords: clinical audit, occupational health, physiotherapy, survey, practice

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Introduction

Clinical audit is a quality improvement practice that aims to improve the delivery of healthcare through the systematic review of care against explicit criteria or standards (Lokuarachchi, 2006). Following completion of the clinical audit changes are implemented at individual and/or service level and further monitoring is used to confirm if the changes lead to improvement in healthcare delivery (Johnston *et al.*, 2000).

In 1989, the National Health Service (NHS) in the United Kingdom (UK) introduced a White Paper titled 'Working for Patients' to ensure that the delivery of healthcare was reviewed and best practice was being implemented (Waclawski, 2009). Since the release of the White Paper clinical audit practice has become a requirement for health professionals working in the NHS. In addition, physiotherapists are required by their regulatory body, the Health and Care Professions Council (HCPC), to undertake this practice as part of continuous professional development (Health and Care Professions Council, 2018).

In the UK, occupational health departments undertake clinical audit practice not just as a medical requirement but as a vital quality improvement initiative (Ujah *et al.*, 2004). A range of occupational health activities have the potential to undergo clinical audit, namely vocational rehabilitation, back pain, depression and anxiety, needle stick injuries, immunisations, pre-employment health screening, types of referrals and common health conditions, cost-effectiveness, skin dermatitis, and client satisfaction. A literature search revealed that physiotherapists affiliated to occupational health services have undertaken clinical audits on clinical and cost-effectiveness of therapeutic interventions and client satisfaction (Addley *et al.*, 2010; Chetty, 2011, 2014; Smedley *et al.*, 2012).

A full clinical audit cycle involves more than just simply collecting information as a benchmark exercise against a standard. It is a process that involves undertaking repeat audits to confirm the impact of any changes implemented, sharing of outcomes to relevant stakeholders, and having a follow-up process that contributes into quality improvement initiatives (Benjamin, 2008). The purpose of this project was therefore to determine the

extent to which physiotherapists affiliated to occupational health services complete the full clinical audit cycle.

Methods

An initial online database search was carried out in Google Scholar, Medical Literature Analysis and Retrieval System Online (Medline), and the United States National Library of Medicine (PubMed) using the terms: clinical audit, occupational health, physiotherapy. This search informed the development of the clinical audit practice survey for the purpose of this project.

Data were collected at the Occupational Health and Wellbeing Conference in March 2022 in the UK. This annual conference is one of the largest international occupational health meetings with representatives from many countries. Occupational health professionals represented included physicians, nurses, physiotherapists, and researchers. The author elected to survey UK based physiotherapists attending the conference about their current clinical audit practice, related outcomes, and follow-up initiatives.

Data collection was undertaken by the author by convenience sampling, selecting physiotherapists that were in attendance over the two conference days. The author approached physiotherapists, identified by their name badge, between conference presentations, on route to the poster presentation area, and during rest breaks, who were affiliated to occupational health services. Participants who verbally consented to take part were asked to complete the clinical audit practice survey and place it in an envelope which was immediately sealed to maintain confidentiality of responses.

Data were collated in an anonymized manner on a spread sheet by the author at the end of each day. Data analysis was performed using the Statistical Software for Excel (XLSTAT) package. This project was classified a service improvement and therefore ethical approval was not required (Health Research Authority, 2017).

Findings

In total, 34 physiotherapists provided verbal consent to participate in the survey. Of these, one was incomplete with only the demographic characteristics of the survey completed and was therefore excluded from the data analysis.

The characteristics of the physiotherapists are shown in Table 1 below. The mean years of employment were 17.3 years. In terms of job role, most identified as occupational health physiotherapists (52%), followed by advance practice occupational health physiotherapists (27%), and the least identified as consultant occupational health physiotherapists (12%) and occupational health physiotherapy managers (9%). In terms of employment status, most physiotherapists worked full time (73%), followed by part time (21%), and occasionally (6%). The main employer was private companies (42%), followed by self-employment (31%), the NHS (18%), and the Ministry of Defence (MOD) (9%).

Table 1: Demographic Characteristics of Study Population (N=33)

Variables	N	%
All participants	33	100
Years of experience	17.3	
Job role		
Occupational health physiotherapist	17	52
Advanced practice occupational health physiotherapist	9	27
Consultant occupational health physiotherapist	4	12
Occupational health physiotherapy manager	3	9
Other (please specify)	0	0
Employment status		
Full time	24	73
Part time	7	21
Occasional	2	6
Other (please specify)	0	0
Main employer		
National Health Service	6	18
Ministry of Defence	3	9
Private Company	14	42
Self-employed	10	31
Other (please specify)	0	0

The responses to clinical audit practice of physiotherapists affiliated to occupational health services are shown in Table 2 below. Overall, the majority of physiotherapists undertook clinical audit practice (94%). In terms of frequency, most physiotherapists undertook annual clinical audits (77%), followed by every two years (13%), monthly (6%) and weekly (4%). With regards to outcomes, 42% of physiotherapists shared their outcomes with both their employing organisation and organisations outside of their employment, 19% did not share their outcomes with any organisation, 23% shared their outcomes with only their employing organisation and 16% shared their outcomes only with organisations outside of their employment. Most physiotherapists did not contribute their clinical audit outcomes into any quality improvement initiatives (71%). Of those that did contribute, 13% contributed only to internal quality improvement initiatives, 6% contributed only to external quality improvement initiatives, and 10% contributed to both internal and external quality improvement initiatives.

Table 2: Responses to Clinical Audit Practice of Physiotherapists affiliated to Occupational Health Services (N=33)

Audit	N (%)	Frequency	Outcomes	Follow-up
Yes	31 (94%)	Weekly = 1 (4%)	Internal only* = 7 (23%)	Internal only*** = 4 (13%)
		Monthly = 2 (6%)	External only** = 5 (16%)	External only**** = 2 (6%)
		Annually = 24 (77%)	Both internal and external = 13 (42%)	Both internal and external = 3 (10%)
		Every two years = 4 (13%)	No sharing of outcomes = 6 (19%)	No follow-up initiatives = 22 (71%)
		No repeat audits = 0 (0%)		
No	2 (6%)			
*shared with employing organisation **shared with organisation(s) outside of employing organisation ***contributing into quality improvement initiatives of employing organisation ****contributing into quality improvement initiatives with organisation(s) outside of employing organisation				

Discussion

The main finding from this project was that the majority of physiotherapists affiliated to occupational health services were involved in clinical audit practice. This is consistent with the clinical audit practices of occupational health physicians and nurses (Lalloo et al., 2016; Verwoerd, 2004). Of those physiotherapists undertaking clinical audit practice most did so annually. This is in keeping with the Safe Effective Quality Occupational Health Service

(SEQOHS) accreditation standards in the UK which require occupational health services including those affiliated to them to have an annual clinical audit cycle plan (SEQOHS, 2018).

The majority of physiotherapists shared the outcomes of their clinical audit with both their employing organisation and with organisations outside of their employment. Informal feedback at the end of the conference revealed that physiotherapists shared their outcomes internally during team development and training sessions, and in professional domains such as conferences and peer-reviewed publications for audiences external to the employing organisation.

The majority of physiotherapists did not contribute their clinical audit outcomes into any quality improvement initiatives. Once the outcomes have been defined and disseminated, contributing them into relevant quality improvement initiatives is required to ensure that broader healthcare processes and structural deficiencies are identified and a sustainable action plan for improvement is developed and implemented (Johnston et al., 2000). The strength of this project is that it is the first to evaluate the clinical audit practices of physiotherapists affiliated to occupational health services in the UK. A main limitation was the small sample size despite the convenient access to a wide number of physiotherapists at the conference.

Conclusion

In conclusion, this project serves as an introduction to understand the clinical audit practices of physiotherapists affiliated to occupational health services. The majority of participants were involved in clinical audit practice and were mainly carried out annually. Very few physiotherapists contributed their outcomes into quality improvement initiatives. A future project is needed to understand the barriers faced by physiotherapists to identify broader quality improvement initiatives and how occupational health can support physiotherapists affiliated to their services complete the full clinical audit cycle. Occupational health services should also encourage physiotherapists affiliated to them to contribute their outcomes into broader quality improvement initiatives so that the full audit cycle can be completed.

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Introduction to Imagining Radical Inclusivity in Work & Learning

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The 'Imagining Radical Inclusivity in Work and Learning' forum was held on the 27th of May 2022 to explore how inclusive principles are being used to frame work-centred learning and to encourage debate about the distinctive challenges facing academic practitioners, researchers and students/learners who work in this field. The theme addressed current policies and the emerging curricula for work-integrated learning programmes. The forum authors embodied a wide range of topics including new ways of working that advocated practitioner-led critique; shared experiences of post-pandemic practice; research surrounding social mobility; implications for learning in the new economy; leadership for change; political and policy imperatives; socio-cultural realities informing educational provision; and inclusive foci within degree apprenticeships.

In the first keynote Mandy Crawford-Lee, University Vocational Awards Council (UVAC), presents 'Access, Participation and Levelling-Up in Technical Education, including Higher and Degree Apprenticeships' where she outlines the strategic aims for UVAC to champion decisive work-integrated education policy and practice within the United Kingdom. Sarah Scowcroft, with Ricardo Barker and Syra Shakir, Leeds Trinity University, introduce an innovative and provocative storytelling toolkit to showcase equality, diversity and inclusion (EDI) issues within the British Values components of the degree apprenticeship in 'Using Film and The Aftermath Debate to Tackle Racism'. Louise Sutton, Consalia Ltd, Yan Mao and Paula Nottingham, Middlesex University, refer to the value specialist providers, employers,

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apprentices and university educators bring about collective engagement in 'Exploring the use of learning communities of practice within a degree apprenticeship through university and partnership provision while incorporating the use of inclusive principles and practice'. In 'Reconsidering negotiated WBL in the digital age' Stan Lester discusses how the use of online-mediated designs and artificial Intelligence might open up access for post-covid work-based higher education. Rebecca Pratchett and Sara Galletly, University of Swansea, demonstrate the strength of responsive and collaborative tuition when considering the student experience of health practitioners in 'Putting the human first: challenging the student-centred approach to work and learning on the covid frontline'.

The second keynote, Anita Walsh, Birkbeck University of London, outlines the defining the features of recognition of prior learning (RPL) and challenged the thinking around effective 'initial assessment' for RPL, particularly in the context of degree apprenticeships. Louise Oldridge and Joanna Booth, Nottingham Trent University, appraise the experience of mature and senior professional learners in 'I'm doing it for me': Supporting the experiences of 'upskillers' on the Chartered Manager Degree Apprenticeship'. Extending the topic of RPL, Helen Pokorny, University of Hertfordshire, presents thoughtful evidence for theorising 'fast-tracked' learner experience in 'Recognition of Prior Learning (RPL) as a specialised pedagogy: inclusion and Degree Apprenticeships'. Finally, Elda Nikolou-Walker, Middlesex University, examines new ways of rendering the work and learning context and connections in 'International Dimensions Of Mediation /Inclusivity & The Workplace'.

The forum abstracts reflect the importance of practitioner led scholarship and the role that self-organising communities play in leading knowledge exchange. We would like to thank the authors for providing their abstracts to a wider audience in this journal. Emerging in disrupted circumstances during Covid-19, the topics respond to the need for a continued critical reframing of work-integrated practice and the importance of social mobility and RPL in designing inclusive practice for work and learning. The publication of these abstracts is to be followed by further writing within this journal and journals such as *Higher Education, Skills and Work Based Learning* (UVAC).

Keywords: inclusivity, work-integrated learning, degree apprenticeship, recognition of prior learning, research, knowledge exchange, writing

Keynote: Access, Participation and Levelling-Up in Technical Education, including Higher and Degree Apprenticeships

MANDY CRAWFORD-LEE *

Chief Executive, UVAC, UK

I will be exploring how UVAC rejects a blinkered approach that focuses on social mobility measures in isolation. Instead, we argue that recommendations for supporting social mobility and levelling up must be determined in the context of the role and purpose of Apprenticeship in increasing productivity, supporting diversity in the workforce and enabling our public sector employers to recruit and train the nurses, police constables and social workers they need. The role of Apprenticeship in the Levelling Up Agenda should also be supported nationally and developed locally in this context. UVAC has called on Government to adopt an ambitious approach. Instead of seeing Apprenticeship as a programme primarily for young people to enter lower level jobs, we argue that Apprenticeship should be an aspirational all age programme that supports individuals from all backgrounds to gain the high productivity craft, technical and professional jobs the economy needs. Crucially, this means substantially more has to be done to support individuals from more disadvantaged backgrounds to access higher level Apprenticeships. Among other measures, UVAC proposes ensuring Apprenticeships at all levels form part of a skills ladder and that apprentices unambiguously gain the knowledge and skills required to progress in their careers.

Keywords: UVAC, Apprenticeships, Levelling, Skills, Access

Biography

Mandy has 30 years' experience of leading and negotiating skills policy, strategic planning and performance management in economic development, vocational education and training reform. She is a sound and respected resource for those involved in the development and

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delivery of apprenticeships at the higher level having led national policy, managed the Coalition Government's successful Higher Apprenticeship Fund and revised the Specification of Apprenticeship Standard in England (SASE) leading to the opening up of pathways in higher level learning for apprentices beyond Level 3 and into a work-based route through to professional, senior technical and managerial occupations and, where appropriate, professional accreditation.

Having worked extensively with government departments, providers in further education, higher education institutions, awarding organisations, professional bodies and public and private sector employers, Mandy has developed effective business and commercial partnerships. Mandy specialises in research, leadership of strategic projects and in skills policy advice, development & implementation including advocacy and lobbying. Higher and degree apprenticeships and higher technical, professional education and skills are Mandy's fields of interest.

Having worked with the University Vocational Awards Council (UVAC) since 2012, both inside and outside of Government, Mandy became its director of policy and operations in 2017 and, in October 2022, its first female chief executive. UVAC on behalf of its 80+ university members, has been championing Degree Apprenticeships since their introduction, and the value of vocational education for over twenty years and is regarded as the most authoritative voice on all strategic and operational aspects of higher and degree apprenticeships in England.

Using Film And The Aftermath Debate To Tackle Racism

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And

RICARDO BARKER *

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And

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School of Children, Young People and Families, Leeds Trinity University, Leeds, UK

Using Film and The Aftermath Debate to Tackle Racism, when inducting new Degree Apprentices on to their programme of study at University within the introduction of Equality, Diversity and Inclusion and its importance within the workplace. The first step is accepting there are problems, then doing something about it. This training is to be used alongside the film 'Re:Tension'. It clearly outlines the role and responsibility of Peers in accepting the existence of racism, then acting on this because they know it is wrong and challenging others who perpetrate discrimination and enforce the silence upon individual people of colour in not speaking out about their experiences.

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OUTLINE

The film 'Re: Tension' was produced and directed by Ricardo Barker, Senior Professional Practice Fellow in Media at LTU as part of raising concerns over racial discrimination at university. This was a piece of work Ricardo had proposed to the university's Race Equality Charter Partnership (of which both Ricardo and Syra Shakir are key members).

Syra Shakir Senior Teaching Fellow in the Institute for childhood and education collaborated with Ricardo Barker to design and develop a Resource Toolkit to be used with the film to provide a formal training package on tackling racism in higher education and our response to the issues raised within the film.

Sarah Scowcroft, Senior Work Based Learning Tutor and Programme Lead for The Supply Chain Leadership Professional Degree Apprenticeship within the Centre for Apprenticeships, Work Based Learning and Skills at Leeds Trinity University identified how this film and toolkit could be utilised with new apprentices and has worked with Syra and Ricardo to implement this.

During the session introducing Equality, Diversity and Inclusion, the film is screened and this then launches into the key role and responsibilities of peers, managers and policy makers within the apprentice's organisations and their reactions to reports/ disclosures/ experiences of racial discrimination. They are then asked to reflect on what they have learnt and experienced in the session as well as reflect on their organisation's strategies, policies and procedures in relation to EDI and whether they are adequate, as well as suggest ways as to how these can be improved based on the discussions which have taken place during the session with their peers.

The toolkit which has been developed includes a Model/ theory which illustrates and epitomises the position of a person of colour in being trapped into this 'Forced Silence'; not being able to speak out about their experiences for fear of a hostile reaction and of painful repercussions. The theoretical model outlines the multiple levels of discrimination and again reinforces that change can only occur if we address the issues at the Peer level first, those who surround the individual person of colour, before then affecting change at the university level. Only by creating fractures at these levels, can any change ever take place at other levels; e.g. the Community and Wider Society. The focus of the training is to put the onus on everyone else. the Peers who surround the person of colour and moving away from the typical rhetoric; it is always the abused person who has to report, speak out and be the responsible for the actions of others essentially.

Keywords: degree apprenticeship, film, racism, equality, diversity and inclusivity (EDI)

Exploring the use of learning communities of practice within a degree apprenticeship through university and partnership provision while incorporating the use of inclusive principles and practice

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And

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And

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Learning communities and communities of practice (CoPs) are important aspects of the degree apprentice (DA) experience within higher education. DA programming differs to mainstream higher education programmes as the apprentices are 'employees' that spend most of their week working within an organisational setting. DAs in the United Kingdom are formally set 20% 'off the job' learning hours that include tuition as well as designated studies directly related to a job roles' knowledge, skills, behaviours and values.

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This presentation looks at how concepts of learning within communities and inclusive practice have been nurtured within a DA programme to develop sustainable curricular and extra-curricular elements. As a part of ongoing research being undertaken using the BSc (Hons) Professional Practice in Business to Business Sales DA, this presentation focuses on how academic providers and partners work together to deliver inclusive tuition while considering the importance of learning communities of practice that must consider participation of employers and professional organisations. Inclusive practice includes requirements outlined in the new university strategic plan and in the Apprenticeship Standards. Emerging findings from recent apprentice/student questionnaires have indicated that apprentices, especially Generation Y and Z (McCrintle, 2014), are interested in how the providers might incorporate their insights about inclusive practice into their studies and professional practice.

The presentation includes reflections from the current Programme Leaders from Consalia Ltd. and Marketing Branding and Tourism and the past Programme Leader (Education) to consider practical recommendations that could be adopted within the learning communities of practice from a Sales area of practice perspective and deliberates on what more needs to be done to create a dialogue that promotes inclusion and diversity (CIPD, 2022) within the university context.

Keywords: degree apprenticeship, university partnership, sales, inclusivity, apprenticeship standards, curriculum

Reconsidering Negotiated WBL In The Digital Age

STAN LESTER *

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The introduction and expansion of Degree Apprenticeships, and higher-level apprenticeships more generally, has had a positive effect on widening access to professional and organisational careers as well as in some fields to progression within professions (Lester & Bravenboer 2020; Lillis & Bravenboer 2022). However, as discussed by Talbot et al (2019) this has been accompanied by a decrease in employer- and individually-negotiated programmes. The reduction in negotiated work-based learning (NWBL) opportunities and decline in heutagogically-based higher education raises questions about what opportunities have been closed down, for whom, and how these might be revisited.

The development of NWBL in the 1990s and 2000s was fairly well-studied (e.g. Duckenfield & Stirner 1992, Stephenson & Saxton 2005, Lester & Costley 2010). These studies indicated that the main client groups for NWBL were typically different from those traditionally associated with either full-time higher education or apprenticeships. Learners were typically adults with substantial work experience (if sometimes in insecure or marginal work), sometimes self-employed, and whose ambitions were often more associated with development within a broad role, business or organisational development, or following an individual career than formal progression into or within a profession or occupation. The need for individual or firm-specific learning is also supported by more economically-focussed studies such as Burgoyne et al (2004) for managers in small firms. While there has been some use of apprenticeships to fill these gaps, the research quoted suggests that programmes based in preset standards and

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curricula are unlikely to be a good substitute for those in which the focus is negotiated and individually or locally driven. On balance there are areas such as progression from assistant-type to professional roles (e.g. teaching assistant to teacher, healthcare assistant to nurse or physiotherapist) where apprenticeships have more to offer, and others such as general management or technical development programmes where they may be able to act as substitutes depending on the level of flexibility needed.

NWBL can be regarded as a 'disturbing practice' compared with traditional full- and part-time degree courses (Boud 2001), and it necessitates a 'realisation' or facilitative rather than a 'delivery' approach (Lester 2002). A barrier to its sustainability is the cost associated with negotiation and support for individual learning. Early attempts at using digital means to streamline some of this – most notably the Ufi-Learndirect Learning through Work initiative 20 years ago – were only partly successful, and focussed on developing a programme outline and learning agreement rather than supporting the later stages of the programme. Advances in digital technology and in its accessibility, and its widespread (if not always well-executed) use for online learning during the coronavirus pandemic (e.g. Lester & Crawford-Lee 2022), suggest a way forward. There appears to be potential to use 'intelligent' and accessible digital platforms to provide a number of benefits including:

- *Making online-mediated NWBL more inclusive by using universal design principles (e.g. Burgstahler 2021) and by considering accessibility issues in relation to learners personally and to their (workplace and home) learning environments.*
- *Making NWBL more cost-effective by the wider use of digital learning communities, online tutor meetings and digital resource networks. These factors may also improve accessibility for some learners, though for others a lack of face-to-face contact can be a barrier.*
- *Expanding learning-from-work opportunities beyond those provided by a physical workplace, for instance through distant projects, collaboration and consultancy.*
- *Further integrating academic and workplace learning, both through online means and through the use of other digital technologies such as augmented and mixed reality.*

Advances in artificial intelligence, particularly intelligent tutoring systems (Schiff 2021), are also likely to improve the capacity to provide individualised support throughout the process before one-to-one interaction becomes needed. On the other hand there are challenges involved in extending the use of digital technologies in NWBL including developing genuinely effective learning communities across disparate groups of learners, and managing learners' needs for support as they experiment with unfamiliar technology.

Keywords: negotiated work-based learning, Ufi-Learndirect, degree apprenticeships, digital technology

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Putting The Human First: Challenging The Student-Centred Approach To Work And Learning On The Covid Frontline

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At Swansea University, we provide part-time work-based learning programmes to registered healthcare professionals with at least 2 years' experience in healthcare. At the outset of the pandemic, our learners were thrown onto the frontline of the biggest public health crisis of the modern era. Many were redeployed to new roles, trained to manage critically ill patients, and manage new teams in new workplace settings. All the while, their wellbeing suffered as they worked long hours in covid-positive environments, living in fear of carrying the virus home to their family. Annual and study leave were cancelled across NHS Wales. To summarise, they had every reason to quit their studies and so we waited for the suspension requests to come in.

Yet, the opposite happened. Far from being disposable, their studies became a lifeline. Supervision meetings became their only opportunity to decompress outside of the workplace. It became a sanctuary, a space to reflect on their 'unprecedented' situation and for personal and professional growth. As a result, our approach changed, adapting to the evolving needs of our learners.

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Within this talk we will critically reflect on our new approach, reviewing the ways in which our practice changed to provide a more inclusive learning environment for our learners on the covid frontline. We will outline the new humanistic approach we adopted and discuss how compassionate leadership played a key role in supporting both our learners and one another. We will discuss the role of both structure and flexibility in inclusive practice when considering how we can best support part-time learners. Finally, we will reflect on our own journey as a team, how our approach to facilitating learning has developed, and how we progress going forward with the human at the centre of everything we do.

Keywords: nursing, covid, humanist approach, flexibility, leadership, part-time learners

RPL: More Than A Tick Box Exercise

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The requirements outlined for RPL, in particular in the context of apprenticeships, can lead colleagues to consider it an administrative process – a tick box exercise.

This is to overlook the role of academic judgement which takes place throughout, and which can be used to include or exclude consideration of valid learning depending on the perspective taken.

Keywords: recognition of prior learning (RPL), academic judgement, apprenticeships

Biography

Anita Walsh joined Birkbeck in September 2005. She joined as a Senior Lecturer in Work-Based Learning, and has recently become a Professor of Work-Based Learning.

Previously Anita was a Senior Lecturer at Kingston University, where she was a member of the University's Academic Development Centre with responsibility for the areas of work-based learning and experiential learning. She was also the Associate Director of the Learning from Experience Trust for a number of years while she has been at Birkbeck.

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Anita is an expert in designing academic programmes which are based on the experiential learning gained through activities in the workplace. In 2009 she was awarded a National Teaching Fellowship for her work in this area. Her main research interest is in the role of experience in learning and in the development of professional expertise, and the pedagogy required to support such learning. Her work is internationally recognised and she has published widely on the need to integrate appropriate learning from outside the academy into the higher education curriculum, basing her arguments on the validity of informal experiential learning and epistemologies of practice. Anita uses her publications and conference papers to encourage more active consideration of the pedagogic and epistemological issues related to a wider recognition of such learning.

Supporting Mature Degree Apprentices

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Whilst existing literature documents experiences of mature students on traditional programmes in higher education (HE), extant literature fails to explore the unique experiences of degree apprentices in both on and off the job training (including academic study). In England, 47% of apprenticeships started in 2019/20 were by people aged 25 and over. Of particular interest are those literature classes as ‘upskillers’, that is apprentices with a diverse range of backgrounds and experience, who are seeking to advance their career through this programme. They tend to be mature students, and in the government’s evaluation of apprenticeships 2018-19 reported lower satisfaction levels than younger apprentices, with lack of support from training providers impacting this figure.

Literature (Fragoso et al, 2013) on mature students generally in HE describes them facing barriers to participation, including paid work, family/caring responsibilities, confidence, institutional and social class concerns. However, care must be taken not to homogenise mature students. Smith et al (2021) explored trajectories into apprenticeships across six universities in Scotland, including ‘upskillers’, and reported mature degree apprentices often

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have more complex support needs and that a larger gap between previous study can lead to imposter syndrome. Research (Fabian et al, 2021) has found that those not specifically recruited as apprentices reported challenges in learning and balancing work-life-study and calls have been made for universities to better understand their experiences.

This paper will report back on initial findings of focus groups conducted with mature degree apprentices on the Chartered Manager Degree Apprenticeship. The outcomes of this exploratory project will provide an opportunity to understand the lived experiences of mature degree apprentices, how similar or different their experiences are to other mature students and identify appropriate support mechanisms. This will act as a basis to inform a more targeted learning and teaching policy, curriculum design and teaching practice.

Keywords: degree apprenticeship, management, upskillers, barriers to participation

Recognition Of Prior Learning (RPL) As A Specialised Pedagogy: Inclusion And Degree Apprenticeships

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Recognition of Prior Learning (RPL) as a specialised pedagogy: inclusion and Degree Apprenticeships. Helen Pokorny, University Campus St Albans. It is interesting to note how the profile of RPL waxes and wanes with initiatives to bring together the world of work and academia. In 2007, HEFCE declared APEL [RPL] a national priority area in the context of provision developed with employers and employer bodies (Kewin et al., 2011). Originally, APEL [RPL] was a key feature of Foundation Degree frameworks. However, to date it remains a marginal practice in Higher Education even though the most efficient and effective route through Higher Education for a large proportion of adult learners would be one that recognises the considerable skills, knowledge and expertise gained through work. Perhaps as Bravenboer (2019) commented ‘...the incentive of meeting the ESFA apprenticeship funding rules will encourage universities to ensure that the entitlement to RPL is placed more centre stage.’

Introducing an individualised process into a system of mass higher education is problematic and RPL has traditionally been developed as an individualistic assessment process. More recently there has been a move to conceptualise RPL as a specialised pedagogy (Cooper et al., 2017; Brenner et al., 2021). Such a conceptualisation can support access to fast-track Degree Apprenticeships by cohorts of experienced learners seeking career development opportunities. It is also a move away from a tick box RPL exercise to that of academic judgements made within a pedagogical framework.

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This presentation discusses how a Degree Apprenticeship open to cohorts of mature learners, provides a specialised pedagogy that not only puts RPL centre stage but also creates a community of learners. For mature learners with complex lives Apprenticeships pose significant potential risks of time and self-esteem. Key to promoting successful engagement and progression has been the strong sense of learner identity gained through the recognition participants get from others as well as from assessors through this process (Pokorny and Fox, 2019).

Keywords: degree apprenticeships, recognition of prior learning (RPL), fast-track apprenticeships, mature learners

International Dimensions Of Mediation /Inclusivity & The Workplace

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This paper will examine the development of concepts and models in Mediation with particular reference to their international relevance and inclusive application in Professional Practice The content of the paper is drawn from the experience and expertise that Mediation as a pedagogical tool can offer, and will be concerned to examine ways in which new thinking and scholarly innovation can be applied in a paid, unpaid, and/or voluntary inclusive, work-based landscape. Mediative tools can offer a learning approach which can help focus on the relevance of the learning to participants in their work (paid/unpaid/voluntary). Thus, the participants can learn methods and methodologies for 'connecting' their (existing and/or potential) employment to wider societal and ultimately global networks and support systems that will improve inclusive delivery within their own professional practice, work-based context.

Keywords: international, professional practice, mediative tools

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