Enhancing Mental Health and Emotional Well-Being: The Impact of Practice-based Research

Introduction to this special issue

SARAH CORRIE [*]

And

CAROL COSTLEY [†]

Middlesex University, London, UK

This collection of posters papers, a webinar and extended abstracts was originally part of a joint symposium between the UK Council for Graduate Education and Middlesex University taking place at Middlesex University on 21st May 2020. The joint event between the UKCGE and Middlesex University was cancelled because of the pandemic yet it is now even more relevant and situationally tied to current circumstances. Some of the abstracts, posters and papers intended for the symposium appear here, in this special edition of the Work based Learning e-journal

With approximately 450 million people worldwide now living with a mental health issue, our collective well-being is one of the most pressing concerns of our time. Scholars and practitioners from a variety of disciplines are examining what needs to occur to enhance emotional well-being at national and global levels and there are exciting opportunities for professional doctorates to exert a significant influence in shaping the knowledge-base and practices of this challenging field.

Professional Doctorates are uniquely primed to undertake research in this area. Doctorates in clinical psychology, counselling psychology and psychotherapy are already helping create a brighter future for those who live with emotional difficulty whilst others with a broader

[*] **Corresponding author:** Sarah Corrie. Email: s.corrie@mdx.ac.uk
[†] **Corresponding author:** Carol Costley. Email: C.Costley@mdx.ac.uk

remit, such as doctorates in education and doctorates in professional studies, are exploring areas that include the contribution of coaching to emotional well-being and interventions for young people. But can we do more? And if so what?

The symposium intended to bring together speakers from a range of disciplines and organisations to explore the topic of emotional well-being and mental health and to consider the contribution that is being made by those undertaking professional doctorates, and those who deliver them. We now do this in the form of this publication. In addition to examples of current research, the publication explores the curriculum, methodologies and supervisory devices that might be particularly helpful for nurturing high impact research and how doctoral pathways can lead to real-world change.

The panel discussion on Enhancing Mental Health and Emotional Well-Being for Students and Staff brought together three individuals talking from varying perspectives. Lucy Holland, vice-President of the Middlesex student union talked from the students' perspectives (including their time during lockdown) and represented the students' point of view with great foresight and experience. Anca Alba from Mental Health Support Service King's College London brought the perspective of staff who support students in their mental health and well-being. Carl Lyons works with staff at Middlesex running sessions to enable well-being for staff across the university and brought a staff perspective. The session facilitated by Professor Sarah Corrie brought about in-depth discussion on the issues and available support for students and staff. Watching and listening to this is a compelling experience.

The poster case studies of doctoral students who are undertaking work in this field will be included digitally on the UKCGE website amongst a collection of impact case studies (see http://www.ukcge.ac.uk/events/icpd-impact-posters.aspx). Posters came from researchers across Middlesex University who are researching in the areas of mental health and well-being. Shirley Allen's work is on how early years teachers may recognise children's mental health issues at an early stage. Nicky Lambert's post doc work recognises and celebrates the personal changes generated by doctoral programmes are equivalent to more traditional outputs. Karen Manville, shows the impact of canine assisted intervention on reducing anxiety, stress and depression. Herbert Mwebe monitors cardiovascular disease risk in people with serious mental illness and bridges a gap for these patients and their physical

healthcare. Jane Obi-Udeaja explores the impact on practice when service users are involved in staff training on the prevention and management of violence and aggression in local NHS mental health inpatient wards.

Then Anca Alba's contribution complements her contribution to the webinar with her preamble on how an integrated approach to supporting students' mental health would allow separate systems and levels of support to connect, communicate and work together to support the student at all levels including academic, pastoral and specialist support level.

The final two contributions are extended abstracts from our two keynote speakers. Vanja Orlans discusses a DCPsych programme and highlights its potential in making a difference to professional, organisational, or social practice, especially the reflexive practice of the researching professionals themselves. She argues that the DCPsych is professional doctorate that enables contextual change. action and useful intervention as a part of the doctoral frame.

David Lane considers the supervision of experienced practitioners who undertake professional doctorates. He notes that there has been increasing interest in how practice is viewed not in terms of individual competence but as part of socio-material practices in the context in which they occur. The idea of considering practices in this way indicates how the practices which inform supervision may also be defined.

This special edition and the planning for the symposium is co-ordinated and facilitated by

Professor Sarah Corrie https://www.sarahcorrie.com/about-me/ and

Professor Carol Costley, https://www.mdx.ac.uk/about-us/our-people/staff-directory/profile/costley-carol

Both from Work and Learning Research Centre, Department of Education, Middlesex University.

Enhancing Mental Health and Emotional Well-Being for Students and Staff: A Panel Discussion

ANCA ALBA [*]

Kings College London, UK

And

LUCY HOLLAND [†]

Middlesex Student Union, UK

And

CARL LYONS [‡]

We Are Conscious, Middlesex staff coach, UK

Youtube link: https://youtu.be/i4jEkg-WjvY

[*] **Corresponding author:** Anca Alba. Email: anca.alba@kcl.ac.uk
[†] **Corresponding author:** Lucy Holland. Email: l.holland@mdx.ac.uk
[‡] **Corresponding author:** Carl Lyons. Email: info@weareconscious.co.uk

Our three panelists discuss issues such as institutional responsiveness, support for staff, the challenges of student loneliness, domestic violence, accessibility to support and stigma.

Anca Alba, *Head of the Mental Health Support Team, Counselling and Mental Health Support Service at King's College London*

Lucy Holland, *Middlesex Student Union, Vice President*

Carl Lyons, *Author and Founder of We Are Conscious*

The session is facilitated by Professors Sarah Corrie https://www.sarahcorrie.com/about-me/ and Carol Costley, https://www.mdx.ac.uk/about-us/our-people/staff-directory/profile/costley-carol

Work and Learning Research Centre, Department of Education, Middlesex University.

Anca Alba, PhD, DClinPsy Head of the Mental Health Support Team, Counselling and Mental Health Support Service at King's College London.

Anca is a Clinical Psychologist and the Head of Mental Health Support in the Counselling and Mental Health Support Service (C&MHS) at King's College London. Anca has worked in the NHS in CAMHS outpatient and inpatient services before joining C&MHS at King's and has experience in working with young people with complex mental health needs.

Lucy Holland Middlesex Student Union, Vice President.

Lucy is the Vice President Art & Creative Industries faculty representing all students within these schools at Middlesex and working closely with the School Voice Leaders on the Middlesex Student Union Executive. Each Student Officer also has particular interests in and responsibilities for other areas of student life and Lucy has a particular role in mental health and well-being.

Carl Lyons Author and Founder of We Are Conscious.

Carl has been a performance coach for over 20 years helping individuals and organisations optimise their health and well-being. He is the author of three highly acclaimed books and has written many articles for publications about self-awareness, personal performance and health. For more information visit: www.weareconscious.co.uk/programmes

If you have any questions for our panelists please send them to Carol Costley c.costley@mdx.ac.uk. Your questions and the responses from the panelists will be sent to you and will appear in the next issue of the journal.

Posters from doctoral candidates across disciplines researching mental health and well being

1. Shirley Allen, Education Department, **Investigating how early years teachers can be supported to engage in integrated working**

2. Nicky Lambert, Department of Mental Health and Social Work, **How working on a Doctor of Professional Studies has redefined the ways that I envisage my role and purpose as a nurse.**

3. Herbert Mwebe, Department of Mental Health, **Cardiometabolic Risk Monitoring in an Inpatient Psychiatric Setting : A Secondary Data Analysis**

4. Karen Manville, Research Student, **Canine Assisted Intervention – the impact of intervention duration on reducing anxiety, stress and depression in Higher Education students: a randomised control trial**

5. Jane Obi-Udeaja, Department of Mental Health and Social Work, **Exploring the impact on practice when service users are involved in staff training on the prevention and management of violence and aggression in local NHS mental health inpatient wards**

Posters also appear here http://www.ukcge.ac.uk/events/icpd-impact-posters.aspx

1. Investigating how early years teachers can be supported to engage in integrated working

SHIRLEY ALLEN *

Department of Education, Middlesex University, London, UK

Children's mental health (MH) has become a more prominent issue during the past decade. Ofsted (2018) assert that children's MH needs are not being sufficiently supported. The DfE's and DH's (2017: 3) Green Paper, 'Transforming Children and Young People's Mental Health Provision' proposed that schools have an important role in identifying children's MH needs 'at an early stage, referring young people to specialist support and working jointly with others to support young people experiencing problems'. This proposal has implications for the efficacy of Early Years (EY) teachers' collaborative working with other professionals, which facilitates a child's access to a range of professional knowledge and skills to support their learning and development (Wong and Press 2012). However, challenges exist to the process of collaborative working and EY teachers' capacity to realise its potential is variable (Nutbrown, 2018). Developing proficiency to collaborate effectively with others requires additional layers of expertise, as well as specialist knowledge and skills associated with particular professional roles (Edwards, 2010).

Employing Bronfenbrenner's (1979) ecological systems theory as a theoretical framework, this research project examines collaborative working in EY provision to inform policy initiatives relating to the professional development (PD) of EY teachers. A qualitative interview study was undertaken that sought the views of EY practitioners and teacher educators about collaborative working and an interpretive paradigm was used to explore the participants' responses (Yin 2016). Research findings indicate the importance of a working environment that promotes open and respectful communication and trusting relationships; encourages innovation in pedagogical approaches and offers PD opportunities

* **Corresponding author:** Shirley Allen. Email: S.F.Allen@mdx.ac.uk

that have relevance to specific contexts of practice. The findings were supplemented by the current evidence base from the literature to suggest recommendations for what a curriculum for EY teachers' PD might reasonably include.

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Preparing the Mental Health practitioners of the future through practice-based research

Middlesex University London

Background

Children's mental health has become a more prominent issue during the past decade. The DfE's and DH's (2017: 3) Green Paper, 'Transforming Children and Young People's Mental Health Provision' proposed that schools have an important role in identifying children's mental health needs 'at an early stage, referring young people to specialist support and working jointly with others to support young people experiencing problems'. This proposal rests on the efficacy of early years teachers' collaborative working with other professionals, which facilitates a child's access to a range of professional knowledge and skills to support their learning and development (Wong and Press 2012). However, challenges exist to the process of integrated working and early years teachers' capacity to realise its potential is variable (Nutbrown, 2018). Developing proficiency to collaborate effectively with others requires additional layers of expertise, as well as specialist knowledge and skills associated with particular professional roles (Edwards, 2010).

Purpose of Study

Employing Bronfenbrenner's (1979) ecological systems theory, this research project focuses on early years teachers' collaborative practice in integrated working.

Aims and Objectives

The project aims to investigate how early years teachers can be supported to participate in integrated working and manage challenges they may encounter when engaged in this activity .

Method

A qualitative interview study was undertaken that sought the views of practitioners and teacher educators about integrated working. An interpretive paradigm was used to explore the participants' responses (Yin 2016).

Data Analysis

Key themes emerged from thematic analysis of the participants' responses in the interviews following 'deep and prolonged data immersion, thoughtfulness and reflection' (Braun and Clarke 2019: 591)

Findings

Research findings indicate the importance of a working environment that promotes open and respectful communication and trusting relationships; encourages innovation in pedagogical approaches and offers professional development opportunities that have relevance to specific contexts of practice.

Conclusion

The project identifies three nested layers of support for early teachers' engagement in integrated working:

- Professional development
- School culture and mentoring
- Education policy

Investigating how early years teachers can be supported to engage in integrated working

Shirley Allen, Middlesex University

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2. Feeling to Thought, Thought to Action: a Learning Journey

NICKY LAMBERT[*]

Department of Mental Health and Social work, Middlesex University, London, UK

Nicky will be talking about the journey her D.Prof has taken her on, the opportunities and challenges it has presented and the progress made. She will talk about the types of learning that happen in a D.Prof and the ways that it can be a life-changing experience. She will be exploring this topic from the perspective of health and wellbeing, and considering the learning journey in terms of both the measurable and the hidden outputs that result from undertaking this form of study.

Academic productivity is often seen as the entire 'point' of learning at this level - however it is just one aspect of the journey. Outputs that impact practice are another outcome and one of ways that D.Profs are differentiated from other types of programme. This work has generated tangible benefits to the health and wellbeing of others and in addition, professional growth has occurred over the timespan of this project. Nicky will describe the ways the D.Prof has redefined the ways that she envisages her role and purpose as a nurse.

Of equal value, in terms of wellbeing, are the personal changes generated by the programme. Nicky will discuss the impact of evolving alongside your D.Prof, of getting through the bleak times and finding your voice.

Notes on contributor

Nicky Lambert

Nicky is an Associate Professor (Practice) at Middlesex University, where she is Director of Teaching and Learning for Mental Health and Social Work. She is registered as a Specialist Practitioner (NMC)

[*] **Corresponding author:** Nicky Lambert. Email: n.lambert@mdx.ac.uk

and is a Senior Teaching Fellow (SFHEA). She is also a co-director of the Centre for Coproduction in Mental Health and Social Care.

Nicky has worked across a range of mental health services both in the UK and internationally supporting staff and practice development in acute and mental health trusts, councils, businesses and charities. She is also a Trustee for West Hampstead Women's centre. Nicky has a professional Twitter feed: https://twitter.com/niadla (**@niadla**) and is keen that all people with an interest in mental health engage together as a community to support good practice and challenge discrimination. She has teaching and research interests in women's health, physical and mental health, co-production, social media and health education (**ORCID iD** 0000-0001-8785-4719)

Her Dprof journey began with a chance encounter with someone crying in a hospital corridor and is still unfolding. Her research began looking at the Experiences of Women with Mental and Physical Health Issues in Accessing and Receiving Care - a topic well within the remit of a mental health nurse. However it's taken her out of her comfort zone and on a journey as an educator, a writer, a broadcaster, a trustee, a spokesperson, and an activist.

Middlesex University London

Enhancing Mental Health and Emotional Well-Being: The Impact of the Professional Doctorate

Nicky Lambert: *Assoc. Prof. (Practice) at Middlesex University, and Dir. of Teaching and Learning for Mental Health and Social Work.*

I am registered as a Specialist Practitioner (NMC) and a Senior Teaching Fellow (SFHEA). I am also co-director of the Centre for Coproduction in Mental Health and Social Care

This poster explores how working on a D.Prof has redefined the ways that I envisage my role and purpose as a nurse.

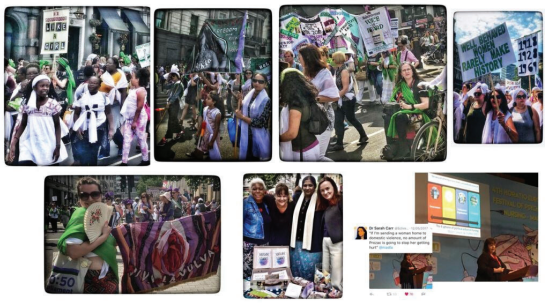
Academic productivity is often seen as the 'point' of learning at this level - arguably it is just one aspect of the journey. Outputs that impact practice are another outcome and one of ways that D.Profs are differentiated from other types of programme. My own work has generated tangible benefits to the health and wellbeing of others and in addition, it has also supported my professional development and this has linked symbiotically to personal growth which has occurred over the timespan of this project.

This poster was adapted from a talk which contends that in terms of wellbeing, recognising and celebrating the personal changes generated by the programme are equal value to the traditional outputs.

Getting through the bleak times

Developing your critical resilience and understanding your strengths and learning needs is key to any successful professional career. These are skills often honed from the rigours of a long term applied project.

- Build links to your community of learning and get a support team in place.
- Expect there to be low points and plan for them. Learn from other people's coping strategies.



Finding your voice.

- **Engage with your research community.** Try to go to conferences (in person or follow along online), attend workshops, special interest groups... go anywhere practitioners from your area of interest meet.
- **Write whenever possible:** Blogs, articles, journalistic articles as well as peer reviewed work.
- **Say yes !** Present your work as often as you can, and for as many different audiences as possible - talk to the public as much as to your peers - use podcasts, festivals, talks.
- **Use Social Media:** link your tweets/Instagram etc. to your blogs, use infographics to make your ideas accessible, use platforms like The Conversation to connect your work to current concerns.
- **Don't be afraid to speak up on your topic** ... you have earned your expertise!

Evolving alongside your D.Prof.

My D.prof journey began with a chance encounter with someone crying in a hospital corridor and is still unfolding. My research looks at the Experiences of Women with Mental and Physical Health Issues in Accessing and Receiving Care - a topic well within the remit of a mental health nurse.

However, my learning quickly removed me from my comfort zone and took me onto a journey with many new roles: as an educator, a writer, a broadcaster, a trustee, a spokesperson, and an activist. All of which have been equally valuable outputs.

Nicky has worked across a range of mental health services both in the UK and internationally supporting staff and practice development in acute and mental health trusts, councils, businesses and charities. She is also a Trustee for West Hampstead Women's centre.

Nicky has a professional Twitter feed: https://twitter.com/niadla (@niadla) and is keen that all people with an interest in mental health engage together as a community to support good practice and challenge discrimination.

She has teaching and research interests in women's health, physical and mental health, co-production, social media and health education

(ORCID iD 0000-0001-8785-4719)

3. Monitoring Cardiovascular disease risk in people with serious mental illness (SMI) in inpatient mental health settings

HERBERT MWEBE *

Department of Mental Health, Middlesex University, London, UK

Serious mental illness (SMI) is associated with mortality rates up to three times higher than those in the general population. Severe mental disorders (such as schizophrenia, psychotic depression, bipolar and schizoaffective disorders) are debilitating and have complex symptoms (i.e. hallucinations, delusions, social dysfunction) which can be life-limiting. While increased suicide rates contribute to the high mortality rates in SMI), most of the increased mortality is due to natural causes, especially cardiovascular disease (CVD) and other chronic diseases (diabetes, respiratory-related complications, cancers). Life expectancy in SMI has been reported to be reduced by up to 25 years than in the general population. Cardiovascular risk is greatly increased in people with serious mental illness with cardiovascular disease contributing to increased mortality and mortality rates in this patient population than other physical conditions. People with SMI are less likely to be offered physical health monitoring checks for cholesterol, glucose checks, blood pressure, pulse, weight measures and others. This focus of my Dprof research project is to explore the practice of mental health nurses in the monitoring of CVD risk factors in people with SMI in inpatient settings and their role in improving physical health needs of mental health service users.

* **Corresponding author:** Herbert Mwebe. Email: h.mwebe@mdx.ac.uk

Notes on contributor

Herbert Mwebe

Herbert is a senior lecturer in mental health in the Department of Mental and Social work at Middlesex University. Herbert has teaching and research interest in improving physical health needs in people with serious mental illness and psychopharmacological interventions in adult mental health settings. The aim of Herbert's current doctoral research project is to explore the practice of mental health nurses in the management of CVD risk in people with serious mental illness.

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CARDIOMETABOLIC RISK MONITORING IN AN INPATIENT PSYCHIATRIC SETTING: A SECONDARY DATA ANALYSIS

Herbert Mwebe: Senior Lecturer; Department of Mental Health; School of Health & Education, Middlesex University

1. BACKGROUND

Poor physical health and multi-morbidity is common in SMI population. While preventative approaches (weight monitoring, smoking cessation, age appropriate screening interventions) in the developed countries has helped to lower CVD mortality/risk in the general public, in people with SMI the screening/monitoring of risk factors for metabolic disease and CVD is not always adequately and regularly done. The excess of death (50%>) in SMI is due to cardiovascular disease (CVD) and other physical conditions including diabetes, respiratory disorders. Mental health nurses are the largest frontline staff group and play a vital role in facilitating timely and opportunistic screening and monitoring activities to address cardiometabolic risk in SMI.

2. OBJECTIVES

- Explore MHNs' practice in the management of CVD risk in people with SMI
- To undertake a secondary data survey analysis of healthcare records allowing a general exploration of the practice regarding the recording of cardiometabolic risk in inpatients.
- Explore barriers to the management of CVD risk and make recommendations in relation to CVD risk management in people with SMI.

3. DATA SOURCES

A structured Ms Excel extraction data tool informed by best practice guidance (RCP,NHSE,CQC,LESTER TOOL, Accreditation for Inpatient Mental Health services (AIMS) was developed and used to extract electronic patient data on screening and monitoring of CVD risk factors across 10 inpatient psychiatric wards. A target sample of 245 electronic records from 10 inpatient wards of patients discharged between 25.8.2018-13.2.2019 with a length of inpatient stay> 40 days was examined. Simple random sampling (Ms excel random number generator) was used to select a final sample of 120 electronic records from a list of 245 RIO numbers based on above inclusion criteria and patients;

- Aged between 18 -80 years
- Currently taking psychotropic medication
- With a diagnosis of one of the following conditions psychosis, paranoid schizophrenia, major depression, dementia, bipolar disorder, mania, schizoaffective disorder & eating disorder (ICD codes(F29X;F200;F600;F312;F32.3;F323;F001;F259;F220;F42.9;F50.01/2;F31.2;F33.3;F323;F332;F23;F60.3;F239)

4. STUDY ELIGIBILITY & ANALYSIS

- All of the 120 records were subjected to a manual search to examine the quality/frequency of recording in terms of screening at baseline within 24 hours, monitoring review within 3 months of admission and evidence of follow-up interventions of CVD risk parameters (blood pressure, smoking and alcohol checks, weight/BMI, waist circumference (WC) (lipid and glycemic checks (baseline within 7 days).
- Descriptive analysis was performed in MS Excel.

5. STUDY RESULTS

Smoking

- **38%** (46 of the 120 patients)not assessed @ baseline; **61%** completed
- Improved recording & monitoring review evident within 3 months of admission (**83%**)
- **55%** recorded current smokers
- Only **17%** offered intervention; No intervention (**32%**)

Alcohol

- **37%** not assessed @ baseline; **62%** completed
- Improved recording & monitoring review evident within 3 months of admission (**81%**)
- **54%** recorded current users of alcohol
- **33%** (problematic use) but only **10%** received intervention; No intervention (**23%**)

BMI & Waist circumference (WC)

- **26%** not assessed @ baseline;
- Improved recording & monitoring review of BMI evident within 3 months (**98%**)
- **82%** did not have a consistent weekly weight recording completed.
- **48%** recorded with a BMI>25kgm2; only **26%** Vs **20%** were offered intervention
- **95%** did not have a recorded **WC** in 3 months of admission;
- **44%** of patients with BMI>25kgm2 did not have a recorded **WC**

Blood Pressure

- **10%** not assessed @ baseline; **86%** completed
- Improved recording & monitoring review evident within 3 months of admission (**100%**)
- **86%** of patients had SBP<140
- **14%** of patients had SBP>140mmhg
- **13%** of patients with SBP>140mmhg were offered an intervention-

Blood lipids

- **41%** not assessed @ baseline; **36%** completed
- Improved recording & monitoring review evident within 3 months of admission -**76%**
- 12 patients had abnormal **cholesterol** levels
- **11 of the 12 patients** were offered intervention

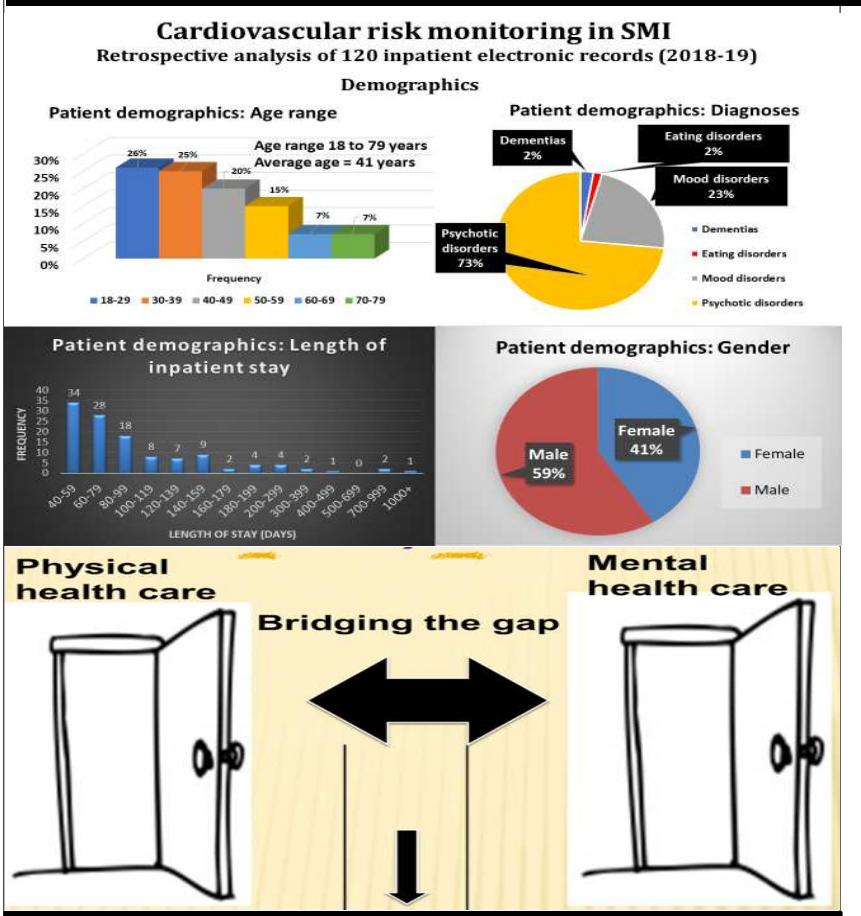
Blood glucose

- **23%** not assessed @ baseline; **16%** refused; **61%** completed
- Improved recording & monitoring evident within 3 months of admission- **(82%)** however ;
- **15%** of patients did not have a recorded glucose check at 3 months review
- **18%** of patients with diabetes/abnormal glucose levels were offered intervention
- 16% not recorded/refused

ECG monitoring

- **95%** had an ECG done in 3 month of admission; **3%** not done; **2%** refused
- All pts (**6%**) with a recorded abnormal ECGs had an intervention
- **25%** of pts over 50s had a recorded ECG completed
- **70%** of pts under 50s had a recorded ECG completed
- **38%** of female and Male (58%) pts had a recorded ECG

6. DEMOGRAPHICS



IN INDIVIDUALS WITH SEVERE MENTAL ILLNESS

7. DISCUSSION

The Royal College of Psychiatrists and NICE guidelines (and Lester UK adaptive version tool kit) provides guidance for clinicians relating to assessment and monitoring of cardiometabolic parameters in individuals with SMI taking psychotropics. As a minimum, the guidance recommends that individuals with SMI should have a physical health assessment at baseline and at least once after 3 months including CVD risk management (and personal history of CVD. There was an average of 61% compliance of the documentation of data on all individual parameters at baseline and monitoring review at least once (86% compliance) across the parameters (smoking, alcohol, BMI, BP, Glucose and lipid, ECG) checks within 3 months of admission. 82% of the inpatients did not have a weekly weight record completed in the first six weeks. 95% of the inpatients did not have a recorded (WC) within 3 months of admission and 44% of pts with BMI>25kgm2 did not have a recorded WC.

Lifestyle factors (smoking, unhealthy diets, alcohol use) need to be addressed collaboratively with patients, follow-up interventions following screening of unhealthy lifestyle behaviour was not always evident in the nurse-patient interactions. All of these modifiable risk factors most commonly reported in SMI are associated with physical medical complications e.g cancers, liver disease, obesity, mental illness, diabetes, hypertension. Mental health nurses and other mental health professionals should actively take a lead role to educate patients, monitor side effects of medications and monitor physical health and identify individual risk factors. Staff should be encouraged and prompted to use the Lester UK adaption tool to screen and monitor physical health risk parameters at baseline and during treatment

8. LIMITATIONS

Clinical data was often poorly recorded, dedicated physical health forms on RIO(Healthcare record systems) were often empty or partially completed. Nearly 95% of the data captured was done manually and extracted from the progress notes view on the RIO system. This presented challenges as the data was not centralised and rather cumbersome to filter from copious amount of patients notes which were not relevant to the study objectives.

9. CONCLUSIONS

The current practice of assessment and monitoring for CVD risk in the study setting appear to be in line with current guidance and standards of physical health monitoring of individuals with SMI. However, as per our findings, further improvement in relation to monitoring of all the parameters is still needed. At the time of the study, the NHS site where this study took place was undertaking a review of physical care practices including development of more robust and responsive physical care electronic recording systems to improve recording across inpatient and community setting. This is a much welcome intervention by the Trust because informal feedback from inpatient staff revealed various challenges staff experienced when using existing recording systems in place.

Canine Assisted Intervention – the impact of intervention duration on reducing anxiety, stress and depression in Higher Education students: a randomised control trial

Karen Manville, PhD Student
Middlesex University

Dr. Gemma Reynolds, Director of Studies
Middlesex University

Dr. Mark Coulson, Second Supervisor
University of East Anglia

Background:

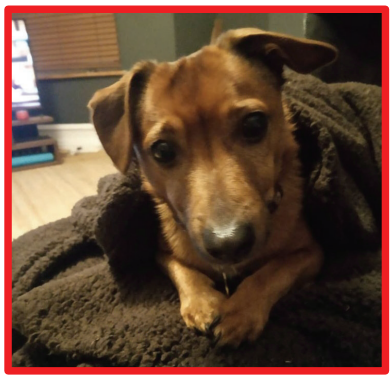
The number of Higher Education (HE) students experiencing some form of mental health issue has increased over the last decade (Thorley, 2017) significantly hindering academic success (Eisenberg, Golberstein, & Hunt, 2009). There are a number of reasons why students may face more issues during their time in HE, including increased tuition fees, living costs, a lack of employment, with social media pressure and influences also adding to their issues during their time in HE (Richardson, Elliott, & Roberts, 2015). Universities are therefore now more than ever aware of the need for alternative support systems to be in place to support HE students through their time in Higher Education. One way of enhancing student emotional well-being is through canine assisted intervention (CAI, Manville, Coulson, & Reynolds, under review). Interacting with a canine has been found to boost physical health and vitality, provide companionship and sensory stress relief (Headey, Na, & Zheng, 2008; Rowe 2010). Despite published studies exploring CAI in HE students (Barker, Barker, McCain, & Schubert, 2017; Binfet, Passmore, Cebry, Struik, & McKay, 2018), there is limited research focusing on HE students with both an experimental and a control group in a range of CAI durations.

Current Study:

Critically, there is a lack of empirical research exploring the parameters of what exactly entails an effective canine intervention session. One such lack of detail involves how long the session must last in order to be most effective. While Adamle, Riley & Carlson (2009), Binfet & Passmore (2016) and Shearer, et al. (2016) all applied long periods of CAI in their samples of HE students (20, 45 and 60 minutes respectively) other research has demonstrated effectiveness even with shorter durations intervention time (Buttelmann & Römoke, 2014), therefore indicating discrepancies regarding the optimum CAI duration.

The current study therefore aims to establish the optimal duration of CAI in improving emotional well-being in HE students. In addition participants interaction levels and canine traits will be measured to explore whether there is an impact on the influence of CAI on mental health.

Hypotheses:
Based on previous research demonstrating that 5 minutes (Buttelmann & Römoke, 2014) and 10 minutes (Manville, Coulson, & Reynolds, under review) CAI duration had a positive effect on HE student mental health, it is hypothesised a shorter duration intervention will have a positive effect on well-being, stress, anxiety and depression.



Elvis and Dahlia, our canine partners.

Results:

1. 4(group: 2-minute, 5-minute, 10-minute CAI vs control) × 2(phase: pre vs post) mixed ANOVA was carried out in all measures.
2. Multiple regression was carried out to explore canine traits and interaction types as predictors of anxiety, stress, depression and well-being.

Analysis demonstrates CAI was effective pre to post-intervention in the 2-minute, 5-minute and 10-minute CAI groups in comparison to a no significant control group in reducing,
1). Anxiety as measured by the VAS and STAI
2). Depression as measured by the BDI
3). Stress as measured by the VAS
4). No significant effect on stress was measured by the PSS or well-being as measured by the WEMWBS
5.) Canine trait and interaction type was found to be a predictor on the increase in Well-Being levels in the 10-minute CAI groups
6.) Interaction type was found to be predictors of stress relief in the 2-minute CAI group

Most importantly it was demonstrated there was no significant difference in CAI effects found between either the 2-minute, 5-minute or 10-minute CAI groups.

Figure 1a

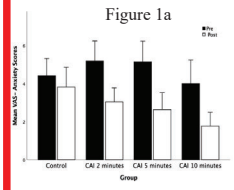


Figure 1b

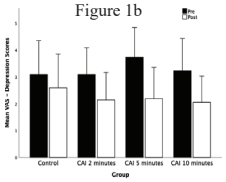
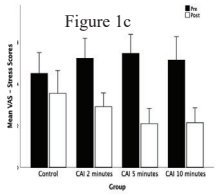


Figure 1c



Figures 1 a, b and c demonstrate pre and post VAS Anxiety, Depression and Stress scores in the CAI 2-minute, 5-minute and 10-minute groups and the control group.

Method:

88 HE participants were randomly assigned to either the 2-minute, 5-minute or 10-minute canine intervention groups or the 10-minute control group.

Exclusion criteria included a fear of, or allergy towards dogs and if participants had ever harmed an animal.

1). Pre intervention: all participants completed three visual analogue scales (VAS, anxiety, stress and depression), the State Trait-Anxiety Inventory (STAI, anxiety), Becks Depression Inventory (BDI, depression), Perceived Stress Scale (PSS, stress), The Warwick- Edinburgh Mental Well-being Scale: (WEMWBS, well-being), and an additional 8 VAS measures to identify canine traits.

2). Those in the CAI groups spent 2, 5 or 10 minutes interacting with a small canine whereas the control group watched an unrelated power point presentation of neutral images for 10 minutes.

3). Post intervention – all participants complete the same VAS and questionnaires to measure their post emotional state.

Conclusion:

No difference in effect was identified between duration groups (2-minute, 5-minute, or 10-minute) signifying it is the act of interacting with a canine, rather than the duration of the intervention that influences mental health in HE students.

CAI is effective in reducing anxiety, stress and depression levels in HE students. Additionally canine trait and interaction type was found to be a predictor in increasing well-being levels and interaction type was found to be a predictor in reducing stress levels.

This has a significant impact on the application of CAI duration as a greater number of students may benefit from CAI given that shorter durations (2-minutes) are as effective as longer durations (10-minutes).

The results of this study positions CAI as a valid support system for students experiencing anxiety, stress and depression and as an intervention to support student mental health that universities can appropriate to build a healthier, more emotionally stable student body.

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Middlesex University London

Contact: Karen Manville
KM1332@live.mdx.ac.uk

5. Exploring the impact on practice when Service users are involved in staff training on the prevention and management of violence and aggression in local NHS mental health inpatient wards

JANE OBI-UDEAJA *

Department of Mental Health and Social work, Middlesex University, London, UK

Background

The involvement of mental health service users (SUs) in my team's prevention and management of violence and aggression (PMVA) training is a recognition of the contribution that the unique insights of people's lived experience can make to the development of practitioners. This research explores the influence of their contribution on staff practice.

Research Aim

To determine whether or not service users' contribution to PMVA training influences the way that staff manage disruptive incidents involving patients on the ward.

Objectives

To find out training participants' perspectives on PMVA before the service user session
To identify changes in perspectives if any as a result of the training
To determine the implementation and sustainability of changed perspectives in practice
To identify from previous SU training evaluation records intents to apply learning to practice.

Method

The descriptive phenomenological approach (Priest 2004) was adopted in collecting data from research participants. Two focus group interviews of ten new mental health inpatient

* **Corresponding author:** Jane Obi-Udeaja. Email: J.Obi-Udeaja@mdx.ac.uk

ward staff and ten mental health final year students were conducted. Semi-structured interviews of ten experienced mental health inpatient ward staff were carried out. A review of a sample from 111 records of feedback from previous PMVA training participants was carried out.

Findings

- *The new staff and students were determined to reflect lessons from SU session in practice.*
- *The experienced staff were reflecting lessons from SU session in ward practices*
- *The previous evaluation records held expressed intentions by the participants to reflect lessons learnt from SU session in practice.*
- *There were challenges to the implementation of SU contribution such as staffing and environmental problems*

Conclusion

The study confirms findings from previous studies on service user involvement which claim that their involvement in the education and training of professionals has the potential to positively influence practice (Turnbull and Weeley 2013, Spencer et al. 2011).

Impact:

The representation of service users in PMVA training is now an essential requirement (Ridley and Leitch 2019). This development promises a transformation of the way that physical restraint is perceived and taught and a positive impact on practice.

Key messages:

- *Acknowledge the potential rift between theoretical principles and practice*
- *Involve service users in training in order to motivate practitioners to translate theory into practice*

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Middlesex University London

Background: The involvement of mental health service users (SUs) in my team's training on prevention and management of violence and aggression (PMVA) is a recognition of the contribution that the unique insights of people's lived experience can make to the development of practitioners. Their contribution to the training is powerful and has the potential to influence staff practice.

Research Question

Can service users make a sustainable contribution to mental health staff practice in the prevention and management of violence and aggression through active participation in training and development?

What did the researcher do?

She explored the impact on practice when Service users are involved in staff training on the prevention and management of violence and aggression in local NHS mental health inpatient wards

Why explore the impact?

There is a dearth of literature on the impact on practice of service user involvement in the education and training of health and social care professionals (Alida et al. 2013, Chambers and Hickey 2012). The contribution of SUs to my team's PMVA training has never been evaluated. The findings will hopefully provide further evidence base to support a sustainable service user involvement in PMVA training delivery.

Exploring the impact on practice when service users are involved in staff training on the prevention and management of violence and aggression in local NHS mental health inpatient wards

Jane Obi-Udeaja

J.Obi-Udeaja@mdx.ac.uk

Supervisors:

Dr. Catherine Kerr

Dr. Gordon Weller

Aim: To determine whether or not service users' contribution to PMVA training influences the way that staff manage disruptive incidents involving patients on the ward.

Objectives: To find out training participants' perspectives on PMVA before the service user session, to identify changes in perspectives if any as a result of the training, to determine the implementation and sustainability of changed perspectives in practice and to identify from previous SU training evaluation records intents to apply learning into practice

Method: The descriptive phenomenological approach (Priest 2004) was adopted in collecting data from research participants. Two focus group interviews of ten new mental health inpatient ward staff and ten mental health final year students were conducted. Semi-structured interviews of ten experienced mental health inpatient ward staff were carried out. A review of a sample from 111 records of feedback from previous PMVA training participants was carried out.

Data Analysis: The thematic analytical method (Braun et al. 2018, Braun and Clarke 2013, 2006) was used for the analysis. Collaboration, criticality and reflexivity employed to enhance rigour (Ravitch and Carl 2021); Tape recorded responses cross-checked with written responses; Themes and categories cross-checked against colleagues'; Core themes used to present the findings and to guide the discussion.

Findings: The new staff and students were determined to reflect lessons from SU session in practice. The experienced staff were reflecting lessons from SU session in ward practices. The previous evaluation records held expressed intentions by the participants to reflect lessons learnt from SU session in practice. There were challenges to the implementation of SU contribution such as staffing and environmental problems.

Conclusion: The study confirms findings from previous studies on service user involvement which claim that their involvement in the education and training of professionals has the potential to positively influence practice (Turnbull and Weeley 2013, Spencer et al. 2011).
Impact: The representation of service users in PMVA training is now an essential requirement (Ridley and Leitch 2019). This development promises a transformation of the way that physical restraint is perceived and taught and a positive impact on practice. **Key messages:** Acknowledge the potential rift between theoretical principles and practice. Involve service users in training in order to motivate practitioners to translate theory into practice.

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Enhancing Mental Health and Emotional Well-Being for Students and Staff: A Working Framework for Integrated Support

ANCA ALBA *

Kings College London, London, UK

A preamble

Recent years have seen an increase in the number of students reporting mental health problems. Distinctions have been made between diagnosed mental health conditions and mental health difficulties that are not diagnosed and support and treatment may therefore vary for these different groups of students. In this context, universities are seeing large numbers of students registering with specialist counselling and mental health services, with some universities reporting between 10 to 12 per cent of their entire student population applying for counselling every year.

One of the challenges universities face is that the evidence base for mental health interventions delivered in university settings to student populations, particularly remotely/online, is still limited. Most of the research distinguishes between clinical and non-clinical populations and a large proportion of studies focus mainly on common mental health disorders such as anxiety and depression. A recent meta-analysis of randomized controlled trials has found that e-mental health interventions can improve depression and anxiety symptoms, although the effect of these interventions on academic performance was discovered to be small and statistically non-significant (Bolinksi et al., 2020). The findings suggested that very few studies measure academic performance. Other research has

* **Corresponding author:** Anca Alba. Email: anca.alba@kcl.ac.uk

similarly found that app-supported interventions, although not replacing professional clinical services, can be effective in alleviating depression and anxiety symptoms in university students (Linardon et al., 2019). However, less is known about the mental and emotional well-being of students in a broader sense and about interventions for serious mental health disorders in students in higher education.

The message professional services seem to send is that the disparity between demand and capacity means that not all students can be supported by counsellors at universities. Aside from the limited capacity of counselling services, some students may require specialist treatment that is not available at university, in which case the students can be signposted or referred to external services. It is not uncommon for students to be open to multiple providers simultaneously in statutory services and at university and may be advised to access support with one service at a time.

Universities need to be transparent about the support available for students at university and its limitations. Universities could provide information to students about existing support elsewhere and make referrals to external services that provide the recommended or required support.

Student communication around mental health difficulties

Professional counselling services are not the only forum in which students talk about and share their experiences of mental health difficulties while they are at university. Regardless of whether students are directly asking for help for their mental health, they sometimes communicate distress or the experience of suicidal thoughts in many other ways and in many different forums: a) to their personal tutors in tutorials; b) to faculty staff including administrative staff; c) to other students and friends; d) to residential wardens; e) when completing mitigating circumstances forms when applying for coursework or exams extensions or other academic adjustments; f) via Twitter and other social media platforms such as Facebook and Instagram; g) in emails to university leadership staff; h) in applications

for funding (such as hardship funds); i) in appeals or complaints; j) to advisors or mentors in other student services (for example, money, housing, international students advisors etc.); k) admissions, funding offices, library services or security staff etc. Anyone in the university community, regardless of role, may become aware of a student who is experiencing and sharing difficulties related to their mental health and may need advice about how to support that student.

Moreover, students can formulate their mental health needs and distress using terminology that only a few years ago would have been found mainly or exclusively in clinical settings in the description of symptoms and pathologies. The content shared by students through all these channels, which often is shared online and not always with the explicit intent to seek help, can raise serious concerns about their safety and risk to self or others as well as their well-being and may need an urgent response from the staff reading or hearing of these concerns.

Serious concerns and information sharing

This reality requires universities to be prepared at all levels to be able to identify and sensitively and compassionately respond in a timely fashion to such concerns. It seems important that universities have in place reliable cross-service processes and systems that work together to allow information sharing regarding students' mental health where there is a serious concern or identified risk to self or others. This information sharing would be on a need-to-know basis and in confidence with specialist services who can assess the students' needs and advise them of support available to them at university or elsewhere.

Many universities already have in place a central or single point of access for student referral and access within 24 to 48 hours to a mental health practitioner who can offer specialist assessment and advice. It is important that everyone at the university is made aware that such processes exist and encouraged to discuss concerns they may have about a student with a senior colleague or a line manager in the first instance.

Remote and online working in the context of a world-wide pandemic has brought new challenges for universities teaching and providing support to students who are not based in the UK. These students may not have access to crisis support, to a GP or to specialist mental health treatment. Moreover, legal limitations mean that university professional services are not able to provide the same level of therapeutic or clinical input to students who do not reside in the UK. Universities have had to adapt existing processes to consider these changes and propose alternative sources of support that all students can access remotely.

Integrated systems of support

When thinking about the mental health support students might request or need, one often thinks about speaking to a counsellor, a psychologist or a psychiatrist and having counselling sessions. Whilst students seem to be more open to speaking to a professional about their problems than perhaps their parents or grandparents, counselling or psychological therapies are not always the first line of support needed or requested by students. The student might face practical problems that are directly impacting their well-being and mental health and may need assistance and advice around financial and housing worries, social isolation, difficult relationships with supervisors or other students, experiencing racism, harassment, discrimination and abuse or needing additional academic skills support.

One might argue that it is self-evident that an integrated approach makes sense, as mental health is directly linked to the material, social and other resources students have available to them including self-reliance and self-efficacy. However, translating the theoretical principle of integrated support in practice in a university setting is far more difficult given that university services, systems and processes have not been designed for that purpose. Existing systems of support such as pastoral support can vary greatly from faculty to faculty within one university, and pastoral support is often provided independently from other support services. Student services may themselves have different recording systems and no

other processes in place for joint working or sharing support plans for students with complex or multiple needs that are affecting their mental health and well-being.

An integrated approach to supporting students' mental health would allow all these separate systems and levels of support to connect, communicate and work together to support the student at all levels including academic, pastoral and specialist support level.

What universities can do to ensure an integrated approach to student support:

- create opportunities to connect professional services with academic support through regular meetings, faculty visits, shared online forums, shared training, cross service events
- provide guidelines and training to all staff regardless of role around supporting students experiencing mental health difficulties; rather than burdening staff with additional roles or tasks, the training could help them feel more confident in having a conversation with a student disclosing mental health difficulties, being aware of available support at university and signposting students to professional support
- provide clear information on their website from professional services about what is on offer and what service are not available to students
- include mental health practitioners with clinical experience in university settings in the decision-making process around organisational structures and development
- encourage professional services to participate in research, service evaluation projects and sharing good practice

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Attending to Mental Health: Individuals, Systems, and the Potential Contribution of the Professional Doctorate

VANJA ORLANS *

Psychology Matters Ltd, UK

The concept of 'mental health' is complex and is often defined as the absence of mental illness or mental distress. The literature detailing the different types of mental illness that need attention tends to be based in a powerful medical model rather than positioned within a psychosocial framework. This has led to some critical debates in the mental health field that highlight and promote a plea for a more contextual approach.

From a 'mental illness' perspective, and following the wide range of issues set out in publications such as the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) or the more recent version of the International Classification of Diseases (ICD-11, 2018) we could imagine that we were dealing with research based issues, definitive signs and symptoms within individuals, and guidelines for treatment planning for those concerned. However, while allowing these diagnostic systems to have some conceptual and clinical usefulness, we also need to attend carefully to a critique of these systems from the perspective of individual reductionism, an over reliance on objectivity and rationality, difficulties about the meaning and reliability of the research that is assumed to underpin these categorisations, and the

* **Corresponding author:** Vanja Orlans. Email: vanja@psychologymatters.co.uk

lack of contextual exploration and understanding of presenting issues. Psychiatry and the DSM-5/ICD-11 are based on a medical model that holds a great deal of power. By contrast, it is essential, in my view, to focus on a more holistic and social model that highlights the relevance of contextual and environmental factors that underpin individual and system health and a sense of 'dis-ease'.

The latter perspective raises issues of scientific rationalism that promotes the language of deficiency. Critics in this tradition point to the idea of mental illness as a 'social myth' than can be used for the purpose of social control (e.g. McNamee and Gergen, 1992). Such writers argue that categorisation systems are not value free and are intrinsically linked to social processes. For example, the issue of homosexuality has had a long political struggle with different versions of the DSM system. Homosexuality was listed as a disorder up to DSM-II; in DSM-III this 'diagnosis' was changed to Ego Dystonic Homosexuality. It was not until DSM- III-R in 1987 that this 'disorder' was dropped (see, for example, Kutchins and Kirk, 1997).

Vanheule (2012) argued for an alternative to the DSM-5 as a support for interventions in psychological therapy. Pilgrim and McCranie (2013) offer a sociological analysis, highlighting the concepts of 'misery' versus 'happiness' and the lack of emphasis on the fact that emotions such as fear and sadness are with most of us quite a bit of the time – perhaps a lot of the time in the current COVID-19 environment. Paris (2013) argues for a more balanced and critical approach to issues described in the DSM-5, while the classic experiment of Rosenhan (1973) provides some interesting data on the possibility that madness, like beauty, might lie in the eye of the beholder. From this perspective, issues of mental health or emotional well-being need to be understood as not necessarily related to the absence of certain diagnostic symptoms. In terms of interventions, Paul Gilbert (2007), for example, has highlighted the need for a focus not just on individual deficits, but also on systemic, social and political processes. The Division of Clinical Psychology of the British Psychological Society (BPS, 2018) has produced a critical document on formulation and treatment that focuses on a Power, Threat, Meaning

Framework that aims to explore an individual's contextual and historical experiences and the phenomenological sense that the person has made of these.

From these perspectives, we can raise the question of how professional doctorates might contribute critically and ethically to such debates, both in theory and in the contribution to professional practices. A key notion for those involved in the management and supervision of professional doctorate projects could be described within the criterion of the 'so what' question. What difference could a proposed practitioner doctoral project potentially make to professional, organisational, or social practice, and importantly to the practice of the professional who is undertaking this research? The idea of 'the product' in the professional doctorate centres on this issue and can be considered within the realms of philosophical, theoretical, methodological, and ethical challenges. Candidates who engage in a professional doctorate are usually arriving with questions that have arisen within their own practice setting. This makes the undertaking of such a doctorate profoundly reflexive, opening the way for contextual change.

By way of highlighting some relevant contributions that incorporate the ideas outlined above I would like to draw attention to a few projects that may be of interest. My own doctoral work focused on the experience of stress in organisations. In several consulting projects that I had undertaken I noticed that there was a strange dynamic at work whereby stress appeared to be passed around the organisation. In effect, it seemed as if 'stress' moved from one desk to another, often surreptitiously! As a result of my project work I proposed that issues of stress needed to be approached from individual, group and organisational perspectives if the difficulties were likely to be resolved in an ethical and appropriately practical way (e.g. Orlans, 1986, 1991).

My approach was subsequently reflected in projects where I would, for example, help an organisation develop a useful counselling service for employees. I always argued that the service needed to be evaluated contextually. This meant that 'problems' that

presented themselves in the confidential consulting room with the counsellor needed to be appropriately analysed in a form that located a number of difficulties with the employee and retrieved a number of others for the attention of senior management as group or organisational issues. I also outlined a strategic methodology to undertaking this in an ethical way that honoured the confidentiality established between a counsellor and their client. My experience was that consent for such an approach was actively welcomed by employees as a way of avoiding turning organisational issues into individual pathology.

Of the many doctoral projects that I have supervised, we can also see a similar focus on contextual factors in which individual problems can be located. For example, Dr Anita Sattar- Jenkins (Sattar-Jenkins, 2019) conducted her research on Asian mothers who gave birth in the NHS in the absence of maternal support. Her project highlighted the important need for the NHS to attend to cultural and language factors in the interactions with Asian mothers and to become much more knowledgeable about the importance of family factors; it also highlighted the role of men and women in Asian culture in relation to birth processes and the need to review and expand the nature of the service available to new mothers. In the course of her doctoral work she had policy discussions about strategic implications for the NHS on the need for attention to cultural factors and the implications for the mental health of patients.

Dr Hannah Cruttenden (Cruttenden, 2019) undertook a narrative study on the experience of older/oldest old adults of the loss of an adult child. This work highlighted the ways in which older adults are often ignored by the care systems in terms of their need to talk with someone about their experiences, the ways in which a phenomenological understanding is potentially key to a more effective approach, and the fact that, going forward, our social systems shall be dealing with a far greater number of older adult issues. This work highlighted the importance of an interpersonal context where phenomenological experience is both respected and supported. At present, such a process based perspective is generally not part of the NHS culture.

Dr Tarun Pamneja undertook a qualitative study of patients in the NHS who had been diagnosed with 'psychosis' (Pamneja, 2018). He conducted in-depth interviews with both patients and their psychiatrists about their respective experiences of the presenting issues and of the experiences of patient and psychiatrist of each other. The project highlighted the need for a greater understanding of both the patient's and the psychiatrist's experience in the understanding of the phenomena of psychosis, the tensions in perspectives that can ensue from a structural perspective within the environment of the NHS, and the need for a shift to a more intersubjective and interpersonal form of relating. Projects such as the ones that I have outlined are also aligned with the position set out by the recent BPS Report on a *Power, Threat, Meaning Framework* in the exploration and analysis of psychological and emotional difficulties (BPS, 2018) and the fact that a diagnosis of 'psychosis' is often related to early and chronic trauma.

I have many other examples of this kind of practitioner research that I have supervised or managed within the DCPsych doctoral programme at Metanoia Institute that have taken such a critical perspective on the subject of mental health and that successfully sought to locate the individual within a contextual frame. What follows from this kind of approach is a much more grounded perspective on relevant treatment and interventions that also often requires a strategic perspective on service delivery. In my view, at a doctoral level of investigation such a critical analysis is crucial, coupled with the professional doctorate's emphasis on the 'so what' question, where knowledge for its own sake is not enough, and where action and useful intervention is a part of the doctoral frame. From such a perspective we can also develop social and policy changes that can potentially bring a more appropriate, effective, and ethical approach to the issue of mental health and emotional well-being.

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Notes on contributor

Dr Vanja Orlans

Director, Psychology Matters Ltd, BPS Chartered Psychologist, AFBPsS, HCPC Registered Occupational Psychologist, HCPC Registered Counselling Psychologist, UKCP Registered Psychotherapist.

Vanja has many years of experience in higher education and in the design and development of professional doctorates. Until recently, she was Senior Director of Studies and Programme Leader of the Doctorate in Counselling Psychology and Psychotherapy by Professional studies (DCPsych) at Metanoia institute, a joint programme with Middlesex University. She was also a Research Tutor and Supervisor on this programme and has seen many candidates through the development and completion of complex projects. Over her professional career she has worked extensively with individuals and organisations, consulting and teaching as well as running a psychotherapy and consulting practice in North London. She also continues to supervise doctoral research projects. Vanja has published widely in both the clinical and organisational fields.

Challenges and contributions in supervising professional doctorates for experienced practitioners

DAVID A LANE [*]

Professional Development Foundation, UK

Introduction: The excitement and challenge of professional doctorates

The advent of professional doctorates for experienced practitioners has created an opportunity for those who have already made a contribution to practice to add to the knowledge base of their discipline (Garnett, Costley and Workman, 2009). This has generated exciting research addressing fundamental questions in practice and client services. Drawing upon their experience has opened questions that were unlikely to be asked by junior colleagues undertaking traditional PhD research.

However, this has raised significant challenges for how we approach supervision with such colleagues. They bring expertise in their area but may have little knowledge of research methods. Our understanding of how expertise develops over the period of a career has increased and we can recognise that the purpose of supervision for experienced colleagues includes working within areas in which they are novices, are competent and are expert (Cavanagh, Stern and Lane, 2015). We can draw upon the literature on expert practice and developmental phases to assist our understanding of the challenges they and we face (Ericsson, 2006).

Professional practice has become more complex, expertise is now challenged and the autonomy once enjoyed has been replaced by change in status from

[*] **Corresponding author:** David A Lane. Email: davidlane@pdf.net

independent to employee for many (Lane and Corrie, 2006). The lenses we use to understand ways of seeing practice through the perspective of individual, interpersonal and systemic approaches have also emerged as a challenge to traditional codified knowledge. The process for providing service to clients has become similarly complex. Therefore, we need to be able to look at supervision of professional practice in terms of diverse purpose, perspectives and process (Cavanagh, Stern and Lane, 2012).

There has been increasing interest in the idea that we should view practice not in terms of individual competence but as part of socio-material practices in the context in which they occur (Nicolini, 2012). The idea of considering practices opens the possibility of seeking to define the practices which inform supervision. There is a parallel dialogue emerging when we look at mental health and well-being. While diagnostic systems based on individual symptomatology have been dominate these are challenged by broader biopsychosocial perspectives on health. It is now possible to view well-being and mental health from individual, interpersonal and systemic perspectives (Corrie and Lane 2021).

Drawing together the experiences of professional doctorate candidates and the issues they face and the pressures of current practice creates the possibility of new contributions to our understanding of mental health and well-being as well as the supervision of research in these areas.

A model for reviewing the practices involved in supervision

The practices we use arise from three key themes that govern our work as supervisors.

1. What is our purpose?

This covers the purpose of the work for the candidate, the supervisor and other stakeholders. A shared concern must be developed to encompass the varied

assumptions made so that differences of purpose can be addressed to ensure a viable collaborative journey. With experienced practitioners this is not necessarily a simple task. They are not a novice dependent on the goodwill of the supervisor or perhaps working as an assistant within a research team. They come with their own expertise, perhaps more so that the supervisor. As an expert they bring capabilities that enable them to see possibilities that would not be available to a novice. This expertise also can lead them into cognitive bias since they may be over confident in the rightness of their position. However, they may also be at the same time novices in the intricacies of research and make assumptions about what is and what is not a viable research question that as supervisors we will need to challenge. There may be other areas where they have a degree of competence that enables them to quickly complete tasks set. There is an increasing understanding that professionals may go through a series of developmental stages and the support they need to progress varies according to the stage within their journey (Stoltenberg and McNeill, 2010). We have then to think about the purpose of the research and their stage of development. At a minimum we need to consider the areas in which they are a novice, competent or expert. The practices suitable to support them will vary accordingly. Useful questions for supervisors to help them to consider include:

Where do I want to get to?

- What does being a doctorate candidate mean to me?
- What do I consider to be my purpose in working towards a doctorate?
- What makes this worthwhile to me and other stakeholders?
- How have I developed this viewpoint?
- Where do I want to get to – professionally and personally – as a result of this journey?
- What has influenced my professional and personal aspirations to undertake a doctorate?
- How well do my professional and personal aspirations add up to an explicit, cohesive and achievable doctorate?

- Have I shared these aspirations with anyone else - my peers and supervisors?
- What are the possible pros and cons of sharing my aspirations?

2. What perspectives inform the shared purpose?

Depending on the developmental stage (novice, competent practitioner, expert) that the candidate brings, different levels of sophistication will apply to the perspectives that they are drawing upon to inform their journey. It is often the case that expert candidates bring an inter-disciplinary understanding to their enquiry based on long experience of the complexity of professional practice. This can represent a challenge to the single discipline supervisor who may be unfamiliar with the perspectives encountered. In areas of practice such as mental health professionals have often adopted an individual approach to distress. It is seen as being within the person and activity has been directed to individual change. Yet, as professional practice in mental health as well as other areas has faced an increasingly volatile, uncertain, complex and ambiguous future (Boulton, Allen and Bowman, 2015, Cavanagh and Lane, 2012, Corrie and Lane, 2021, Taleb, 2012) it is recognised that we have to draw upon broader perspectives including interpersonal and systems levels of understanding. This opens up a wide range of research perspectives but also necessarily introduces considerable complexity into the definition of purpose and perspectives that may inform the journey (Lane and Corrie, 2006).

Useful questions include:

What do I have to do to get to where I want to be?

- What ideas currently influence my journey?
- What do I need to do to seek wider perspectives of value to my journey?
- What development issues might these raise for me to address?
- What needs to happen next?

- How can I use a self-development plan to best effect for my journey?
- Compared to where I want to get to, both professionally and personally, how well am I doing now?
- What tools, resources and people are available to help me assess my capabilities and achievements?
- What could I audit myself against?
- What external standards/examples are there that might be of use to me?

3. What process will be necessary to complete my journey?

Essentially supervision consists of three (as a minimum) process elements. We work with candidates to develop their capabilities as researchers and in practice doctorates and also as professionals. This is sometimes called the formative or developmental role of the supervisor. It is typically about developing skills or building upon existing skills. The second key role is that of building the quality of their performance as researchers/professionals. This is sometimes called the normative function of supervision ensuring that candidates understand what an effective performance looks like and can learn to reliably meet that standard. The third and most difficult of the roles is where we need to challenge the beliefs and assumptions they hold. We help them to explore the paradigms they are using, challenge them and transform their ways of seeing the world. They are seeking to innovate to produce original and significant work. This will potentially involve moving to new uncomfortable positions. This can disrupt their thinking and be a cause of considerable stress. It is sometimes called the restorative role as supervisors will often have to assist the candidates through a very difficult period in their journey. Useful questions include:

What is the next step and how will I know when I get there?

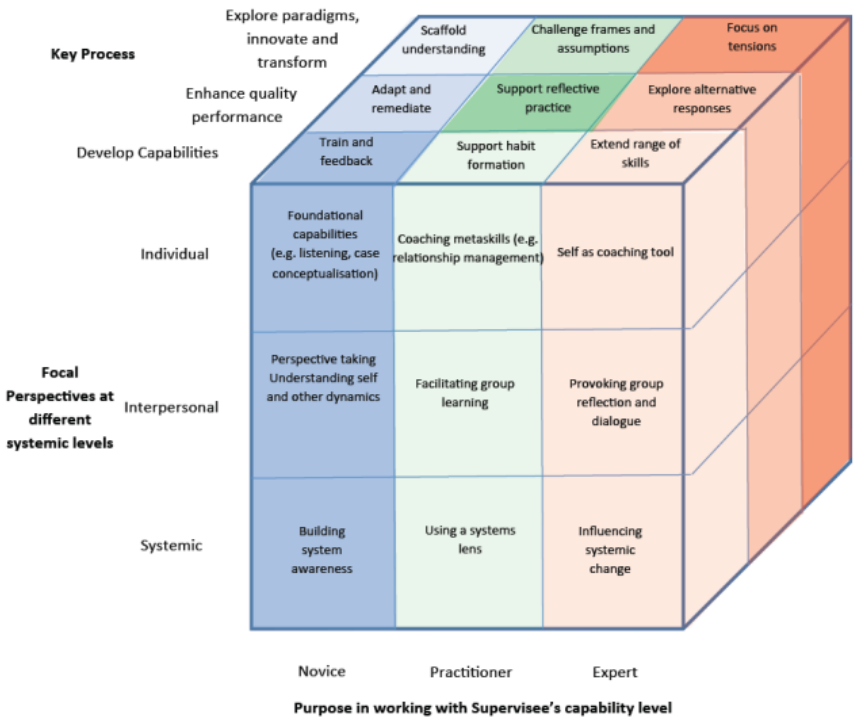
- How often should I audit my capabilities and achievements?
- What is the best way to document my assessment and audit my process?
- How often do I need to reassess my professional and personal standards?

- How can I develop my willingness to explore challenging ideas or areas of practice?
- Within my practice can I develop systems to encourage others to become actively involved in my professional development and be willing to challenge my approach?

This gives us three dialogues for supervision - that of purpose, perspective and process and within these the respective developmental positions (novice, competent, expert), focal perspectives (individual, interpersonal, systemic) and key processes (developing capabilities, enhancing quality performance, exploring paradigms, innovation, transformation).

Combining these dialogues and positions creates 27 potential supervisory practices. The 27 practices are not fixed but rather emerge as relevant to the particular social and material assemblage involved. Thus, supervisor and candidate build the practices that make sense for them in the context of the project. The practices listed below arose from an analysis of the work of three experienced supervisors looking at some cases and commonly emerging practices. The case study that follows illustrates this process of emergence.

Table 1. Coaching Supervision Cube - Combining Dialogues



Copyright 2015 Cavanagh, Stern and Lane, Coaching Supervision Cube – combining dialogues

Understanding practices

There is an increasing recognition that the social world consists of practices. That is, the human activities and the process of establishing meaning occur within social and material assembles which are made and remade in space and time using tools, discourse, our bodies and organisational activities. Thus, to understand supervision we have to define the processes, sources of meaning making and purposes in terms

of a performed activity (Nicolini, 2012). We move away from the popular notion of understanding our work as defined by supervisory competences towards understanding the performances undertaken which are embodied in both the material and social realm (Lane, 2020). As we move from an individualistic to a situated sociocultural view of learning we have to take account (Fenwick and Nerland, 2014) of environments within which learning takes place and therefore it is always situated in activities in given settings and communities in time and space. The cube above, by combining the meaning making activity of purpose, perspective and process, enables the assembly of such tools, concepts, people and organisational factors that can generate the performed activity of supervision. Each block within the cube represents a performed activity, that is, a practice, as it emerges in a particular space and time. We have to recognise in the encounter what is happening inside, what is happening outside and what is happening over time.

Below is an example of a candidate undergoing supervision for a practice based doctorate as part of a cohort. Each member of the cohort has shared as well as individual concerns they wish to explore. The example draws upon material published by Middlesex University looking at journeys in higher education, and in particular practice based doctorates (see Garnett, Costley and Workman, 2009).

A case example

The Royal College of Veterinary Surgeons (RCVS) wished to develop a framework of education in General Practice for Vets. There was no existing research framework for establishing this so RCVS and the Society of Practicing Veterinary Surgeons (SPVS) approached the Professional Development Foundation (PDF) to explore this area. Through the Institute for Work Based Learning at Middlesex University a research-led programme was established to bring a group of eight experienced Vets together to agree an overall purpose for the work which was then split into individual topics each contributing to the outcome for a Master's degree. Core themes from that work were further explored in five practice doctorates. This paper explores the

issues that arose in supervision interpreted in terms of the supervision cube (see Table 1 above).

Starting with Purpose

The candidate is highly experienced and expert in the field of veterinary general practice which is the subject of the research. As a researcher having completed a master's project there is a level of research competence. However, in terms of a complex doctorate level of research they are a novice. The research purpose is to contribute one element to an overall group strategic piece of research involving both the participants, other members of veterinary teams in several practices, their peers in the doctorate cohorts and the professional body. The aim is to create a model for general practice that can become a nationally available award in this area. The overall purpose was to explore practice based on a series of studies of patterns of activity and identification of necessary skills, knowledge and capabilities for engaging in work as an advanced practitioner. The purpose of the supervision was to enable the candidate to develop necessary capabilities, to understand the complexities of researching the field and to provide guidance on appropriate standards.

Exploring perspectives

This is a very involved piece of research looking at individual practices - beliefs and activities. However, these take place in a team context involving several interpersonal interactions (vet with other staff, vet with human client, vet with animal, animal and client with reception staff and nurses) in a specific physical space involving several material activities as well as social interactions. The performed act investigated in the research thus involves the perspectives of individual actors and what they bring into the space, the activity between them as it plays out in the interactions and the acts that follow the event resulting in changed behaviour from the animal and human client. However, the research is intended to understand the performance as an activity having implications for the systems within which general veterinary practice happens. The intent is to impact the future patterns of activity

that will be proposed to the professional body as a result of the work and which will, therefore, have to take into account systemic influences on practice. Candidate and supervisor need to explore the perspectives that could inform the research activity to ensure that the issues are fully understood and that it is possible to contribute to the evidence base for the discipline.

Considering process of supervision

The conversation between them about purpose and perspectives provides some clarity for the candidate and supervisor on the areas they need to address in terms of process they may use in the supervisory activity to ensure an appropriate performance. The candidate started the dialogue by looking at the relational aspects of working with the individual participants. So, in the cube they considered what foundational capabilities would be required. They decided that the candidate had the necessary understanding and also was fully aware of the metaskills necessary for relational management. Less certain was the question of managing those individual relationships as part of a complex research project (the expert level) and therefore they decided that some work would be needed to extend skills in this area. So, the process needed for developing capabilities was one of extending an existing skills base into a new area of activity.

The second initial area that the candidate wished to explore was the possibility of some group based reflections between the veterinary teams to explore areas of practice. They had experience of working within teams in their own practice setting and felt competent to run group learning experiences at an interpersonal level. However, given that the research was going to involve challenging thinking about practice they felt uncertain that they had the skills to provoke and challenge in a group situation in a way that would be safe for participants. So, in term of enhancing the quality of their performance they agreed that some further work on supporting reflective practice as a process would be necessary.

They started to discuss influencing the system and considering how they could adopt a systems lens on the work. Some reading around this was agreed. The question of how to influence system change at the expert level was left for a future stage in the supervision. They also discussed exploration of paradigms. It was clear from the outset that there could be some challenge to existing frames and assumptions for the participants. This was an area that the candidate was uncomfortable with at this stage, so some work was agreed on how to scaffold understanding with a view to them developing challenge processes. It was recognised that this might indeed create tensions at the systems level since there were existing vested interests which might oppose this work. Learning how to lean into and build on tension and create a generative dialogue that could accommodate differing views was seen as a possible further area for supervision in the future.

At each stage of the research different issues emerged at the individual, interpersonal and systemic levels and the expertise of the candidate to meet the purpose of the research gradually developed. The process used varied depending on the level of expertise they held in the issues raised. Some involved direct teaching of skills, some building reflective practice and some learning how to use tension to create change. The key is that the practices will vary in time and space. Hence the practices outlined above will emerge from dialogue around the purpose of the work, the development stage of the practitioner, and the process that enables them to engage fully in different ways as the work progressed.

Conclusion

Practitioners deal with an increasingly complex world and practice based research has to reflect that, it cannot work on rigorous application of defined protocols. Much of our working context is concerned with non-linear and complex situations (Cavanagh and Lane, 2012). We cannot always apply simple linear supervision models that do not recognise the emergent nature of the activity. This potentially creates a problem for a view of the science-practice divide as one built on a narrow

scientism rather than the phenomenology that underlines the material world we seek to understand (Salkovskis, 2002):

> "Modern science, then, challenges the notion of an ordered and objective reality which we can uncover with increasingly sophisticated techniques. Its Purpose is to understand the non-linear relationships that characterise complex systems, including human ones. Its Perspective is that aiming for prediction and control is a misleading basis upon which to build a science. The task is a holistic endeavour in which we seek to facilitate connections that might enhance self-organisation. The critical determiner is relationship because the universe evolves in the Process of our interacting with it."

(Lane and Corrie, 2006, pp. 86)

If the task is a more holistic endeavour our role as supervisors is to facilitate these connections. We seek to provide a narrative framework for the supervision process in that is individualised and self-reflective (Lane and Corrie, 2006). However, if we are going to view supervision in terms of practices, those practices should also be both reflexively and relationally narrated (Lane, Kahn and Chapman, 2016). We must pay close attention to the contextual factors that impact on the construction of our practice and be willing to entertain a range of ways of knowing. Our supervision practice is socially constructed in conversations with our supervisees not predetermined by us or by the dictates of a specific approach. We are seeking to enable our supervisees to become more articulate (Stengers, 1997). Nicolini (2012) has drawn out key implications of Stengers' approach which are relevant to the complexity of professional practice and therefore our approach to supervising research on practice. He argues that being articulate is to be able to appreciate differences that matter. This creates the possibility of making new and even enlightening connections between things of the world. Good research on practice is generative not eliminativist, thereby, increasing our capacity to make connections. Hence as supervisors adopting good science we do not close down the possible connections in order to operate a limited model that pre-defines what is and is not worthy of exploration (Lane, 2017).

Nicolini (2012) argues that all science is performative and constructivist. Thus, if we think about the supervision of research it requires engaging with the world of practice in a way that gives it a chance to bite us. If we are to understand any practice (supervision in this case) we get close to the activity at hand and build, or slice, the world in terms of the practices. Our theory/method must become articulate and offer our candidates resources for building supervision narratives that plot the world of practice in all its complexity – not using ready-made plots to stitch it together.

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Notes on contributor

David A Lane

David A Lane – is Director and co-founder of the Professional Development Foundation. As well as contributing to research and professional development Professor Lane has worked in a wide range of organisations including major consultancies, multinationals, and public sector (including health, social care, education and emergency services) and government bodies. He also pioneered the international development of work based masters and doctorate degrees for experienced practitioners. He has published widely on coaching, therapy, organisational development and supervision.

He was Chair of the British Psychological Society Register of Psychologists Specialising in Psychotherapy and convened the European Federation of Psychologists Associations group on Psychotherapy. He has served on committees of APECS, BPS, CIPD, EMCC and WABC, as well as being a founder member of the Global Coaching Community. He is a Fellow of BPS and his contributions to counselling psychology led to the senior award of the BPS for "Outstanding Scientific Contribution". In 2009 the British Psychological Society honoured him for his Distinguished Contribution to Professional Psychology. In 2016 he was made an Honorary Associate of the Royal College of Veterinary Surgeons for contributions to developing the field of general practice and the professional development of its members and also was elected a Fellow of the Academy of Social Sciences for contributions to education and of APECS for coaching. He also holds a lifetime achievement award from the University of Surrey for contributions to Applied Psychology.

Physical Health Monitoring in Individuals with Severe Mental Illness: An Audit in General Practice in North London

DANIELLE A ROBERTS[*]

GP Vocational Training Scheme, Imperial College Healthcare NHS Trust, London, UK

And

HERBERT P MWEBE[†]

Department of Mental Health & Social Work, Middlesex University, London, UK

Poor physical health is common in people with Severe Mental Illness (SMI). Two-thirds of deaths in SMI could be avoided if patients are offered prompt physical health screening for known risk factors. We aimed to identify SMI patients registered at a General Practice and audit their care in relation to physical health monitoring.

We included adult patients with coded diagnoses of SMI. We selected 18 best practice criteria for physical health monitoring, based on Quality and Outcomes Framework (QOF) indicators for mental health, NICE guidelines and other professional guidance. Data was obtained from electronic patient records and examined over a 12-month period.

Only 5 out of 18 best practice criteria achieved compliance above the expected standard of 70% (annual record of blood pressure, smoking, alcohol, medication review, prescription on repeat template). Care planning achieved 69%; and most of the remaining parameters (pulse, BMI, weight, QRISK2, serum lipids, glucose, dietary advice, physical activity, drug use) reached levels around 50-60%. Particularly low compliance (<40%) was found for ECG, pregnancy/contraception advice and medication side-effects.

There is definite room for improvement regarding physical health monitoring of SMI patients within general practice. We recommend increased attention to annual physical health checks, particularly cardiovascular risk factors, and the consistent offer of targeted interventions. Organisational financial incentives are also effective at increasing compliance results.

Keywords: severe mental illness, physical health monitoring, general practice, mental health professionals, cardiometabolic risk

[*] **Corresponding author:** Danielle Roberts. Email: d.roberts@imperial.ac.uk

[†] **Corresponding author:** Herbert P Mwebe. Email: h.mwebe@mdx.ac.uk

Background

Poor physical health and multi-morbidity is common in people with Severe Mental Illness (SMI). SMI is defined as any disorder of the mind which causes debilitating psychological problems of a degree and nature that the individual's ability to engage in functional and occupational activities is severely impaired (Public Health England, 2018). Individuals with SMI have shorter lifespans compared to those without mental illness (Rodgers et al., 2018). It is estimated that 2 in 3 deaths in this patient population are from physical illnesses that can be prevented (Mental Health Foundation, 2016). Thus, up to two-thirds of mortality in SMI is avoidable if patients are offered prompt physical health screening checks for known health risk factors (Silverwood et al., 2019).

Major causes of mortality and morbidity in SMI individuals have been linked to common medical complications; particularly smoking- and obesity-related cardiovascular and respiratory problems, as well as chronic physical illnesses such as diabetes and hypertension (John et al., 2018). In fact, cardiovascular disease (CVD) accounts for 40-50% of overall mortality in SMI, according to research (Ringen et al., 2014). Metabolic syndrome (sometimes also referred to as Syndrome X or Dysmetabolic syndrome) is a cluster of cardiovascular risk factors including hypertension, abdominal obesity, dyslipidaemia, insulin resistance and glucose intolerance. The rates of metabolic syndrome are reported to be as high as 60% in individuals with SMI (Crump et al., 2013); the use of psychotropic agents, especially antipsychotic drugs, further increases the incidence of cardiometabolic risk factors in the SMI population (Shiers et al., 2014). With the rise in obesity and diabetes mellitus globally, a parallel increase in rates of metabolic syndrome seems inevitable. A complex interplay of aetiological factors, including lifestyle and environmental influences, for example smoking, unhealthy diet, psychotropic medication, sedentary behaviours and social deprivation, may all contribute to the pathogenesis of metabolic syndrome. Yet, for individuals with SMI, all these risk factors are more prevalent, up to twice as many, compared to the general population (Pradhan & Joshi, 2019; Pillinger et al., 2020).

Findings from the National Audit of Schizophrenia (Royal College of Psychiatrists, 2014) support earlier research findings and highlight the need to improve the focus on physical health needs in SMI. The audit of 5,091 records of people with SMI receiving care in mental health settings in England and Wales, found that the frequency of screening and monitoring interventions for physical health needs was significantly lower than in the general population. The report found that measures for weight and/or body mass index (BMI) had been recorded in less than half of the patients; and that interventions were only offered to just over half (54%) of patients with known high blood pressure. Several national policies and guidance frameworks including: the Royal College of Psychiatrists' Accreditation for Inpatient Mental Health Services (AIMS; RCPsych 2019), Care Quality Commission- physical health checks in SMI (CQC, 2017), the National Institute for Health and Care Excellence (NICE, 2014), the Quality and Outcomes Framework (QOF; NICE 2019), the Commissioning for Quality and Innovation- improving physical health for people with SMI (CQUIN; NHS England 2019), and the Lester UK adaptation of the Positive Cardiometabolic Health Resource tool (Shiers at al., 2014), provide best practice recommendations for improving physical health monitoring and outcomes in SMI, informed by current evidence. Similarly, the NHS Five Year Forward View for Mental Health and the NHS Long Term Plan for Mental Health prioritises the need for action to address the physical health needs of individuals with SMI in order to reduce health inequalities (NHS England, 2018).

Aims

- To identify all patients with severe mental illness registered at a General Practice in north London, and to evaluate and audit their care, specifically in relation to physical health monitoring.
- To propose strategies and recommendations to improve physical health monitoring in patients with severe mental illness within general practice.

Methods

The audit included all adult patients (over the age of 18 years) registered at the selected General Practice (GP) with a coded diagnosis of severe mental illness. For the

purposes of this audit, the following SMI diagnoses were included: schizophrenia, bipolar disorder, psychotic depression, and other psychoses; since these were the conditions specified in the mental health quality standards (QOF indicators) as constructed by NICE (NICE, 2019). Manual searching through the mental health register at the GP practice was performed to identify those patients with coded diagnoses of SMI as above.

Data was obtained from electronic patient case records and captured on a structured data collection form created in Microsoft Excel. Expected standards, outlined in Table 1, were largely based on the list of Quality and Outcomes Framework (QOF) indicators for mental health, as these components were developed from NICE best practice guidelines (NICE, 2019). In brief, QOF is an annual incentive programme for GP surgeries, which aims to improve patients' quality of care by financially rewarding practices for good practice, based on several indicators across several key areas of clinical care and public health. Although a voluntary programme, participation rates for QOF 2018-19 were very high at 95.1% (NHS Digital, 2020).

We then reviewed the NICE guidelines relating to psychosis, schizophrenia and bipolar disorder (NICE 2014; 2020), the Lester UK adaptation of the positive cardiometabolic risk assessment tool in SMI (Shiers et al., 2014), as well as activities agreed by the regional clinical commissioning group (CCG) and covered by the North-West London GP local enhanced services (NWL LES), for further recommendations both nationally and locally regarding annual physical health checks and monitoring for SMI patients. This generated 8 further components to be included in the audit, as shown in Table 1.

Two additional parameters of interest for the audit were: (i) Record of whether psychotropic medication was prescribed on the electronic repeat template, as this is good prescribing practice and allows for prompts to be generated to ensure patients receive regular medication reviews by a healthcare professional; (ii) Assessment of whether an enquiry about side effects of psychotropic medication was undertaken and recorded in the patients' notes over the past year; and whether a quantitative tool such as Glasgow Antipsychotic Side-effect Scale (GASS) or Liverpool University

Neuroleptic Side Effect Rating Scale (LUNSERS) was used (Waddell & Taylor, 2008; Day et al., 1995).

The chosen timescales for outcome measurement were generally based on those outlined in QOF standards and NICE guidelines; therefore, the parameters were evaluated over the preceding 12 months (period between January 2018 to January 2019).

For this audit, compliance for each parameter (Table 1) was assessed against an expected standard of 70%, as this is generally the cut-off for QOF payments, and features at the higher end of achievement thresholds with regards to identifying good quality care. We then applied a Red-Amber-Green (RAG) traffic light rating of compliance achieved for each parameter, such that ≥70% was rated Green; 40-69% was Amber; and <40% was Red.

Formal ethical approval was not required since the methodology was that of a clinical audit and thus no new patient data, care or intervention was collected or administered. Yet, in line with good medical practice and information governance, we obtained approval from the practice manager, partners and leadership team to undertake the audit, and ensured patient anonymity and confidentiality when reviewing the patient records and documenting the results. However, in the event of discovering any clinical errors or omissions with the potential for significant patient harm, we raised the particular issue with the patient's named GP for follow-up accordingly, and then subsequently disseminated the learning points more generally to the wider healthcare team during a meeting at the practice.

Table 1: Key best practice criteria for physical health monitoring in people with severe mental illness.

QOF indicators:
a) Record of **total cholesterol: HDL ratio (serum lipids)** in the last 12 months
b) Record of **serum glucose or HbA1c** in the last 12 months
c) **CVD risk assessment (QRISK2)** performed in the last 12 months (in patients aged 25-84 years)

d) Comprehensive **care plan** documented in the last 12 months
e) Record of **alcohol** consumption in the last 12 months
f) Record of **blood pressure (BP)** in the last 12 months
g) Record of **body mass index (BMI)** in the last 12 months
h) Record of advice given regarding **pregnancy/contraception** and patients' contraceptive intentions recorded in the last 12 months (in women aged <45 years)
Components from NICE guidelines, Lester Tool and GP Local Enhanced Services:
i) Record of **weight** in the last 12 months
j) Record of **ECG** in the last 12 months
k) Record of **pulse** in the last 12 months
l) Record of **dietary advice** in the last 12 months
m) Record of **physical activity levels** in the last 12 months
n) Record of **smoking** status in the last 12 months
o) Record of **drug misuse** status in the last 12 months
p) Record of **medication review** in the last 12 months
Other parameters of interest:
q) Psychotropic medication prescribed on the electronic **repeat template**
r) Enquiry about **side effects** of psychotropic medications in the last 12 months and whether GASS / LUNSERS tools were used

Abbreviations- QOF: Quality and Outcomes Framework; HDL: high-density lipoprotein; HbA1c: glycated haemoglobin (A1c); CVD: cardiovascular disease; GP: general practice; ECG: electrocardiogram; GASS: Glasgow antipsychotic side-effect scale; LUNSERS: Liverpool university neuroleptic side effect rating scale.

Results

A total of 59 patients were included on the mental health register at the selected GP practice; of which, 54 patients (92%) had coded diagnoses of SMI. The 5 other patients had diagnoses of either an acute psychotic disorder; psychotic episode; or resolved psychosis; and were no longer taking any antipsychotic or mood-stabilising medications. Regarding the breakdown of coded SMI diagnoses for the 54 individuals with severe mental illness included in the audit sample: 27 patients (50%) had a diagnosis of schizophrenia or psychosis; 20 (37%) were diagnosed with bipolar

disorder; and 7 (13%) had psychotic depression. All SMI patients were prescribed psychotropics for their mental illness.

The age range of the included sample was 18-88 years, with an average age of 47 years. 20 patients (37%) were within the age bracket of 18-39 years; 24 patients (44%) were between 40-60 years; and 10 patients (19%) were over 60 years old. The gender split was 44% male to 56% female. We also looked at the degree of multi-morbidity in the sample, finding that 69% of individuals had comorbidities; of which the most prevalent conditions were high cholesterol, hypertension, diabetes, asthma, osteopenia/osteoporosis and fatty liver disease.

Tables 2 and 3 show the record of monitoring for each physical health parameter as outlined in Table 1, in the last 12 months: period between January 2018 to January 2019. A summary of the audit compliance results of the 8 QOF indicators is given in Table 2; of which only 2 (record of alcohol consumption and blood pressure) reached the expected standard of 70%. Almost all the other parameters achieved >50% compliance (care planning, BMI, serum lipids, serum glucose, QRISK2 cardiovascular risk assessment); however, record of pregnancy/contraception advice was particularly poor, with only 9% compliance in women aged under 45 years.

Table 2: Summary of audit compliance results: Quality and Outcomes Framework (QOF) indicators examined over a 12-month period.

Criterion	Expected Standard	Audit Compliance	RAG Rating
Alcohol consumption	70%	85%	Green
Blood pressure	70%	70%	Green
Care plan	70%	69%	Amber
BMI	70%	56%	Amber
Serum lipids	70%	56%	Amber
Serum glucose	70%	54%	Amber
QRISK2	70%	52%	Amber

Pregnancy/contraception advice	70%	9%	Red

Abbreviations- RAG: Red-Amber-Green; BMI: Body mass index; QRISK2: a cardiovascular disease risk assessment tool.

Table 3 presents the compliance results of the 10 remaining physical health parameters included in this audit of general practice; from criteria derived from NICE guidance, Lester Tool, locally agreed measures included in NWL LES, and other parameters of interest. Only 3 parameters (record of smoking status, medication review and psychotropic medication prescribed on the electronic repeat template) achieved the set standard of ≥70% compliance. Over 50% compliance was reached for most of the remaining criteria (record of pulse, weight, dietary advice, physical activity, drug misuse). Record of ECG offered or performed within the last 12 months was only found in 26% of patients' notes. Similarly, only 39% of patient records had an enquiry about side effects of psychotropic medication in the last 12 months; and when noted, these were simply a general comment stating that the patient mentioned no side effects. Yet, none of the patient records in the sample evidenced a detailed enquiry into the type and extent of common specific medication side effects, nor the use of a quantitative scoring system such as GASS or LUNSERS tools.

Table 3: Summary of audit compliance results: Other parameters examined over a 12-month period.

Criterion	Expected Standard	Audit Compliance	RAG Rating
Smoking status	70%	89%	Green
Medication review	70%	83%	Green
Prescription entered on repeat template	70%	81%	Green
Pulse	70%	63%	Amber
Weight	70%	59%	Amber

Dietary advice	70%	57%	Amber
Physical activity	70%	57%	Amber
Drug misuse	70%	54%	Amber
Side effects enquiry	70%	39%	Red
ECG	70%	26%	Red

Abbreviations- RAG: Red-Amber-Green; ECG: electrocardiogram.

Discussion

Out of 18 parameters included in this audit, compliance against the set standard of 70% was only met in 5 criteria (28%), as shown in Table 2 and Table 3. Compliance scores over the set standard is highly commendable, although this may reflect local financial drivers pursuant to those criteria. For example, 3 of the 8 QOF indicators recommended by NICE were included in the General Medical Services (GMS) contract for QOF 2018/19 in England (NHS Digital, 2020); and it was these 3 indicators (alcohol consumption, blood pressure and care planning) which achieved the highest percentage compliance across the list (Table 2). Equally, most of the remaining QOF indicators were included in the locally agreed North-West London local enhanced services (NWL LES) contract, and we noted reasonable compliance rates of above 50% for all these parameters. However, contraception advice was not included in the England QOF 2018/19, nor local NWL LES contracts, thus likely explains why the compliance level was so low (9%). Yet providing pregnancy and contraception advice in this patient group is recognised by NICE as good practice, particularly considering the risks of conceiving whilst on psychotropic medications. For example, mood-stabilising drugs are known to be teratogenic: The Medicines and Healthcare products Regulatory Authority (MHRA, 2018; BNF, 2019) set strict guidance and advise that sodium valproate should not be administered to women of childbearing age due to the high risk of serious neurodevelopmental disorders (30–40% risk) and congenital malformations (approximately 10% risk). Besides, it would be anticipated that any psychotropic medication taken by the mother may cause side effects in the developing

foetus, as well as the careful consideration and specialist obstetric input which would be needed for management of the high-risk pregnancy and high-risk mothers themselves (Mwebe, 2018).

Moreover, any missed opportunities to conduct physical health monitoring and implement strategies to address unhealthy lifestyle behaviours is likely to further widen the health inequalities and provision of life-saving interventions desperately needed in the SMI population. This is particularly relevant here, as our study found that almost 70% of individuals in the sample suffered from multi-morbidity; of which common comorbidities included those related to cardiovascular disease (high cholesterol, hypertension and diabetes). As Silverwood et al. (2019) argue in their review, two thirds of mortality in SMI is avoidable if patients are offered prompt physical health screening checks for known health risk factors. Of particular note, checks including blood pressure, pulse, weight/BMI measures, serum lipids, serum glucose checks, smoking and ECG monitoring, can assist in identifying individuals at most risk of cardiometabolic complications (Mwebe & Roberts, 2019; NICE, 2016); especially cardiovascular disease, which is the leading cause of premature death in SMI.

As a result of the findings from this audit, we held a multi-disciplinary team (MDT) meeting at the GP practice in order to highlight these learning points to the full clinical and wider administration team and share our discoveries and recommendations. Furthermore, we are aware and are pleased that greater emphasis and attention is being placed on physical health monitoring in SMI patients in the realm of higher education for both medical and nursing students. Although habits, attitude, culture and established practices of experienced mental health professionals may prove more difficult to impact upon, and thus frequent continuing professional development (CPD) updates over time and the growth mindset of lifelong learning is to be encouraged among all healthcare staff. Clinical audits and service improvement projects are good platforms for exploring practice issues, and through which, evaluation of systemic processes can help to inform changes needed in practice and improve overall patient care. Encouraging involvement and raising the profile of quality improvement projects within practices could be a starting point to orientating staff toward evidence-based

healthcare provision. Equally, learning from such initiatives may help to augment current literature, alongside informing future research projects and impacting curriculum design and planning of healthcare-related course delivery.

According to the British Heart Foundation (2018), rates of CVD-related mortality have dropped in the general population over the past 20 years due to improvements in diagnosis, early screening and treatment; but in the SMI population, the health inequality in terms of prompt CVD management remains evident. Our audit results found that the compliance for ECG monitoring, as per the findings in Table 3, was very low at 26%. This percentage not only included those patients who had an ECG performed within the last year, but also took into consideration those individuals who were offered ECG testing but declined or did not attend for the appointment. Thus, it appears that although awareness around ECG monitoring in SMI has generally improved over the last decade, these essential physical health checks remain largely overlooked. Regular ECG checks are significantly important in the SMI population because of the risk of potentially fatal acquired long-QT syndrome with prolonged use of antipsychotic medications (Collins & Altman, 2012; Ringen et al., 2014; Kahl et al., 2018). ECG monitoring can also act as a screening tool for ischaemic changes, arrhythmias and other cardiac-related abnormalities.

The QRISK2 (updated to QRISK3 in 2018) is a tool embedded into primary care computer systems in General practice and is useful as a prediction assessment tool for the risk of developing cardiovascular disease over a ten-year period based on modifiable and non-modifiable risk factors. QRISK3 which now includes the use of antipsychotic medication and mental illness as potential risk indicators is very relevant to users of mental health settings as these medications are associated with a considerable degree of increased CVD risk (Hippisley-Cox et al., 2017). However, the application of QRISK tools across psychiatric services, especially in secondary mental health services (inpatient wards, community recovery teams) remains unclear and inconsistent. Research has found that due to confusion around roles and responsibility regarding physical care monitoring in primary and secondary care services, these settings may miss opportunities to offer individuals with SMI physical health monitoring checks and follow up interventions. For example, preliminary research

findings (from an unpublished study into cardiometabolic risk monitoring across 10 London acute inpatient psychiatric wards) found that QRISK assessment for inpatients was generally not conducted, largely with the expectation that the patient's general practitioner would follow up and offer the checks and necessary interventions instead (Mwebe, 2020). But this assumption is flawed, as it is vulnerable individuals, such as the SMI population, who tend to suffer as GPs become increasingly overworked and the robustness of call-recall strategies to prevent loss-to-follow-up falter. Furthermore, this notion of healthcare professionals omitting patient assessments and interventions in the hope and expectation for another colleague to assume the task, goes against the good practice and collaborative mantra from Public Health England of making every contact count (Public Health England, 2016). This is even more pertinent in the SMI population, in which active engagement with services is more likely to be variable and inconsistent. Therefore, the need for clear communication between primary and secondary care is paramount, particularly following patient discharge from hospital, and ensuring there is sufficient detail in the discharge paperwork to GPs and/or community mental health teams (CMHTs) informing them of what has been done during admission and what still needs to be done or needs following up in the community.

This audit highlights the need for increased health promotion strategies (baseline checks, monitoring and follow-up interventions) for smoking, alcohol, recreational drug use, sedentary lifestyle and dietary advice to be addressed collaboratively and consistently with patients. Our findings showed that the practice scored below the set standard (70%) in the latter three criterions, and yet active management for all of these indicators ought to be adapted as an integral part of the patients' assessment and treatment plan. This is because all these exogeneous factors carry potential risk in influencing body physiological processes and thus can destabilise homeostatic processes. For example, certain drugs, chemicals and substances can influence the rate of biotransformation by increasing or inhibiting the metabolic action of liver enzymes. Of note, the polycyclic aromatic hydrocarbons in tar (found in cigarettes) induce liver CYP450 enzyme activity and so increase the clearance of drugs from the body. As such, smokers with mental illness might require higher doses of their prescribed

psychotropic drugs, e.g. clozapine, olanzapine (Mwebe, 2018). Yet increased doses not only enhance the effects of the antipsychotic drug but can also intensify its side effects. Moreover, smoking cessation in this patient population can lead to increased drug plasma levels if appropriate advice and care is not given to medication planning and reviews. As such, it is imperative that all the above factors, considering lifestyle choices and behaviour, become part of routine conversations and included into patients' care plans (Action on Smoking and Health, 2018).

Social-economic factors in the SMI population are key drivers for widening social and health inequalities; research consistently shows that poor physical and mental health are more common in those with a low socio-economic status (Mental Health Foundation, 2016). Weight gain issues, harmful use of recreational drugs, poor housing and unhealthy eating are some factors driving poor health in this patient group; individuals with SMI are more likely to feature in all the above for a myriad of reasons (Mental Health Foundation, 2016). In order to identify those at most risk, healthcare professionals need to first understand and appreciate the influences such factors have on health (with consideration for environmental, system and individual factors) to tailor strategies and address health inequalities (Mutsatsa, 2015). Our results showed compliance of 69% for care planning, just slightly below the set standard of 70%.

However, more concerning was the finding that only 39% of patient notes had a recorded entry about medication side effects in the last 12 months; none of which featured a detailed enquiry or use of quantitative rating scale. Screening for side effects associated with the use of psychotropic medications is a vital and an essential activity in the care planning process of SMI individuals, not least as an attempt to reduce negative iatrogenic effects on an individual's quality of life, but also because of the known cardiometabolic risk that these medicines carry. The Glasgow Antipsychotic Side-effect Scale (GASS) includes specific questioning regarding cardiometabolic risk (weight gain, cardiovascular effects, glucose abnormalities), as well as covering: central nervous system, extrapyramidal, gastro-intestinal, anticholinergic, hormonal and genitourinary side effects (Waddell & Taylor, 2008). The Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) is an older, alternative scoring system containing a similar comprehensive assessment of side effects (Day et al., 1995). These

tools can greatly enhance the medication review process and can facilitate the crucial input of patient's views about treatment in order to guide evidence-based prescribing; and therefore increase concordance and effectively manage the individualistic balance of risk: benefit ratio (Mwebe, 2018; NICE, 2014; Holland et al., 2018). Hence, while the audit results demonstrated a positive 83% compliance with annual medication reviews, there is a need in practice settings for more detailed discussions relating to medication use, and the nature and degree of specific side effects.

Utilising repeat templates to order prescriptions for SMI patients can act as a key prompt for regular medication review. Fail-safe strategies such as these, are particularly apt for the SMI group, in which a robust system may be needed to tackle recurrent non-attendance and did-not-attends (DNAs). Various possible reasons for non-attendance to appointments in the SMI population have been proposed; these include poor physical health; chaotic lifestyle often due to the nature and severity of mental illness; some patients might not consider these meetings important, and for others it might be due to anxiety, fear, social phobia, stigma of living with mental illness and/or distressing side effects of psychotropic medication (Mental Health Foundation, 2016; Das-Munshi et al., 2018).

As the General Medical Services contract for QOF 2018/19 in England only included a small proportion of the list of best practice QOF indicators for mental health recommended by NICE, it is even more important for GP local enhanced services contracts to include those missing criteria, as one cannot ignore the undeniable weight and driving force of financial incentivisation (Doran et al., 2011).

Conclusion

There is definite room for improvement regarding physical health monitoring of SMI patients within general practice. Our audit found that only 5 out of 18 best practice criteria achieved compliance above the expected standard of 70%. Considering the significant physical health burden and potentially avoidable premature mortality rates within the SMI population, much more needs to be done to address the widening health inequality gap. This begins with increased vigilance and commitment to annual

physical health screening checks, particularly cardiovascular risk factors, and consistently offering individuals prompt and targeted interventions as a result.

Specific recommendations for improvement

- Clear and explicit communication is needed between primary and secondary care, particularly following patient discharge from hospital. The discharge paperwork to GPs and/or CMHTs should clearly detail what has been done during admission and what still needs to be done or needs following up in the community.
- GP practices should ensure they have contingency plans in place, in case service users DNA their physical health monitoring appointments. For example, reception manager or mental health lead at the practice could be tasked with contacting these patients and rebooking the appointments.
- Primary care computer systems have comprehensive templates with physical health tools embedded within them, that can be used for SMI patient reviews. Using such templates will reduce the likelihood of missed physical health check parameters.
- Frequent review of compliance against best practice guidelines should be assessed at GP practices; followed by regular MDT meetings highlighting the current performance and areas for improvement. Where clinical errors or omissions are discovered with the potential for patient compromise, this should be reported immediately to the appropriate patient care coordinator.

Further relevance for clinical practice

- General practice staff should be aware that people with severe mental illness are at greater risk of morbidity and mortality, and therefore, should recognise the significant role they have in detection, prevention and management of cardiometabolic risk and other related physical co-morbidities.

- Financial incentives are effective at increasing compliance results; ideally, all key best practice criteria for physical health monitoring in SMI should be included within the national QOF contract or GP local enhanced services contracts.
- Conducting detailed enquiries into side effects of psychotropic medications is essential; quantitative rating tools (i.e. GASS or LUNSERS) can provide a structured and helpful framework for this.
- Robust call-recall systems are needed in primary care to tackle non-attendance within this vulnerable patient group, and to enable the patient and carer to be actively involved in optimising physical health monitoring and management.

Acknowledgements

We would like to express special thanks and gratitude to staff at the North London General Practice who allowed us this opportunity to carry out this audit.

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Notes on contributors

Dr Danielle Roberts

Dr Danielle Roberts is a GP Specialist Trainee on the London Imperial Vocational Training Scheme and a part-time research associate at University College London. She graduated from University of Bristol with Bachelor of Medicine and Bachelor of Surgery (MBChB) in 2015, awarded with Distinction; and also attained a First-Class Honours Bachelor of Science in Physiological Science (BSc). Danielle completed her Master of Science in Evidence-Based Healthcare (MSc) at University College London, again awarded with Distinction. Beyond her career path in general practice, she has a keen interest in mental health and academia.

Herbert Mwebe

Herbert Mwebe is a senior teaching fellow and a senior Lecturer in Mental Health in the School of Health and Education at Middlesex University. Within the Department of Mental Health, Herbert delivers physical health training for both undergraduate and postgraduate programmes. He is the CPD programme lead in the department, and his teaching and research interest focus on improving physical health in serious mental illness and psychopharmacological interventions in mental health settings. Prior to entering academia, Herbert worked in both inpatient, community and primary care settings; between 2013-2014 in General Practice. He worked in General Practice leading on a mental health project (PMS+ Mental Health Project) in City and Hackney commissioned by NHS England with a key function to providing timely management of people presenting with mental illness in primary care.

Ontario's Postsecondary Cooperative Education in a National and a Global Context: a mixed-methods exploration into its strength and issues

QIANG ZHA[*]

Faculty of Education, York University, Canada

And

QING WU

Institute of Education Sciences, Wuhan University, China

Abstract: Postsecondary cooperative (PSE co-op) education is a structured method of combining classroom-based education with practical work experience, for which Ontario is termed a "hot bed." Adopting a mixed-methods design, this study explores the status and characteristics of Ontario's PSE co-op in the national and the global contexts through the knowledge map analyses. Then, with three case studies at University of Waterloo, Brock University, and University of Victoria, it examines particular aspects of Ontario's PSE co-op concerning some significant questions such as what exactly distinguishes PSE co-op in Ontario, what can be done—especially with new "work-integrated learning" ideas and approaches--to continuously improve this type of experiential education, and how co-op education can be steered to better meet the changing needs in the 21st century.

Keywords: Ontario PSE Co-op; Status and Characteristics and Position; National and Global Contexts; Mixed-Methods Analysis

[*] **Corresponding author:** Qiang Zha. Email: QZha@edu.yorku.ca

Introduction

Postsecondary cooperative (or co-op) education is a structured method of combining classroom-based education with practical work experience for the students in universities and colleges. A co-op education experience provides academic credit for structured job experience (Groenewald, 2004), and it is believed to provide benefits for students (including motivation, career clarity, enhanced employability, vocational maturity) and employers (labour force flexibility, recruitment/retention of trained workers, and input into curricula) as well as educational institutions and society (Braunstein & Stull, 2001; Bramwell & Wolfe, 2008; Bayard and Greenlee, 2009; Morris, 2010; Reid, 2010; Sattler et al, 2011; Peters et al, 2014). Research shows students with co-op experience outperform non-co-op peers: they are more active in learning, more realistic in terms of expectations, clearer about their own abilities, more confident, as well as more competent in terms of "soft skills" that feature cooperative effect (Van Gyn, 1997; Blair & Millea, 2004; Noyes & Gordon, 2011). In the 21st century, co-op education takes on new importance in helping young people to make the school-to-work transition, and build experiential learning initiatives (Grosjean, 2003; Haddara & Skanes, 2008).

Canada is commonly regarded as the leader of offering co-op education in postsecondary stage (Axelrod et al, 2003; Tamburri, 2014). The first Canadian PSE co-op program was launched in 1957 at the University of Waterloo in Ontario (Barber, 1968; McCallum & Wilson, 1998; Haddara & Skanes, 2007). Ever since, Ontario is termed a "hot bed" of co-op education (Reid, 2010), with 24% of Ontarians with postsecondary education reporting participation in co-op (compared to 17% nationally) and 37 colleges and universities (out of a total of 47) in Ontario offering co-op programs. Naturally, this phenomenal co-op presence in Ontarian universities and colleges should be reflected in research literature. As such, this paper explores the status and characteristics of Ontario's PSE co-op in the national and the global contexts through the lens of research literature, via a bibliometric analysis or more precisely a knowledge map[†]

[†]Knowledge map is here an approach to applying knowledge graph and virtualizing bibliometric analysis. In this study, we use keywords in PSE co-op education literature to imbed nodes (demonstrating research topics), and co-existence of nodes to determine coverage area in constructing a knowledge map, which in turn depicts the

analysis. Arguably, a bibliometric analysis based on a knowledge map has never been applied to studies of PSE co-op in Ontario as well as Canada. Then, this paper examines particular aspects and questions concerning Ontario's PSE co-op, resulting from the knowledge map analysis, such as what in real world distinguishes PSE co-op in Ontario, what can be done to continuously improve this particular type of experiential education, and how co-op education can better meet the needs of an increasingly knowledge-based economy in the 21st century and in the meantime forge the principle of equality and equity. The second strand of this study is conducted through three case studies respectively in University of Waterloo, Brock University, and University of Victoria.

Context of This Study and Literature Review

Now co-op education is described as part of a work-integrated learning (WIL) spectrum (Sattler et al., 2011). WIL describes a range of educational activities that unites what is learnt in an academic setting with what is experienced in a practical working environment. Co-op is not to be confused with other WIL forms such as practicums, work-study positions, placements, internships, apprenticeships, or job shadowing (McRae & Johnston, 2016; Reinhard et al., 2016). These branching ideas differ for reasons such as their purpose, context, nature of integration, and curriculum issues (Sattler et al., 2011). With that regard, co-op is defined as a progressive and formal integration of a student's academic studies and work experience in a structured and educational manner. As such, co-op education is equipped not only to prepare students for workplace but also nurture good citizens (Hall et al., 2011). It bears the potential of being compatible with liberal arts education (Ricks, 1990), and supporting growth of critical thinking (Bygrave & Gerbic, 1996), as well as benefitting disadvantaged social groups, e.g., visible minorities and females (Metghalchi et al., 2013; Samuelson & Litzler, 2013; Raelin et al., 2014; Taylor et al., 2015).

knowledge network and characteristics of the field of PSE co-op education studies in a specific jurisdiction or beyond.

Areas for improvement in PSE co-op education has become a research focus (Schaafsma, 1996; Haddara & Skanes, 2008). McRae and Johnston (2016) suggest that the future of co-op programs needs to be oriented towards reflection of learning and work experiences. Such reflection can validate purposes outlined in curriculum through the generation of authentic feedback from the learner. Through a series of constant reflection, students should be able to make connections between their experiences and learning objectives. Although opportunities to reflect are now incorporated in co-op curriculum, students often neglect making these connections and enhancing their experiences (Garavan & Murphy, 2001; Jones, 2007). This is largely because they don't know what objectives were initially set, thus have no idea how to make sense of these connections. Without fully understanding the significance or meaning behind the theoretical component of practice, students may lose interest and motivation in their co-op experiences—which might be unintended effects of co-op education. By the same token, a formal assessment of experiences acquired through placements can contribute to evaluating the effectiveness of experiential learning too. It is problematic, however, that written goals in co-op educational guidelines often do not recognize employers as potential co-learners (Schaafsma, 1996). As such, employers can be left unaware of the learning objectives set out for students working in their organizations. Such a scenario often makes individual employers feel disconnected to the students learning experience or as though they have irrelevant responsibilities, hence tarnishing the meaningful knowledge that students are encouraged to gain through experiential learning (Fleming, 2015). Such literature concerning areas for improvement is important yet scattered, and needs to be synthesized systemically.

Research with respect to co-op programs used to be predominated by quantitative methods (Jones, 2007), e.g., surveys that gathered data about co-op experiences and student perceptions in order to examine the benefits and disadvantages of co-op education (Coll & Chapman, 2000). As such, research findings tended to be too generalized and tenuous for other academics to extend conclusions. Subsequently, researchers become attracted to qualitative research methods because of its ability to probe answers and insights for in-depth inquiries (Coll & Chapman, 2000). Researchers have also suggested that blended methods of quantitative

and qualitative research are valuable strategies for studies in the realm of co-op learning because they can enrich the data collected (Schaafsma, 1996; Coll & Chapman, 2000). Insofar, PSE co-op research draws primarily on case study. Most research about co-op programs commonly pertains to their design, providing insights into co-op education curriculum and administration (Schaafsma, 1996; Coll & Chapman, 2000).

The Research Design and Methods

As such, this study adopts a mixed-methods approach/design, drawing on strength of both quantitative and qualitative studies. It starts with a quantitative strand, a knowledge map analysis of academic journal articles regarding PSE co-op education worldwide, pooled via data crawling with the words “cooperative education,” “co-op education” and “co-op” in four major databases of scholarly publications, namely, Web of Science (WoS), ERIC, Springer and SSRN. We searched in both standard keywords and/or article titles—in case there are journals not requiring the use of standard keywords—to crawl data for the knowledge map analysis. Succinctly, the data consist of all the standard keywords and titles used in those selected journal articles. This analysis aims to position Ontario nationally and globally in terms of its research level, research contribution and shared research hotspots, as detected in academic literature. Here, research level is defined by such characteristics as research extent (topics covered) and research cohesion (collateral relations between topics), manifested in the country-specific knowledge map as number of nodes (keywords/research topics) and connection between them. Put succinctly, a greater number of nodes means more research topics covered and a larger research extent, and more linkages between nodes indicate a stronger research cohesion shown by a country’s PSE co-op studies. Research contribution is based on a global knowledge map of PSE co-op studies, and determined by the share of a specific country vis-à-vis the total. In practice, this is done through a cluster analysis applied to the global knowledge map of PSE co-op studies that generates 7 thematic areas, then discerning shares contributed by researchers from different jurisdictions in each and every thematic area. Finally, shared research hotspots are explored to shed light on correlations

between jurisdictions investigated and thematic areas identified, through constructing a knowledge map of the most shared research topics. Specifically, this process determines hotspots worldwide regarding PSE co-op studies, which are the most popular and arguably cutting-edge research topics, and in turn Canada's and Ontario's relations to those hotspots. Technically, such knowledge maps are constructed with assistance of the computer software instrumental and available such as CiteSpace, Pajek and BICOMB (Bibliographic Items Co-occurrence Matrix Builder). For technical reasons, Canada is compared with other jurisdictions mostly in the quantitative strand or knowledge map analysis, then Ontario is examined against the rest of Canada. Put succinctly, Canada is used as a medium to project Ontario on a global knowledge map. Given the nature of a wide-scope and a large-scale inquiry of this task, a quantitative strand stands out as an appropriate approach, and such quantitative research design and process are illustrated in Figure 1 below:

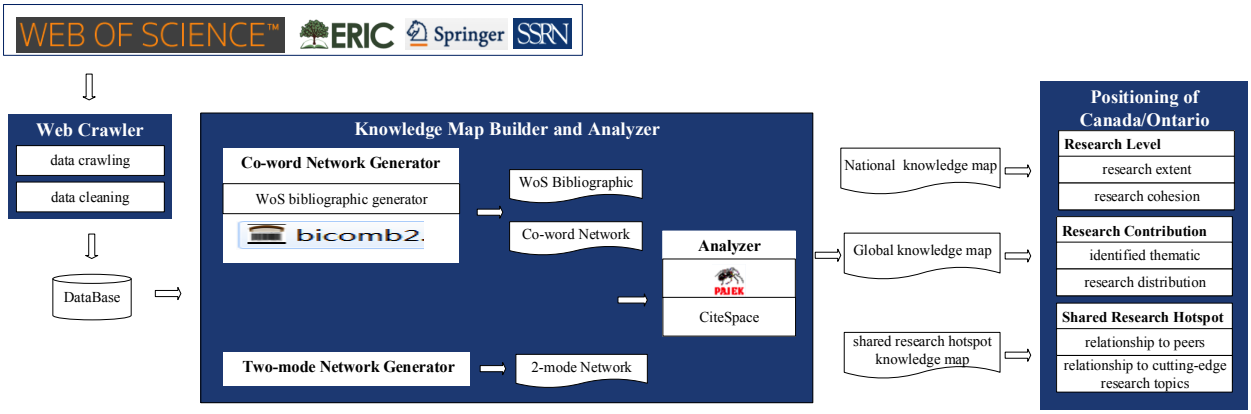

Figure 1: The Research Design of Knowledge Map Based Analysis

While the knowledge map analysis may empirically position Canada's PSE co-op education on a global knowledge map, hence project Ontario's in a global context (via revealing its status in Canada), it has no capacity to shed light on the reasons and factors behind the scene, and more importantly to elucidate the current dynamics for change. As such, a qualitative strand featuring in-depth interviews with insightful informants is added to explore the specific factors that explain the characteristics of Ontario's PSE co-op as depicted on the knowledge map, and by so doing to relate those characteristics to the ongoing changes in Canada. As such, the

qualitative strand fits well to further and substantially probe the strength and gaps of Ontario's PSE co-op in a national context, which is implemented with three case studies conducted in Spring 2017: University of Waterloo and Brock University in Ontario, and University of Victoria (UVic) in British Columbia. The University of Waterloo is chosen because the university is best known in Ontario and Canada for providing co-op opportunities across all programs of study. It now operates the largest postsecondary co-op program in the world: almost two-thirds of its undergraduate students, approximately 19,000, are enrolled in more than 120 co-op programs and on co-op placements with 6,300 employers. While the university's undergraduate enrolment grew 38% between 2004 and 2013, its co-op enrolment grew 58% in the same period. Brock University presents a different case from Waterloo (in terms of curricular strength and program offerings), and the third largest co-op program in Ontario, with one of the most diverse choices of co-op program areas. In addition, it features nearly 100% placement rate for students across all programs, which represents one of the highest and most consistent placement rates in the country. The University of Victoria is selected as a benchmarking case in the national context. Located closer to the booming Asia-Pacific economies, it has seen a steady increase in placements since 2008. Now, it operates the largest co-op program in western Canada, offering 224 co-op programs for almost every academic program of the university (which open doors to international students) and placing over 3,500 students with 1,200 companies and organizations. Altogether 5 informants were interviewed in three case study universities, all with portfolios in charge of the co-op program in their own universities. In addition, 4 informants working with the Higher Education Quality Council of Ontario (HEQCO), the Ontario Universities Council on Quality Assurance (the Quality Council) and the Canadian Association for Co-operative Education (CAFCE) were interviewed for specifically relevant questions and for the purpose of data triangulation. The interview sessions were semi-structured, with assistance of a list of questions informed by both outcome of the knowledge map analysis and the literature itself.

The Status and Characteristics of Ontario PSE Co-op in a Global Context as Evidenced in Research Literature

Data collection and data synthesis

The data in this study, journal article keywords, were searched in and collected from Web of Science (WoS), ERIC, Springer and SSRN. Such an approach to data collection has an obvious advantage regarding data quality, yet limitations concerning non-English data, e.g., literature in German and Chinese. Altogether there were more than 2,000 journal articles that were identified as relating to co-op education. Among them, however, there were 578 articles concerning co-op in high schools, which had to be left out. There were another 52 articles excluded due to missing information about the authors' institution and geographic location. In addition, some countries had very few articles about their PSE co-op education, which would not only contribute little to this study but also potentially skew the analysis. Therefore those countries together with their articles were removed from this study. As a result, a total of 7 countries each with 15 or more articles entered the dataset and analysis in this study, as described in Figure 2 below:

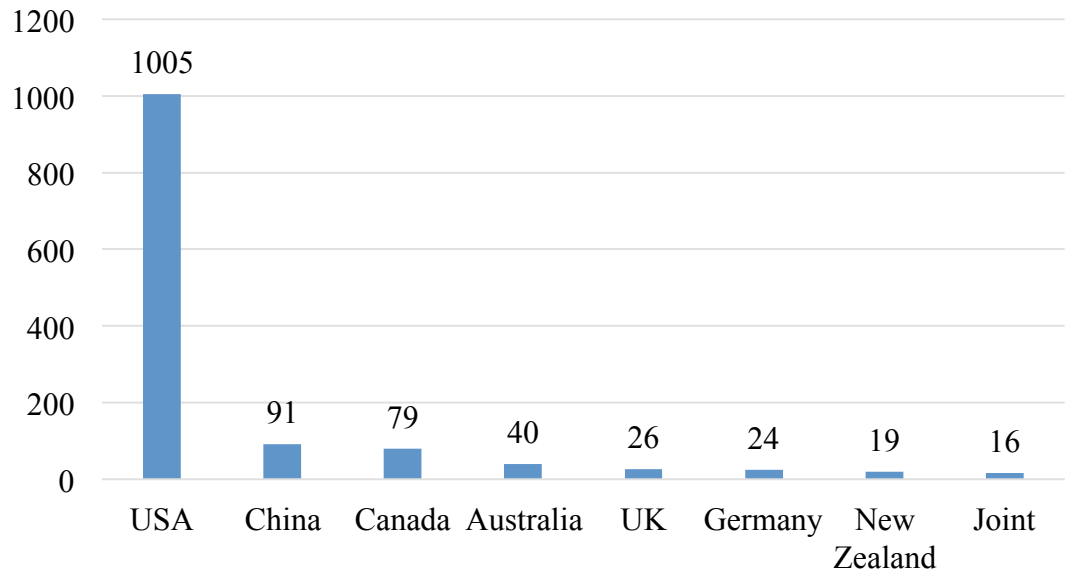

Figure 2: Countries and Their Articles Included in This Study[‡]

Positioning Canada and Ontario on knowledge maps

Figure 2 tells us that articles concerning PSE co-op education in Canada don't quantitatively dominate the relevant literature body. Canada's visibility in the literature came next to the USA and China, though, this might be reasonable given that postsecondary education sectors are much larger in the USA and China than Canada. Notably, among Canada's 85 articles (a number after adjustment for joint authorship), Ontario has the largest share of 48.2% or 41 articles. Albeit the size disadvantage (compared with that of the USA, China, the UK, and Germany etc.), Canada and Ontario are characterized by a high research level but a modest research cohesion with respect to PSE co-op studies, as shown in Table 1. In this table, as explained earlier, nodes refer to keywords or research topics. In order to get a clean picture, keywords are filtered, and only those with high frequency (constituting 50% of each country's total keywords) are retained as the nodes to construct national knowledge maps. Table 1 essentially shows structure and characteristics of those national knowledge maps: average density is the ratio between actual number of connecting lines and the possible maximum, average distance is the mean of all the lines between those nodes, and cohesion index is used to measure level of bundle between the keywords. These indicators combine to describe research level of the selected systems.

Table 1: Research Level of PSE Co-op Studies in Major Jurisdictions

Jurisdiction	Selected Nodes	Average Density	Average Distance	Cohesion Index
USA	162	0.4939	1.50610	0.61211544
China	67	0.0882	2.79964	0.38025210
Canada	149	0.1404	1.89080	0.37910821
Australia	80	0.2430	1.78734	0.49002474
UK	54	0.2257	1.83788	0.48309662
Germany	27	0.4387	1.57846	0.73178295
New Zealand	35	0.4286	1.57143	0.62605549

[‡] Joint authorship is then adjusted for analysis, through adding one (1) article to the jurisdiction of each and every co-author.

Ontario	71	0.2285	1.77666	0.47530422

Canada possesses the second largest number of nodes (research topics), only next and quite close to that of the USA, despite of the huge difference in size of PSE in the two countries. Ontario has the fourth most nodes, accounting for 47.7% of Canada's total and slightly behind Australia. These figures attest that Canada enjoys a rich and a wide range of PSE co-op practices, and Ontario contributes almost half of Canada's research articles and research topics in this regard. Such an abundancy regarding research topics and outcomes arguably manifests the status of development and maturity of PSE co-op education in Canada and Ontario. However, neither Canada nor Ontario seems to stand out in terms of research cohesion. Among the three indicators pertaining to research cohesion, Ontario is ranked the 5th and Canada the 7th on average density, which indicates a relatively low level of collateral studies between those research topics; Canada has the 2nd highest average distance value while Ontario is the 5th on this indicator, which shows Canada as a whole suffers from a considerably sparse distribution of research topics/ideas (distant from each other) but Ontario appears to be relatively better, i.e., Ontario has a more balanced coverage of research topics than the rest of Canada; Ontario is placed the 6th and Canada the 7th on cohesion index, which points to a poor bundle of those research topics in Canada as well as Ontario. Altogether, these indicators prove aspects of PSE co-op education are studied quite sparsely and not much in a related manner in Ontario and Canada, though Ontario seems to be better than the rest of Canada. A follow-up cluster analysis reveals both Canada and Ontario lean towards Australia and the UK in terms of research level. In spite of a sizable pool of research topics (next only to the USA), Canada is far behind the USA, Germany and New Zealand with respect to research cohesion; so is Ontario. Put succinctly, many of those research topics tagged to Canada and Ontario are quite convergently studied, rather than being cross-examined.

As such, there is a need to find out what specific aspects of PSE co-op education are convergently studied in Canada and Ontario. For this purpose, a global knowledge map is constructed employing most frequently used 200 keywords (which account for 52% frequency

of use of all keywords)[§], with assistance of CiteSpace (particularly the thematic clustering and jaccard index), as displayed in Figure 3. As a result, seven thematic areas are spotted from this pool of keywords, each based on a considerable amount of core concepts. Specifically, Thematic Area #1 (T1) "Program Administration" consists of the core concepts such as "program descriptions," "program design," "program development," "program evaluation," program implementation," and "cooperative planning"; Thematic Area #2 (T2) "Federal Aid" pertains to "federal legislation," "federal program," "financial support," "grants" etc.; Thematic Area #3 (T3) "Teaching and Instruction" includes "behavioral objectives," "competency based education," "instructor coordinator," and "curriculum guide" and so on; Thematic Area #4 (T4) "Stakeholders' Attitudes and Co-op Outcomes" relates to "administrator attitudes," "college credits," and "cost effectiveness"; Thematic Area #5 (T5) "Impact on Education" has "academic achievement," "educational change," "educational improvement," and "educational innovation"; Thematic Area #6 (T6) "Co-op Influence Based on Institutional and Student Characteristics" centers on "educational finance," "enrollment," "institutional characteristics," "student characteristics"; and Thematic Area #7 (T7) "Career Development" focuses on "career choice," "career counseling," "career guidance," "career planning," and "career development." Table 2 records more details regarding those identifiable thematic areas.

[§] Effectively 98 keywords contributed to constructing the global knowledge map, after leaving out those indirect or nonspecific words about cooperative education such as postsecondary education, higher education, university, college, community college, two year college, adult education, college student, college graduates, college faculty, advisory committees, engineering education, business education, trade and industrial education, foreign countries, etc.

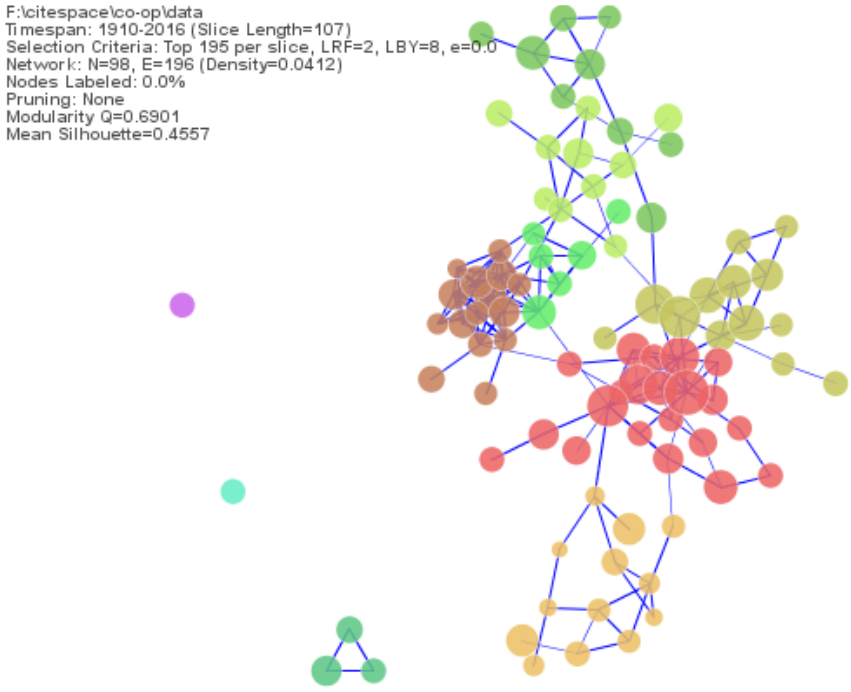

Figure 3: A Global Knowledge Map Regarding PSE Co-op

Table 2: Identified Thematic Areas on the Global Knowledge Map Regarding PSE Co-op Education

Theme	Description	Amount of Core Concepts
T1	Program Administration	21
T2	Federal Aid (policy, financial support)	15
T3	Teaching and Instruction	13
T4	Stakeholders' Attitudes and Co-op Outcomes	10
T5	Impact on Education	12
T6	Co-op Influence Based on Institutional and Student Characteristics	6
T7	Career Development	9

Table 3 shows that, like many other jurisdictions, Canada devotes the largest portion of its research topics (35%) to co-op program administration, i.e., how to plan, design, implement,

and evaluate co-op program. Next to program administration, Canada pays relatively a great attention (32%) to stakeholders' attitudes and co-op outcomes, which is in turn a phenomenon worth attention in this study. Another significant area is career development, in which Canada shows the largest share (12%) relative to all other peers in this study. When converting such contributions into percentage as shown in Table 4, Canada excels among all but the USA: enjoying a larger contribution in all the thematic areas, particularly in Thematic Areas #4 (T4) "Stakeholders' Attitudes and Co-op Outcomes" and #7 (T7) "Career Development." Table 5 reveals Ontario's contribution to Canada's overall accomplishment: while Ontario focuses its own attention on Thematic Areas #4 and #7 as well, it dominates Canada's performance in Thematic Areas #4 through #7, prevailing the contribution ratio as from 42.86% to 100%. As such, it might be fair to say Ontario remains Canada's leading place with respect to PSE co-op education practices and research, as evidenced in academic literature.

Table 3: Keyword Contributions in Each Thematic Area (in frequency of the total & percentage of the own)

Jurisdiction		T1	T2	T3	T4	T5	T6	T7
USA	*f*	865	401	279	448	183	223	151
	%	**34**	16	11	18	7	9	6
China	*f*	2	0	3	3	6	0	0
	%	14	0	21	21	43	0	0
Canada	*f*	47	8	7	42	9	4	16
	%	**35**	6	5	**32**	7	3	**12**
Australia	*f*	35	1	5	26	8	3	0
	%	**45**	1	6	33	10	4	0
UK	*f*	12	1	6	17	5	3	2
	%	26	2	13	37	11	7	4
Germany	*f*	13	0	1	3	2	2	1
	%	**59**	0	5	14	9	9	5
New Zealand	*f*	7	3	1	16	1	4	0
	%	22	9	3	50	3	13	0
Total		981	414	302	555	214	239	170

Table 4: Keyword Contributions to Global Knowledge Map (in percentage)

Jurisdiction	T1	T2	T3	T4	T5	T6	T7	Total
USA	88.18	96.86	92.38	80.72	85.51	93.31	88.82	88.70
China	0.20	0.00	0.99	0.54	2.80	0.00	0.00	0.49
Canada	**4.79**	**1.93**	**2.32**	**7.57**	**4.21**	**1.67**	**9.41**	**4.63**
Australia	3.57	0.24	1.66	4.68	3.74	1.26	0.00	2.71
UK	1.22	0.24	1.99	3.06	2.34	1.26	1.18	1.60
Germany	1.33	0.00	0.33	0.54	0.93	0.84	0.59	0.77
New Zealand	0.71	0.72	0.33	2.88	0.47	1.67	0.00	1.11

Table 5: Ontarian Contributions in the National and Global Context

	T1	T2	T3	T4	T5	T6	T7	Total
Ontario Frequency	11	3	2	18	6	4	12	56
% of Ontario Total	19.64	5.36	3.57	**32.14**	10.71	7.14	**21.43**	100
% of Canada Total	23.40	37.5	28.57	**42.86**	**66.67**	**100.00**	**75.00**	42.11
% of Global Total	1.12	0.72	0.66	3.24	2.80	1.67	7.06	1.95

Finally, based on the global knowledge map previously constructed with frequently used keywords, a country dimension is added to construct a knowledge map of shared research hotspots. This knowledge map takes the form of a 2-mode network[**] and is used for two purposes. One is to identify degree of keywords (research topics) shared by the countries studied, as displayed in Figure 4. Canada is depicted to share most research topics with the USA, 60 in total. Figure 4 further reveals that Ontario shares 31 research topics with the USA, while the rest of Canada shares 41 with the USA. On the other hand, this process of analysis also sheds light on what keywords are most shared, and 16 are identified as being shared by 5 or more jurisdictions. Table 6 records them, and fits them to the previously discovered thematic research areas. It indicates that Thematic Area #1 ("Program Administration"), #3 ("Teaching

[**] A 2-mode network has two sets of nodes, and ties exist only between nodes belonging to different sets (De Nooy et al., 2011, p.103). In this study, the two sets of nodes are keywords and jurisdictions, and a jurisdiction is linked to a keyword if it appears on the jurisdiction's national knowledge map (a 1-mode network). Two-mode networks are often transformed into 1-mode networks for analysis, because most network measures are solely defined for 1-mode networks (Latapy et al., 2008), as demonstrated in Figure 4.

and Instruction"), #4 ("Stakeholders' Attitudes and Co-op Outcomes"), #5 ("Impact on Education") and #7 ("Career Development") are studied by researchers in most jurisdictions, thus contain the cutting-age topics in the terrains of PSE co-op studies. As discussed above, Canada and Ontario perform well in such cutting-edge research terrains as "Program Administration," "Stakeholders' Attitudes and Co-op Outcomes" and "Career Development," yet underrepresented in those of "Teaching and Instruction" and "Impact on Education."

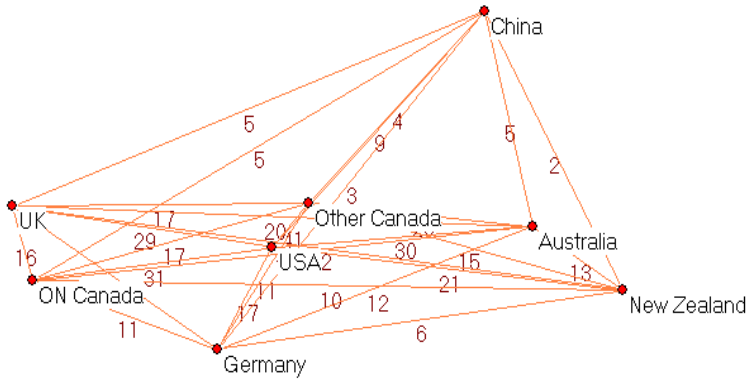

Figure 4. Level of Shared Research Topics between Countries.

Table 6: Cutting-Edge Research Terrains and Topics

Most Shared Keywords	Theme #	Thematic Description
school business relationship, school community relationship, program descriptions, partnership in education, program administration, program evaluation	T1	Program Administration
teaching method	T3	Teaching and Instruction
education work relationship, outcome of education, employer attitudes, student attitudes, program effectiveness, experiential learning	T4	Stakeholders' Attitudes and Co-op Outcomes
educational change, educational policy	T5	Impact on Education
job placement	T7	Career Development

In sum, Canada (including Ontario) poses as contributing modestly to scholarly literature with respect to PSE co-op education (accounting for only 4.63% of the total), though, this modesty should be corrected by the size of Canada's PSE sector, particularly in comparison with that of USA and China. Subsequent to such correction, Canada as well as Ontario seem to perform well, relative to such peers as the UK, Germany and Australia, in terms of research extent or sum of research topics covered in the literature studying their PSE co-op education. Besides, Canada and Ontario are present in a majority of the research terrains containing the cutting-edge topics. The real problem seems to stem from rather poor research cohesion or a lack of collateral relations/connections between those research topics, especially for Canada as a whole, while Ontario appears to be in a slightly better position. Arguably, many issues regarding PSE co-op education might be intrinsically related, thus need to be cross-examined. As such, a high degree of research cohesion should be viewed as an indicator of healthy development and growth about PSE co-op research and practices. For Canada and Ontario, attention seems to be convergently focused on certain selected areas, e.g., stakeholders' attitudes and co-op outcomes, and career development. While this pattern sheds light on uniqueness of PSE co-op education in Canada and Ontario, it also ushers in the necessity to pay due attention to cross-examining the issues from multiple perspectives and in an interconnected manner.

The Status and Characteristics of Ontario PSE Co-op Education in a National Context as Illustrated with Three Case Studies

The knowledge maps analysis, while depicting the characteristics of PSE co-op education in Ontario as expressed in scholarly literature, leads to further questions such as: What exactly distinguishes Ontario as a PSE co-op education leader in Canada? How can co-op education program be improved in Ontarian universities in the changing context? Specifically, how can co-op education provide students with a structure within which they can reinforce employability skills, examine larger issues about work and society, and undertake the crucial activities of critical reflection? Or, how can co-op education in Ontarian universities prepare students for

the both roles as workers and citizens in the 21st century? How can co-op education in Ontarian universities employ active participation approaches and forge principle of equality and equity? Arguably these are the important questions resulting from the study based on knowledge maps or derived from the research literature directly, which cannot be addressed by the quantitative analysis.

As such, three case studies are introduced, as explained previously, in University of Waterloo and Brock University in Ontario, and University of Victoria in British Columbia. Five informants were interviewed in the three universities[††], who provided responses and inputs based on their work experiences as well as reflections of co-op education in Ontario, Canada and worldwide. In addition, four informants working with HEQCO, Ontario Quality Council and CAFCE were interviewed to address relevant questions or verify the data. Their responses and inputs shed light on themes elaborated in the remainder of this paper.

Ontario remains a leader of PSE co-op education, yet there is a need to boost the research

Albeit modest (and sparse) coverage in PSE co-op research and rather low research cohesion as indicated in academic literature, Ontario remains a leader of co-op education at university level, according to the key informants at University of Waterloo and Brock University. A number of reasons and factors arise from their responses. First and foremost, there is a high level of consensus concerning co-op education in Ontario and the universities as to what it entails, and how it is organized and practiced, which is not necessarily the case in many other places. Specifically, co-op education means a program that alternates periods of academic study with periods of work experience in appropriate professional fields in accordance with explicitly and concisely shared criteria among all the stakeholders such as: both work and academic terms offered in full time and following a formalized sequence (the total amount of co-op work experience is normally at least 30% of the time spent in academic study), work terms exposed

[††] Initially the researcher meant to interview more informants in the case study universities, but then found the centralized (and a hierarchical) structure of administration regarding co-op program made it unnecessary, as 1-2 top administrators possess and control all the details needed for this study.

to the work environment during more than one season of the year, students receiving remuneration in the work term, students' performance in the workplace supervised and evaluated by the employer, etc. Behind this approach is an educational philosophy that stresses experiential learning, rather than the idea of putting in place a job placement mechanism. To a large extent, such an approach of enhanced experiential learning is supported with a strong institutional commitment in the case study universities, all with a centralized structure supported by a good size of staff and budget. While this is the case across Canada, Ontario stands out enjoying a large employer base (partially due to the economy size) and enormous support from co-op program alumni grown over the years. In many senses, the value of co-op education is embedded in a supportive culture in Ontario, in which there are clearly understood long-term expectations with all sides, e.g., universities, employers, students, etc. (Grubb & Badway, 1998). Such a culture featuring explicit expectations for co-op education "may be more powerful in the long run than a complex set of regulations and bureaucratic requirements" (Grubb & Villeneuve, 1995, p. 27). This in turn perhaps explains why Ontario dominates Canada's research literature in such thematic areas as "Stakeholders' Attitudes and Co-op Outcomes" (T4), "Impact on Education" (T5), "Co-op Influence Based on Institutional and Student Characteristics" (T6), and "Career Development" (T7).

Nonetheless, Ontario now faces competitors and challenges, as well as the issues. Internationally, Australian universities involve academics in administration and management of co-op program—as opposed to full-time staff in Ontarian universities—which in turn boosts scholarly explorations of this particular type of experiential learning. In Canada, British Columbia rises with significant emphasis and distinctive strength with respect to co-op research and pedagogy, which will be elaborated with details in the following sections pertaining to PSE co-op education quality control for continuous improvement and especially co-op education catering for the both roles as workers and citizens in the 21st century. Within Ontario, in spite of widespread co-op program in the universities, research is hardly systemic, but rather ad hoc, largely resulting from the practitioners' individual pursuit. This situation should explain why Ontario's research literature concentrates on co-op program administration and stakeholders'

perspectives as well as co-op outcomes, as they mostly come from co-op practitioners' reflections of their work experience or as required by the accreditation process, while faculty researchers of higher education studies don't necessarily view co-op education as a conventional area of scholarly exploration. This situation certainly ushers in limitations for co-op education research in Ontario, and across Canada as well. In this regard, an informant expressed her frustration:

> *"there is a handful of us in Canada….these are practitioners who have started our PhDs and started doing research, so really there are handful of us….but it is very odd ad hoc and based on individuals. Where you will see a difference is in Australia…"*

Furthermore, "it is a class structure of whose knowledge counts. And if it is not done by faculty researchers then it is not really legit….I did accomplish a doctorate but I am not in a tenure-track position."

When asked how to boost research about co-op education in the universities, the informants in the case study universities came up with two interesting ideas. One is from a key informant at University of Victoria particularly, that community engagement might be a hook to get faculty researchers on board: co-op education used to be viewed as a kind of

> *"sidebar industrial model….but when I start using the community engagement language and this is how we have mapped it out at the University of Victoria….then all of a sudden faculty members are interested. And I think that is the hook."*

Indeed, co-op education can be held as a form of community engaged learning, which is in turn an important part of community engagement strategy. As the "anchors of creativity," postsecondary institutions are now indeed expected to become community players that support growth through the exchange of knowledge and career developing opportunities (Bramwell & Wolfe, 2008, p.1176). The other idea is shared by a number of informants that the

escalating interest in Work-integrated Learning (WIL) could help heighten the status of co-op education as a core form of experiential learning. Traditionally, co-op education "somewhat lives between the administrative world and the academic world," while WIL now helps confirm "we are an academic program," as observed by an informant. Notwithstanding, staff and faculty associating with co-op education need to pay close attention to the articulation and integration between the curriculum in classroom and the experience in workplace. As an informant asserted, "I believe that the learning that students do in the workplace is extremely powerful learning….but we don't take advantage of that ourselves as a learning organization," while another informant in a different university echoed "I would say the biggest challenge in the centralized system is maintaining the connections to the curriculum in the faculties."

Quality control has gaps, especially for the sake of continuous improvement

Canada, including Ontario, enjoys a unique strength of having in place an accreditation policy and mechanism, which is not matched by any other jurisdictions in the world. The accreditation is composed of eight parts, and requires enormous details with respect to structural criteria, co-op education in the institutional context, criteria of institutional commitment, criteria of quality program delivery, and criteria of monitoring and evaluation. Accreditation standards are developed to establish co-op program "as an educational strategy and to provide leadership in ensuring quality co-op programming" (CAFCE, n.d.). Arguably, this is responsible for a convergence of research literature on co-op program administration, stakeholders' attitudes and co-op outcomes, as co-op education practitioners often possess and also need to update such details periodically as a result of the accreditation exercises.

Nonetheless, an accreditation cycle is of six years. What happens within those six years with respect to co-op program quality assurance? It is basically left to internal assessment in the university. There is no doubt that the universities take their reputation and educational quality seriously, and in the three case study universities the co-op students are required to complete surveys regarding their workplace experience. While such a practice is common in increasing (if

not all) universities that offer co-op program, it doesn't go without concern. One concern is that quality control is pretty much left to the students themselves, and in particular their self-report feedback. In this regard, the research informants with HEQCO voiced a need to develop the assessment tool that may ensure triangulation of the experiential learning:

> *"reliance on any one person's opinion, whether you just ask faculty members or you just asked students for their personal analysis of their skills or if you just ask employers….or use any one tool then you are only getting part of the story."*

A veteran informant in a case study university shared this concern by saying "it is all done by volunteers….and we do the reviews and then we assume….we don't do a site visit, we don't double check." Furthermore, the HEQCO informants envision a necessity of assessing the students' overall skill development via experiential learning, including critical thinking and communication skills, rather than merely job specific skills, for university education now increasingly concerns transferability of knowledge and skills. Another concern is expressed by a university-based informant that those rich data coming from co-op students survey are not always systemically analyzed because there are not sufficient researchers:

> *"I'm looking for more researchers that would like to partner with us to look at you know what are the impacts of what we are doing. I am talking about doing my Masters just because I have all of these data sitting in front of me (laughing)….I did do a callout to the associate deans which they are pushing out, especially because we have a very great Faculty of Education that has teaching and learning as a component of our Master's program."*

More importantly, a couple of research informants in this study were concerned with how to effectively use the outcomes of external and internal assessments for the purpose of continuous improvement of co-op program, i.e., putting in place a mechanism that constantly collects and timely feedbacks all the stakeholders' opinions and needs, and "integrating that

more in the classroom then students need to know certain things so making sure that they have that knowledge before we put them into that place technically" (stated specifically by one informant). This informant also emphasized that learning objectives should be the core concerning the practice of assessment, and "continuous improvement is looking at your learning objectives and then making sure that you are [always] hitting those objectives." Another informant in a different university resonated this point and extended it with the notion that "there is more work that can be done on a quality assurance framework to help not to police but to help programs really have a fulsome holistic program that is really solid." She then elaborated this point: "there should be integration with the curriculum, assessment and learning outcomes as well as reflection, [as] ongoing meaningful support. So these components need to be there." These comments and observations might shed light on the reason behind Canada's and Ontario's literature gap in co-op education pedagogy and improvement of teaching/learning (Thematic Area #3), as this is an area that seriously requires faculty researcher to step in, which however is not happening. As this same informant put it,

> *"that integration piece is missing…. I could probably count on one hand the number of faculty members who would say I have a whole class who has just come back on a work term. What did you learn? How does that relate? What did you do in your work terms that relates to what has helped you understand this? It's very rare, and that is an untapped resource in my opinion."*

She further stressed her point that

> *"we work hard on our side to help the students to see between the curriculum and the experience and that is what we do in our learning outcomes and our assessments and our reflections but it doesn't happen in the classroom…."*

New models of co-op education are emerging elsewhere to prepare students both as workers and citizens in the 21st century, as well as forge the principle of equality and equity

Co-op education is arguably "the heaviest hitting of all of the experiential" (quoting one informant in this study), yet in the meantime "co-op is relatively the most rigid framework in the experiential" (citing another informant) for its very specific requirements. In this context, how could co-op education be steered to better meet the progressive needs of an increasingly knowledge-based economy in the 21st century? Specifically, how can co-op education provide students with a structure within which they can reinforce employability skills, examine larger issues about work and society, and undertake the crucial activities of critical reflection? Arguably, co-op education now increasingly face the needs to address the task of preparing students for fulfilling the both roles as workers and citizens in the 21st century. Furthermore, how could co-op education push for the principles of equality and equity in participation in the context of an increasingly knowledge-based economy? Put another way, co-op program in the university should deliberately foster equality and equity regarding students' career preparation and development. The research informants provide meaningful and inspiring insights into the issues and prospects down the road. Notably, University of Victoria in British Columbia appears to be a leader regarding such notions and practices, which in turn ushers in implications for universities in Ontario, and further entails certain changes characterizing future model of co-op education.

Specifically, University of Victoria seems to have spearheaded the notions catering towards co-op students' lifelong skills and career development:

> *"We want our students to develop their leading edge. And how they are going to get to this point is by answering these four questions for themselves. What do I love? What am I great at or could be great at? What can I be paid for and at least be sustained in? And what does the world need? And learning how to put it all together so that they can make a difference and have their leading edge,"*

Asserted a research informant at UVic. In practice, UVic co-op program now deliberately employs the notion of competency as a pathway to integrating curriculum and experience. In operations, a few sets of generally essential competencies across all academic program areas and employer sectors are now brought in, namely ten core competencies and intercultural competencies—in addition to the program and profession specific competencies (e.g., those about Anthropology, Business, Education, Engineering, Fine Arts, Humanities, Law, Science, etc.)—which not only serve to connect academic study to the world of work but also benefit co-op students' long-term career development. In particular, the Ten Core Competencies, including personal management, communication, managing information, research and analysis, project and task management, teamwork, commitment to quality, professional behaviour, social responsibility, and continuous learning, serve as a framework to align experiential learning with the UVic Learning Outcomes, and more importantly transfer "the competencies you've developed in the classroom to the workplace and understand the gaps between what you know and what you can become" (citing the UVic *Description of the ten core competencies*). As such, this framework shall have a strong implication for co-op education pedagogy and outcome assessment in the years to come. Further, UVic has identified a set of Intercultural Competencies for the sake of working in culturally diverse environments, which unpacks such competencies around four particular dimensions, namely, intercultural motivation, intercultural knowledge, strategic thinking, and appropriate behaviour, and helps co-op students to become a solid global worker and citizen. Altogether, the UVic framework of essential competencies takes a significant step forward considering co-op students' skills and career development in a much wider horizon and in the context of globalization, which shall in turn usher in a considerable impact on university education as a whole.

In a concrete way of fostering equality and equity in co-op education, UVic attends to co-op needs of international and indigenous students. UVic has developed "an intercultural competencies development curriculum that is offered for students whether they going or coming," told an UVic informant. As a result, UVic has witnessed a good increase of international students enrolled in its co-op program, who now account for approximately 12%

at undergraduate level and 25% at graduate level. Arguably, University of Waterloo and especially Brock University have a good number of international students engaging in co-op education as well. As a matter of fact, Brock University has the highest percentage of international co-op students at graduate level across the country, at some 70%. However, none of the Ontarian universities seems to have deliberately worked out the framework like UVic's Intercultural Competencies available to international students, which has implications not only about inclusiveness but also concerning equality and equity in co-op participation. In this regard, UVic's endeavour of recruiting indigenous students in co-op program might have an even stronger bearing on equality and equity. Since 2008, UVic has put in special effort and resource to forge co-op participation among its some 1,200 indigenous students, through hiring an indigenous co-op coordinator and exploring opportunities of co-op work in community, which are in favour of indigenous students with respect to their culture and values that stress a balance between physical health, intellectual health, emotional health and spiritual health. More recently, UVic launched the first indigenous international co-op exchange program in the country, which sends indigenous Canadian students to Australia and New Zealand to work there in the indigenous community settings. Such moves of UVic showcase not only the possibility of linking co-op program to equality and equity in education but also the necessity of conducting research concerning co-op education influence based on institutional and student characteristics.

Conclusion and Recommendation

The outcomes of this mix-method study first detect the status and characteristics of PSE co-op education in Ontario on the national and global knowledge maps, which are constructed via bibliometric analyses of the research literature. Relative to size of the university sector, Canada and Ontario show a solid position in terms of research extent (i.e., research topics covered in the literature regarding their PSE co-op program), and those research topics relating to Canada and Ontario collimate with many cutting-edge topics depicted on the global knowledge map. However, there appears to be a weak research cohesion (i.e., a lack of collateral relations and

connections between those research topics) in both cases of Ontario and Canada, though Ontario appears to be slightly better than the rest of Canada. For Ontario and the rest of Canada, attention seems to be convergently focused on certain selected areas—compared with peers like Germany, New Zealand, Australia, the USA and the UK—such as co-op program administration, stakeholders' attitudes and co-op outcomes, and career development. While this pattern sheds light on unique aspects of PSE co-op education in Ontario as well as Canada as a whole, it also ushers in the necessity to address cross-examination of PSE co-op issues from multiple and correlational angles. Regardless, Ontario is cast a leader on the national knowledge map, for it dominates most thematic areas regarding PSE co-op education in Canada.

The further study via interviewing co-op program staff in the three case study universities reveals the reasons behind a lack of research cohesion: most papers about PSE co-op education in Canada and Ontario have been authored by co-op program staff who have interest in pursuing academic research about this particular type of experiential learning. Given the fact that an accreditation process in Canada periodically requires and updates details concerning the aspects of co-op program with respect to structural arrangement, institutional context, institutional commitment, program delivery, monitoring and evaluation etc., it is thus straightforward why co-op program staff favour writing about administrative issues of co-op program, co-op stakeholders' attitudes, and co-op outcomes. Furthermore, co-op program is traditionally considered as part of student affairs, thus career development is naturally a research focus for co-op staff. Apart from these research topics, there are clearly gaps for Canada and Ontario concerning other important themes and topics identified on the global knowledge map, e.g., teaching and instruction, impact on education, co-op influence based on institutional and student characteristics. A crucial factor behind the scene is a lack of interest on the part of conventional postsecondary education researchers in studying co-op education. As such, it is pivotal to lure mainstream researchers into PSE co-op education studies, for a couple of reasons. First, it is pressing to rigorously study Canadian and Ontarian experience where co-op education has grown steadily and practiced fruitfully for decades, and project the successful experience onto the global knowledge map. As an informant rightfully pointed out, "unless you

have stuff published it's like it is not happening. So we need to support researchers publishing and people publishing in this space." Second and relatedly, while publishing "is super important" (citing the same informant), it cannot fall on co-op staff entirely. Rather, the mainstream researchers should step in and fill out those important gaps in the literature concerning Canadian and Ontarian experience, e.g., co-op impact on education as a whole, which could in turn depict a better picture of Ontario in the national and global contexts, as well as Canada on a global knowledge map. More importantly, those researchers may help address how new work-integrated learning ideas and approaches shall improve co-op education, and how co-op education can be steered to better meet professional and social needs in the 21st century, like fostering critical thinking ability for a lifelong career, and boosting dynamics for equality and equity in the workplace.

With respect to PSE co-op practices, Ontario remains a leading place as well, partially due to a high level consensus (among all the stakeholders, especially the industry partners) regarding co-op program operations, and an extraordinary alumni support, as well as Ontario's massive economy size (which in turn ushers in a constant and often an increasing demand for professional employees). Notwithstanding such advantages and legacies, Ontario faces challenges from peers in Canada, which is exemplified by some of the innovative practices observed in the benchmarking case in this study, i.e., UVic's using the framework of essential competencies as an efficacious pathway to effectively integrating curriculum and experience, and critically empowering co-op students for their lifelong career in the context of an increasing knowledge-based economy as well as an intensifying process of globalization. Arguably, such moves would certainly have an impact on pedagogy and delivery of co-op education in the university. Further, they could forge new models of co-op education that provide student with a structure within which they can reinforce employability skills, examine larger issues about work and society, and undertake the crucial activities of critical reflection. In this regard, Ontario seems to have lagged behind and not paid sufficient attention. As such, it calls for a research agenda that helps discover and boost similar initiatives in Ontario universities and colleges, as well as co-op education influence based on institutional and student characteristics.

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Legal Safeguarding for Work-Based Learners in Creative Educational Models

ELDA NIKOLOU-WALKER*

Department of Education, Middlesex University, London, UK

This article considers the extent to which the legal framework of Higher Education in the UK (2000-2010) responded to the needs of the professional work-based student, while in both employment and study.

Drawing on Case Law, Education Law and the body of literature on Work-Based Learning (WBL) it discusses the context of the professional student and the relationship between the learner, the employer and the HEI, primarily from a legal perspective.

Professional work-based students usually gain highly work-applicable learning through creative academic and experiential methodologies, however they are situated between the provisions of education law and employment law without specific legal protection for their position.

This article argues for a more creative approach to brokering an innovative, ethical and productive relationship between the HEI, the employer and the employee as a work-based learner.
More effective relationships between these key stakeholders would enable the proper recognition, accreditation and safeguarding of a highly creative way of adult learning.

Keywords: Work-Based Learning (WBL), Higher Education, Flexible Study, Legal Framework, Education Law, Professional Student

Introduction and Background

Work-Based Learning (WBL) is a creative means of learning using neoteric tools and in-work applications to encourage novel adult participation, however the concept has always reflected the complexity of the relationship between working and learning, and the benefits of learning in the workplace. Government papers, such as '21st Century Skills: Realising our Potential' (DFES, 2003) and the Leitch Report (2006), have focused the attention of Higher Education providers to engage more fully with employers in the design and development of awards (Braham & Pickering, 2006),

* **Corresponding author:** Elda Nikolou Walker. Email: E.Nikolou-Walker@mdx.ac.uk

albeit without obligating employers to reciprocate.

It was always believed that the government regarded an increased emphasis on flexible WBL and other non-traditional modes of study, as important mechanisms for meeting the country's skills agenda and improving economic growth. To meet the needs of this constantly growing demand, HE needed to embrace a different approach to learning and teaching, which enabled students to, for example, learn through presentation of individual portfolios including a unique reflective account of the student's experiential and creative narrative of learning, through the experience of their work and studies.

The Emergence of Professional Work-Based Learning

It was understood that this approach amounted to a requirement to change from purely traditional modes of study to an increase in work-based or work-related study. Higher Education Institutions (HEI) across the UK were recognising that knowledge could be created outside of academia and that Universities were no longer seen as the exclusive providers of learning. There seemed to be an appetite amongst professionals for recognition of value of their non-traditional study, in the form of claiming academic credit. Furthermore, employers were more and more recognised as relevant and appropriate partners in learning programmes, rather than just recipients of University designed courses (Harvey, 1990).

Meanwhile, employers themselves were increasingly allocating time and budget to establishing in-house educational bodies (e.g. academies, institutes) through which Work-Based Learning could be provided and internally accredited. While historically this kind of Work-Based Learning was largely limited to apprenticeships and practical work, now professional employees could enrol and complete courses which were closely related to the practice of their profession and could only be defined as Work-Based Learning. Since there was no formal distinction between all these types of learning regardless of where or by whom they were delivered, a wide legal 'grey-area' was opened-up.

For some professional areas, stronger links between employers and HEIs were emerging and it has been acknowledged by authors such as Medhat (2008), that more intense discussions were required between the two parties, in order to fully understand the principles of WBL and transfer

the language of higher education to the workplace. In addition to the flexibility afforded by the WBL route, a number of key benefits are shared by the student, the employer and the University through the introduction of WBL programmes. These include ‘a reduced pattern of attendance; a reduction in time away from work; and a reduction on the strain of facilities for the University.' (Johnson, 2001, Braddell, 2007). The progression in WBL by the professional student, needed to be viewed in terms of how they and the traditional student's situations were similar or contrasting.

The traditional student could for example, attend ‘full-time’ at University and may or may not have found ‘part-time’ work, with no relevance to the HEI. However, the professional student in ‘full-time’ employment, would usually be in at least some way sponsored by the employer, and this would have informed a different understanding of academic progression. The employer in this case, would have a vested interest in the studies and potentially also in the HEI attended. As a consequence, the employer would also, it was assumed, have a close interest in the skills, knowledge and attitudes which the learner would develop, resulting in greater competence transferred into the workplace.

The Professional Learner in the Work Context

Typically, the professional student came from a technical organisation, and their learning was related to industrial, technical and scientific development and training. Development was mainly assessed through examinations and accreditation gained through the process of empirical research and/or hard evidence of compliance with a specific standard of pre-set criteria.

Work-Based Learning was situated within the context of the paradigm shift from an industrial to a knowledge society (Nikolou-Walker, 2004). Work-Based Learning had no single definition, but some of those tendered argued that WBL could be seen as 'a result of changes from an elite to a mass model of higher education' (Light & Cox, 2001) to a more creative, learner-centred and experienced-led model (Baud & Solomon, 2001). WBL was based upon the premise of a relationship between the HEI, the student and the employer, but the predominant question remained: who had a duty of care to whom? This question as to the nature of their status, usually 'opened' the legal debate on HEIs, and it was frequently followed by questions such as: was the relationship between the WBL stakeholders, (i.e. the HEI, the student and the employer) purely consensual, contractual or a hybrid of both?

Quality in a Creative Learning Approach

At this juncture it is important to acknowledge the emergence of employer-provided professional education since it offered employers the ability to define both what would be learned and how. They were able to choose who delivered learning programmes and had full control over the nature of the learning contract, the enrolment criteria for employees, how much of their work-time would be allocated to learning, and crucially, measures to evaluate the impact and return on investment of the learning undertaken. Since none of this required negotiation with an academic body, it appeared a relatively simple way to provide learning opportunities to employees. It also offered the opportunity to branch out into more creative, experiential learning environments and modalities, designed specifically to fit the requirements of the workplace rather than the structures of academic curricula.

While for HEIs, any deviations from the traditional method of study had to be proven to be as good as, or better than the organisational 'norm', employers were becoming more concerned with achieving specific workplace ‘impact’, as a result of the learning undertaken. For HEIs the challenge of providing relevant, learner-centric and experience-led models of learning in non-traditional settings might be extensive, but for employers it was relatively easily overcome, since employer-provided education was largely governed – where relevant - through employment law. In contrast for HEIs, the shift from an industrial to a knowledge society demanded new approaches to learning and development, creating an innate difficulty in affording adequate support when providing for the professional student embarking upon an innovative WBL programme.

Legal Protection for the Student

The professional student had also to be considered by the HEIs as an equal with their colleagues drawn from the traditional student body, so for example equality laws made it necessary for the HEIs to ensure that they fully considered aspects of equality that had rarely affected their historic student pool, such as family circumstances and related pressures or complexities. Thus, as R v Birmingham City Council exp Equality Commission (1989) ruled, direct discrimination on grounds of sex (i.e. treating a woman less favourably than a man), was or would be treated as unlawful with the motivation being irrelevant. Another landmark case regarding direct discrimination, was

in Cooke v University of Nottingham and Iacovetti (1995); whereby Cooke's successful application was based upon discrimination due to Cooke's having children.

The Education Laws revolved around the governance of the HEIs and their respective roles, responsibilities of and appointment to their Boards (i.e. 'Board of Governors', 'Head Teacher', 'Library Boards', etc.), so had little to do with 'supporting' the professional student. Within workplaces the governance structures of internal education providers, while sometimes being labelled 'Faculty', by no means automatically followed the model or roles and responsibilities of HEI boards legislated for through the Education Laws, which for HEIs primarily ensured compliance with accounting procedures, the setting and collecting of student fees, loans and financial support. These had no impact on employer-provided education which was in any case only loosely governed by Employment Law.

Meanwhile the developing educational law was attempting to transform access to the Higher Education sector, making it more inclusive. For example, according to current Law, any form of proven disability is now supported by the Disability Discrimination Act (which is also fully applicable to the workplace) and education for young workers is facilitated through apprenticeship schemes. However, there is still no accommodation in Education Law for the mature student in professional employment.

This trend might have provided the evidence that the evolving education law, was more concerned with establishing HEIs as business entities (thus, making them competitors with employer-established offerings), than promoting the potential benefits of WBL as a creative and academically worthy approach to learning in the workplace and through work. WBL was here primarily envisioned through enhancing the HEI-Employer relationship, with the employer as a key stakeholder, or customer, and the work-based learner being educated in both HEI and work environments, and therefore positioned – perhaps awkwardly - in the space overlapping two entities.

Legal Status of Higher Education Institutions

To determine the HEI status as either public or private bodies was crucial to this argument, and as both European and domestic case law has proved, this was still difficult. For example, in Turpie v University of Glasgow (1986), an Industrial Tribunal ruled that the University [Glasgow] was not an organ of the State [public body] although some 80% of its funding came from the State.

However, in Foster v British Gas Pie (1990), another Tribunal ruled that Universities were indeed public. A specific example is in this case, offered regarding freedom exercised in organising, for instance, teaching and research. This however, was subsequently overturned by the European Court of Justice (ECJ) - the latter stated, that no one test of a University's status could be used as a determinant, instead it seemed to be the case that the State had a legal right to control the policy of the body concerned. For example, the 'Education' (section on 'Student Support') Regulations (Northern Ireland) 2009, adopted the ECJ rationale and expressed this in regulation 6 (5c) and Section 65(3a), of the Further and Higher Education Act ,1992.

The Human Rights Act (2000) however, took a different approach and considered Universities to be 'hybrid' institutions. A hybrid institution was actually determined by Lord Woolfe in Poplar Housing v Donaghue (2001). In this case, demarcation between whether the body and its functions were public or private was, indeed, one of fact and degree.

This discussion was relevant because private bodies were governed by a different legal regime. It can be argued that Universities were indeed 'public'; despite their historic independence and control of subject matter (e.g. 'course content', ability to award degrees etc.), they were ultimately controlled by laws of the State, as well as Acts and Orders which determined how such institutions should behave and ultimately, comply with the rules and regulations set down by the Government in Parliament. Albach (2000), argued that 'these trends in massification, accountability, privatization, marketization, and an unprecedented level of participation have caused a shift in the boundary between public and private sectors'. The Further Education and Training Act (2007) extended to England and Wales, with few sections applicable to Northern lreland (NI). This Act facilitated the empowerment of local bodies (Department of Education [DE] in the NI context), with powers which up until now had resided with the Secretary of State.

These institutions, in turn, placed a duty on the HEIs to consider consulting on any decisions that may have affected current and potential students, [Regulation 22 S(1) and employers 22(2)]. Regulation 11 of this Act was applicable to the Secretary of State, the Learning and Skills Councils (England), the Welsh and Scottish Ministers. NI Departments, persons or bodies wholly, or partly funded from public funds, (that have had functions relating to education and training) and persons or bodies specified, (or of a description specified), by order made by the appropriate national authority for the purpose of this section.

Thus, it may be suggested that the professional student in 'full-time' employment could, in fact, be protected through the application of the latter two sections. Adopting this would, perhaps, have provided an opportunity to further promote the concept of WBL (as it fitted best with this category of student). It could also be argued that this may have promoted the role of the employer (i.e. persons or bodies specified).

Further opportunities may have existed under Regulation 28 of the Act, which referred to the power of the Regulatory Bodies in England, Wales and Northern Ireland, (in order to make an order, or regulation, using Statutory Instruments). Section 6, however, explicitly stated that such powers involved the inclusion of making different provision for different cases/areas. It could be suggested that, these could, in fact, refer and protect, the employer (different cases), Work-Based Learning (different areas) and the professional student (specific cases).

Despite the 156 Regulations, the Learning and Skills Act (2000), referred only to three which applied to Northern Ireland (and another five to all of the UK). The applicable sections governed the controls around finances and account management by the HEIs and any suggested amendments should have been under the consent of the Secretary of State. In addition, there was no mention of the WBL context and nothing in the Regulations appeared to be directly applicable to the Work-Based Learning area.

The dearth of direct legal provision or guidance for the work-based learner seemed to give a rationale to the notion that employers were well-placed to provide professional study programmes, and indeed that this offered a relatively simple and potentially highly flexible solution to the prospective work-based learner. In addition since even under the limited powers of the Higher Education (Northern Ireland) Order, 2005 there was no reference to 'handling' and/or

management of the mature/vocational student in ‘full-time’ employment; and furthermore the ‘full-time’ employed student (unlike the ‘traditional’ student), could not apply for loans or support under the Regulation 5(c) of the Education (Student Support) Regulations (NI), 2009 (the Regulation stated that a person was not an eligible student for a loan after the age of 18, or when an agreement for a loan had been made and not ratified under the age of 18), outside of the workplace the professional student would need to bear personally the financial burden of studying, if eligible to enrol with an HEI.

The Challenge of Accrediting Work-Based Learning

In contrast, the major challenges faced by the providers of ‘in-house’ learning were that in the absence of a partnership with an academic institution, they were largely unable to offer a transferrable award or accreditation no matter how much study an employee had undertaken, nor how academically valuable that learning was considered to be. Secondly, employers could effectively commission whoever they liked (or could afford) to deliver educational programmes, without any obligation to make academic credentials a mandatory criterion. Thus, in attempting to put the learner at the centre and deliver highly profession-relevant, innovative, experiential learning, employers were potentially placing significant demands on learners without being able to meaningfully validate their learning.

Legal Status of Partnerships

It would seem obvious to look for a solution in better-defined roles for both employer and HEI, working in partnership. However here too, the law did not adequately provide for, or protect the employer, but rather appeared to lay a rather onerous burden of liability. For example, in the promotion and development of WBL, the Teaching and Higher Education Act (1998) did not include any safeguards, enhancements, or even any possible 'list' of roles or liabilities for the employer. Instead, all references to the employer were financial and centred around the repayment of loans by students who defaulted (with provision made for the recovery of the outstanding balance, from monies paid to the student by the employer).

The Education and Skills Act, (2008), though only applicable to England and Wales, did not explicitly contain a role for the employer (which could have been conducive within WBL), although

the employer was required to allow the individual learner to participate fully in the relevant offering of training and education; usually through ensuring their eligibility (working twenty hours or more per week) and adapting their working pattern to meet the needs of the course. While this flexibility fully reflected the benefits of WBL by satisfying the needs of the student/employee, optimising 'study-time' and minimising time away from work and disruption to the operations of the employer, it could be seen as a missed opportunity to fully embrace the model of WBL where student, learner and HEI are aligned in collaboration. Equally, although the 'willingness' of the employer to participate was sometimes enforced (with punitive measures), enforcement notices where they occurred, usually failed to result in compliance. This was a distinct deviation from the spirit of WBL, which had the flexibility to address the employer's needs, and reset the parameters of study to respond to operational pressures.

The fact that the above legislation did not adequately provide for a better and/or 'higher profile' for the employer, could be viewed as giving credence to 'the very notion [that] combining education and the workplace [could be] problematic.' (Costley, 2000). However, Tasker and Peckham (1994), Barnett (2000), and West (2006), all suggested that academic and industrial values were incommensurable and that it was only through mutual respect that collaboration could be fruitful.

Student Well-being for the Professional Work-Based Learner

From the perspective of student well-being, it would be generally expected that the working professional might be more likely to have to balance the pressures of domestic and working life with the addition of academic study, leading to a variety of stresses and undoubtedly, competing priorities. Whereas in employer-provided and sponsored learning, it would be within the prerogative of the employer to require that the student defer or exit the program of study if a significant negative impact was noticed, for the HEIs legislation such as, 'The Disability Discrimination Act' (2005), placed them in a more precarious position in terms of their obligation to student well-being, as the Act removed the need for mental disorders (e.g. 'depression' etc.), to be clinically recognized before the HEIs needed to act. In some instances the HEIs might have focused on the role of 'knowledge' and may, for example, have demonstrated that they 'did not know and could not reasonably have been expected to know.' (The Disability Discrimination Act (2005), s285(4).) Yet in instances where positive relationships between HEIs and employers

existed, the facilitation of information-sharing could have gone a long way towards supporting the work-based learner. In addition, the typically close relationship between the Work-Based Learning tutor and the student, could have enabled the tutor to advocate for support for the student within both the workplace and the HEI. In contrast, in employer-provided learning, this 'brokering' role would most likely have been played by the programme lead, and the evaluation of the impact of the additional burden of study would have formed a critical component of the approval process for the student to undertake the learning programme.

The HEI, it could be argued, would benefit greatly from employer relations enforced by law. The employer could secure the student's agreement to inform the HEI regarding any current workplace adjustments made for their employee. This would provide the HEI with the information needed to optimise their participation in the learning and increase integration with other students.

The Nature and Value of a 'Learning Contract'

Since, Education Law in itself appeared to have made inadequate provision, or protection for the employer, if the HEI and employer brokered an effective relationship to promote the merits of Work-Based Learning, could this constitute the basis of a contract and therefore may it ultimately be in contract law, that the 'remedy' could be found? The elements of a legally binding contract were 'agreement', 'intention ' and 'consideration'. Within the process of application, acceptance and enrolment onto HEI courses, the payment of course fees, as listed in the prospectus was in legal terms, viewed as the 'consideration' (Elliott & Quinn, 2003). Therefore, the contract was between the HEI and the student. In Dunlop v Selfridge (1915), which was the leading case to define 'consideration', Pollock stated that 'an act of forbearance of one party, or the promise thereof, (was) the price for which the promise of the other (was) bought, and the promise thus given for the value is enforceable.'

It was also accepted that the HEl-student relationship was based on the establishment of a contract between two competent parties. However, 'employer supported', or 'sponsored courses', may well have challenged this, as they added an extra dimension: The employer defined the workplace involvement, despite the fact that the student may have identified the course, and authorisation or approval from the employer was then sought in order to fund the course. The employer may then have formally applied to the HEI on the student's behalf, or the student(s) may

have done this directly. It can be argued that the new element of this type of arrangement was the emerging tripartite relationship that intellectually started developing between the student, tutor and employer. The first two parties belonged to the 'traditional' form of learning offered thus far by the HEI's , whereas the addition of the employer began to 'muddy the waters' both from a legal perspective, as well as the definition of the exact role that the employer's presence was going to have regarding the nature of the overall 'contract'.

Once accepted, it was the employer who would pay the fees and not the potential student. Using this definition it could, perhaps, be deemed that the contract was constituted between the HEI and the employer and not the student. However, the only contract that seemed to be formulated within the HEI was that with the student. Thus, the HEI would usually have neither rights, nor obligations in respect of the employer.

In addition to this, the student may have been prohibited to formally agree acceptance onto a specific course, unless they could demonstrate compliance with their employer's educational policy. The formulation of the contract had also to have been completed by authorised officers, which typically limited the range of HEIs the student could apply to. On the part of the HEI this was an officer directly employed by the HEI, while in the workplace final approval tended to rest with a senior figure in the Human Resources or Learning & Development departments. This brokering of sorts, could be considered to support the idea that the employer should have had a (more) prominent role within the education process, although it could also be argued that these employer representatives might have been in a position too far removed from the student to advocate for truly learner-centred education.

Knowles (1986), advocated the use of 'learning contracts' as an alternative way to structuring a learning experience, replacing a 'content' plan with a 'process' plan. Knowles defined the 'learning contract' as

> *'a formal written agreement between a learner and a supervisor which detailed what was to be learnt, the resources and strategies available to assist in learning it, what would be produced as evidence of the learning having occurred and how that product would be assessed.'* (1986: p163).

This definition excluded the employer from the contract since 'supervisor' here referred to the learning – rather than the workplace - supervisor. However, Stephenson and Laycock's (1993)

redress followed by defining a 'learning contract' as 'agreements negotiated between students and staff and, where appropriate employers' (1993: p17).

Knowles (1986) also recognised that the formal terminology and use of the word 'contract' contributed to his notion of andragogy (Greek for 'man-led'), i.e. the mature student accepted responsibility for, and set the direction of their own learning. This demonstrated a divergence from the previously accepted norm for study, i.e. pedagogy (Greek for 'child-led'), where the teacher assumed responsibility for the learning and therefore, accordingly, 'plotted' the course of study for the student. However to take this concept of contract and responsibility to its logical conclusion, the student themselves would have the additional challenge of taking the lead in brokering arrangements between the HEI and their employer, with no guarantee of success.

Anderson et al (1996), Boud and Solomon (2001), Rhodes and Shiel (2007), and Lester (2007), frequently substituted and interchanged the words 'contract' and 'agreement', 'softening' the formal language in use. This could be viewed as a tacit acceptance of Knowles andragogy theory. These scholars saw this phenomenon as a shift from one where redress and appeals could be induced by aggrieved parties; to one where the HEI retained the power to determine how the WBL would be managed and organised. However, Stephenson and Laycock's (1993) theories went even further, one could argue, with a play on semantics as they denied that 'learning contracts' were 'contracts' at all!

In the workplace meanwhile, ‘Personal Performance Agreements’ (PPA) had begun to be introduced between staff members and their 'Line Manager' to establish learning needs which directly related the learning to the requirements of the work. This process produced a ‘Personal Development Plan’ (PDP) which was considered to be an illustration and timeline for when these needs were to be satisfied.

Successfully Brokered Partnerships

A successful example of partnership was within the Northern Ireland Civil Service (NICS), where professional disciplines used structured career paths agreed with HEls, for their staff to complete. A framework, for example, could be an agreement between a University and the Central Procurement Directorate (CPD) within the NICS. This agreement usually encompassed a specific

development structure which was pursued by the individual staff member. The structure was also agreed between the University and the Employer and meetings and feedback sessions were held between the two parties to discuss the effectiveness of the framework against the originally set and agreed organisational objectives.

This approach was supported by Garnett (2000), who stated that 'for the agreement to work properly, the employer needed to be an active partner and the organisation's culture ought to be clearly understood and managed by the HEI.'. Others (Nikolou-Walker & Garnett, 2004) argued that the distinctive feature of any Work-Based Learning process was the link between an external organisation and an education authority.

In the above example, the HEI appointed a 'course leader', to whom staff could go to discuss issues /concerns, regarding the content and pace of learning. The core content of the course was fundamentally shaped by the organisation's objectives and the completion of the framework of study usually led to recognition by the organisation. This example demonstrated the mutual benefits that learning agreements and WBL could bestow on both the HEI (which had an agreed pool of learners) and the employer (whose organisational objectives for staff learning were being externally supported in an academically rigorous fashion).

The development of further similar agreements frequently resulted in the HEI maintaining a position of power, however were the number of potential students from the employer to diminish, HEIs had to fill places on the course by offering it to other students, since it was critical for the HEIs to attract appropriate quotas of students and ensure the respective payment of fees, to ensure the economic viability of each course.

Opportunities and Benefits of Stronger Collaboration

It could also be argued that the HEIs often missed out on the opportunity to attract new students, as there was little evidence that they actively maintained and strengthened relationships with employers of their ‘current’ students. As the workplace changed, an adaptive approach was critical in ensuring the relevance of the HEIs offer to working professional students, requiring HEIs to take a proactive approach to understanding the needs of the workplace and employer. Similarly, contact between the student and the HEI was rarely sustained once the course was completed.

With the adoption of the continued contact prevalent in the WBL approach, there was a greater opportunity for a HEI to share in the success and the credit when a student, applying their newly acquired knowledge, found a solution to unresolved problems within their organisation. For example, a major exercise for the employer may have contained within it a discrete, specific piece of work, the completion of which would simultaneously satisfy the needs of the employer, the University and accredited learning. (Costley et al., 2010). This was a demonstrably significant benefit to all parties of an effective working relationship between the student, the employer and the HEI, yet none of the legislation framing the education sector in general included roles and responsibilities for the employer, nor allowed for HEIs to follow student's progress once their studies had been concluded. Costley et al. (2010), state that a tripartite (HEl/student/employer) discussion usually assisted on congruent outcomes for all parties.

This article attempted to unravel the complexities of a myriad of different and varying legislation applying to an area of continuing study: Work-Based Learning. The body of legislation has had no single easily-read piece of law which can be applied, and arguably because of the adversarial nature of this particular legislation, it may continue inadequately to respond to the need for the brokering of innovative relationships between professional students, employers and HEIs. A flexible, adaptive approach is urgently required from employers and HEIs in order to support the work-based learner, and for that student's creative learning pathway and achievements to have their full value and impact from both a professional and an academic point of view.

Is it not regrettable, that today in 2020 there has been no significant advance in the interests of the work-based learner from the legislation passed over a decade ago?

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The Role of Self-reflexivity in Transition Leadership Training in the Healthcare Sector

JOAN CAMILLERI *

University of Malta, Msida, Malta

*Leaders in the healthcare sector, frequently find themselves attempting to improve service provision by adopting evidence based-best practices, as requested by policy. Notwithstanding, change implementation is often not straight forward. As an insider-turned-researcher I initiated a Maltese National Healthcare Service-wide doctoral inquiry into the lived experience of leaders during change and transition, to gain insight into which leadership styles and managerial skills characterise an effective transition leader from a psychotherapeutic perspective. The inquiry was divided into two phases, using mixed methods with an action-research element. Arising themes indicating the need for individual proactive self-actualisation, development at an emotional-transferential level and the undoing of identity following organizational/personal shifts, provided a platform for the co-creation of a Training Manual focusing on self-reflexivity. Training using the Manual was offered to the participants facilitating their looking more closely at how power relations stalled personal and organisational growth by hindering change implementation processes. Encountering the need to unblock shame, some met impasse, others modified their underlying metaphor/identity enhancing a change in behaviour while retaining the power inherent in their previous identity, while others yet noted that the training enhanced their managerial skills. The Training Manual was well received in the healthcare field and beyond. The results of the inquiry suggest that self-reflexivity is an essential element when planning training for leaders and that **self-actualisation, and self-reflexivity** are essential managerial competences supporting transitions while enhancing creativity and inter-dependence. This implies that self-reflexivity needs to be introduced in mainstream managerial training.*

Key words: Leadership, Self-actualisation, Self-Reflexivity, Shame, Power, Identity and Transition management.

* **Corresponding author:** Joan Camilleri. Email: joan.camilleri@um.edu.mt

Introduction

As part of a doctorate by professional studies I carried out an inquiry into the lived experience of leaders during organisational change, exploring ways of facilitating transition management training. The Maltese National Healthcare Service (MNHCS) was adopted as a case study. Part of the Public Sector, this organisation is one of Malta's main employers. As it mirrors trends across the European Union and the United Kingdom, where many of its employees' train and offer training, results obtained could be shared outside the Maltese Islands.

The outlay of this article involves: a description of the background and the need for change; a literature review with considerations relevant to the local field and research design; methods and methodology describe how phenomenology was adopted as the overarching orientation and how Critical Narrative Analysis integrated with an action-research element involving an advocacy-participatory paradigm, led to the construction of Phenomenological Critical Narrative Analysis as a tool for data analysis; Ethical considerations and means used to retain insider-researcher objectivity follow; data collection included participative-observation during Communications Macro Target Team (CMTT) meetings, unstructured interviews with volunteering Heads and reflexive self-annotations, supporting triangulation; data analysis supported the emergence of spontaneous themes forming the platform for the writing the Training Manual in collaboration with the participants; findings of the CMTT sessions, exploratory Interviews and the collaborative evaluation of the Manual are then described; a section on self-reflexivity elucidating insights generated from the study, is followed by a synthesis; a section about Post-doctoral work describes some products, the wider professional influence of this research and modifications in the training manual in light of more recent practices and learning

Background and Context – the need for change

Reviewing MNHCS work practices, and observing the need to follow international trends towards transdisciplinary care-plans, and knowledge-sharing (Azzopardi Muscat, et al., 2014; Grech, 2002) the MNHCS Permanent Secretary requested initiation of a Ministry-wide Re-engineering plan, in a mechanistic context lacking human/material resources. Heads were encouraged to adopt a complementary shift in leadership style/managerial skills from technical administration to team-management. Technical administration defined as ensuring resource availability so clinical interventions could be adequately carried out. Team-management defined as multidisciplinary collaboration in careplan creation/implementation, introducing standard operational procedures and new services (NHSS, 2014). The existing knowledge-based, labour-intensive context, required substantial restructuring (Dalmas, 2005).

Senior management, seemingly unaware that the collaborative spirit set forth in policy challenged the clinicians' individualistic identity (Micallef, 2003), promoted clinicians to managers, adding financial auditing/business plans to their habitual interventions. Faced with difficulties when juggling with a change in sense of self/role/style, clinicians-cum-managers attempted to change behaviour, while safeguarding their sense of self/identity (Vassallo, 2007). Work-based observations indicated that the training offered while based on international standards, met with limited success (Dalmas, 2005) as only Heads interested in management attended training which started after change was implemented (Micallef, 2005).

As a senior psychologist in the MNHCS, facing similar dilemmas, I asked my supervisor, "What can I do?" Her reply, "Who do you become?" challenged me. If I wanted to *become* a team manager I needed to let my technical administrator *identity* go. This inner shift was facilitated by the narrative function of the personality (Chidiac & Denham-Vaughn, 2008), asking "*Who am I/Who do I become?*" during the accommodation phase of the transition/developmental process (Ginger, 2006). Identity modification, required critical self-reflexivity. This observation initiated a doctoral inquiry into the exploration of the lived experience of leaders during change

and transition, to gain insight into more appropriate supportive interventions (Barr & Dowding, 2012).

Objectives

This inquiry aimed at gaining insight into leaders' underlying processes as they developed in their contextual changes; which managerial skills enhanced the change/transition process; what were their training needs/preferred approaches, and to co-create/validate a related training manual.

Literature Review

Change starts by letting go current ways of thinking, feeling and behaving, so new ways may be created, accepted and adopted (Bridges, 2003). This transition process entails modifications in the interpretation of meaning (Dima & Skehill, 2011; Manderschied & Harrower, 2016) which emotional, transferential, projective and spiritual processes of becoming may hinder/support. Adapting healthily to shifts in context is a choice one makes when reconnecting one's life narrative pre- to post-disruption (Barber, 2006).

Integrating managerial and psychotherapeutic change models (Kaplan & Norton, 2008; Ginger, 2006) indicated how, theoretically, the lived experience of transition during organisational change may develop:

An overarching organisational goal is split into smaller ones that may be catered for by its various entities/departments. Given their central role as culture carriers, leaders, need to be the first to adopt the required shift (Amado & Elsner, 2007; Binney et al., 2012), to promote it in others (Baek-Kyoo, 2005; Hawkins & Smith, 2013). As leaders become aware that they need modify their sense of self/identity, they may re-enact habitual, possibly ineffective coping mechanisms (Thomas & Hardy, 2011). Increasing leaders' awareness about their reaction to change, could support insight, facilitating acceptance and participation in the transition process

(Gilley et al., 2011; Farrell, Keenan et al., 2013). Since, transition managers need to reform their sense of self/role/identity, to model new ways to employees, (Nicholsen & Carroll, 2013) they would benefit from developing consciousness of self-change over time (Oyserman et al., 2004), becoming aware and accepting who they are, while recognizing who they need to become. To achieve this, they could engage in inner dialogue, asking: *What are my needs?* – identifying unconscious aspirations*; Who do I need to become?* – enhancing self-awareness, facilitating identity modification (Gilbert & Orlans, 2011); *What do I want?* – making conscious decisions. Emergence of the leader's effective style would occur simultaneously with transition unfolding at organisational level, influenced by the wider field (Binney et al., 2012).

Achieving self-change requires reflective thinking during which one gains awareness of predominant processes by coming in touch with the regular interactions and practices taking place in the surrounding culture (Syed et al., 2012). This process may motivate leaders to challenge the habitual way in which things are done, and to adopt relevant values to facilitate effective service provision (Cartwright, 2002). By reflecting on their practices, leaders could increase awareness of their training needs (Camargo-Borges & Rasera, 2013; Gibson & Hanes, 2003). This implies that reflective thinking could improve governance through leaders' appropriate and relevant self-development (Grey 2007). To this end, training could focus on increasing self-awareness, understanding the process one needs to embark upon to develop an identity which enhances goal achievement and self-fulfillment (Hawkins & Smith, 2013). Training could adopt an action-research approach in the form of supervised practice at the workplace, (Hawkins & Shohet, 2012) supporting leaders to replace competency training with "learning to learn" (Gray, 2007, 478), in a confidential setting, promoting critical self-reflection (Chidiac & Denham-Vaughn, 2009).

If MNHCS leaders could critically self-reflect while introducing care-plans/audits, they could facilitate a shift in the organisation's underlying goals, policies and norms, improving governance (Kitchenham, 2008). Since Bridges (2003) described the leadership style relevant to

transition and Barber (2006) depicted how to support various phases of change, it was beneficial to focus the inquiry on the impact change implementation has on the leader (Robson, 2002) focusing on lived experience, gaining insight into underlying processes as Heads responded to organisational change (Reissman, 2008). Applying this knowledge to training programs would benefit all stakeholders (Binney, et al., 2012; Gray, 2010; Thomas & Hardy, 2011).

Methodology

Exploring leaders' lived experience to better understand how they may be supported, required empathic understanding of their individual story (Cresswell, 2007). The chosen methodology had to appeal to their sense of logical structure so they could feel sufficiently comfortable with the innovative. A phenomenological overarching orientation, narrative analyses with a critical thrust including an action-research element (Langdridge & Hagger-Johnson, 2009) was deemed appropriate. The methodology of this inquiry was, split into two phases:

Phase 1: – Exploration, description, and interpretation of the Heads' lived experiences within their context as they occurred, using first-person action-research practices and phenomenological critical narrative analysis. This facilitated delving into new areas of knowledge, developing insight into common phenomena. Arising themes were used as a platform to co-create a Training Manual.

Phase 2*:* – Determination of the effectiveness/validation of the Manual with the participating Heads, evaluating its impact on their shifts of sense of self/role/identity, using second-person action-research practices in a participatory manner, and critical self-reflective, change-supporting elements. Narrative and paradigmic modes were employed. The former explored Heads' desires, goals and intentions through their stories, the latter facilitated the logico-scientific understanding of experiences through empirical observation (Langdridge, 2007). Constructionism supported the assumption of a position of advocacy, raising awareness, establishing dialogue with what unfolded in the field while being critical of the same (Camargo-Borges & Rasera, 2013; Figure 2).

Phenomenological Critical Narrative Analysis*:* (PCNA) was developed by integrating critical narrative analysis (Langdridge, 2007) with second-person action-research practices (Cresswell, 2007). Critical moments were introduced into the analyses through hermeneutic reflexivity (Langdridge & Hagger-Johnson, 2009), involving a critique of the illusion of subjectivity. PCNA supported the exploration of the Heads' underlying process by highlighting identity changes, allowing themes to emerge spontaneously in a hierarchy of patterns from the data collected and flexible analyses of Heads' stories/text on a case-by-case basis, identifying patterns of meaning within/across data; presenting the whole in a structured manner (Langdridge, 2009).

The Action-research approach entailed the organisations mode, supporting collaboration among professionals to reflexively improve professional practice (Hughes, 2008). This approach was chosen for its problem-solving focus, and its mirroring coaching models' framework (Hawkins & Smith, 2012). As the inquiry required a critical self-reflexive focus, Barber's (2012) model highlighting action and critical self-reflection at each phase, was adopted.

- Pre-contact: Awareness of conscious/unconscious processes, different levels of experience and personal politics manifested as behavior, mindset, emotions and motivation.
- Orientation: Researcher and participants draw a contract engaging in preparatory activities.
- Identification: Problems are identified, remedies discussed and solutions attempted.
- Exploration: Monitoring the impact of strategies implementation on all stakeholders.
- Resolution: Measuring success, termination of the alliance and final reflections.

Ethical permission to carry out the doctoral inquiry in Malta was obtained from the Maltese Data Protection Board and the Malta University Research Ethics Board. The research proposal was approved by the Metanoia/Middlesex Ethics Committee. Being an insider-turned-researcher, while placing me in a position to gain valuable insights, raised ethical concerns (Czarniawska, 2004). Acknowledging my presence in the field could influence study outcomes, I adopted a psychotherapeutic approach to interviewing to decrease my impact, while attempting to be as critically reflexive as possible by distancing myself from feeling part of the

organisation (Frambach, 2003). I adopted a heuristic approach to ensure personal integrity and ethical expression (Finlay & Evans, 2009) while focusing on not eliciting desired data (McLeod, 2010). Democracy was attained by adopting an action-research approach (Hughes, 2008).

Methods and Research Design

The inquiry required a flexible research design lending itself systematically to the collection and analyses of data-rich information, facilitating working with shifts in sense of self/role/identity producing themes, allowing the research question to be re-shaped by subsequent questions (Robson, 2002). Data source and methods triangulation were adopted at each phase (Langdridge & Hagger-Johnson, 2009). It became a multi-stranded metastory, (Bamberg, 2006) diverse from that offered by the politically powerful (Czarniawsa, 2004).

Sampling and Participants: Names of potential participants were obtained from an organisational consultant, and a letter was sent to all. Volunteering participants, held various posts in the MNHCS ranging from public health/medical consultants to executive managers to healthcare administrators. Ages ranged between 31 and 58 years. The age of appointment to leadership positions varied between 22 and 47 years. Their length of stay in leadership ranged from 9 months to 36 years. All held a position requiring contract renewal every three years. Their extent of leadership training ranged from none to Master's-level. Motivation to participate included:- interest in the research topic, finding solutions for management issues and introducing staff support. Four participants dropped out and were replaced for the evaluation of the Manual.

Data Collection:

Macro-level (socio-cultural) data was collected during attendance of an Internal Communication Macro Target Team (CMTT) sessions. Adopting an observer-as-participant stance I heard the voices of management undergoing anxiety when faced with change (Czarniawska, 2004). Participants, permitting my attendance, vetoed audio-recording of sessions, so I took down conversations *verbatim* on a notebook computer, noting the persons involved, events narrated in a time sequence, and emotions exhibited (Robson, 2002). The first

Head to speak was coded CMTT1 and so forth. Attending the CMTT meetings allowed me to observe the outcomes of non-reflective change impementation, providing supportive information for the exploratory interviews (Cresswell, 2007), .

Micro-level (emotional-projective) data was collected through exploratory interviews during transition, before the sense-making retrospective process and contextual influence set in, decreasing faulty recall. I met the Heads approximately once every four months at T1-T2 -T3 over a year. Interviews scheduled by appointment, were conducted at their offices (Gray, 2007). Heads allowed me to record the interviews. The first interviewed Head was coded H1 and so forth. This process gave them time/space to narrate their story from the introduction of the organisational shift to their new roles following contract renewal, demotion or dismissal (Nicholsen & Carrol, 2013). Reissman's (2008) five phases of representation were adopted for the interviewing, transcription and relating processes:

T1 the research question; "*What is your lived experience of change and transition?"* was asked at the start of the interviews. "*What metaphor symbolises who you are in your current position?"* was asked at the end. Interviews were transcribed and analysed between sessions. Arising themes from individual participants were sent to them personally for feedback.

T2 and subsequent interviews commenced with the question "*What are your reflections on the themes arising from the previous discussion?"* Training needs/desired approaches were explored. A draft Training Manual based on arising themes was sent to the participants between T2 and T3.

T3 - themes arising from T2 and the draft Training Manual were discussed.

An amended Training Manual was Shared amongst participants who volunteered for training.

To determine the effectiveness of the Training Manual – I focused on process studies, encouraging stakeholders to participate in decision-making at all stages of the action-research cycle (Fillery-Travis & Lane, 2006). The evaluation consisted of: training-in-activity with each participant indicating what was learnt; the PCNA of exit interviews; and metaphor analysis (Lawley, & Tompkins, 2013; Figure 3 overleaf).

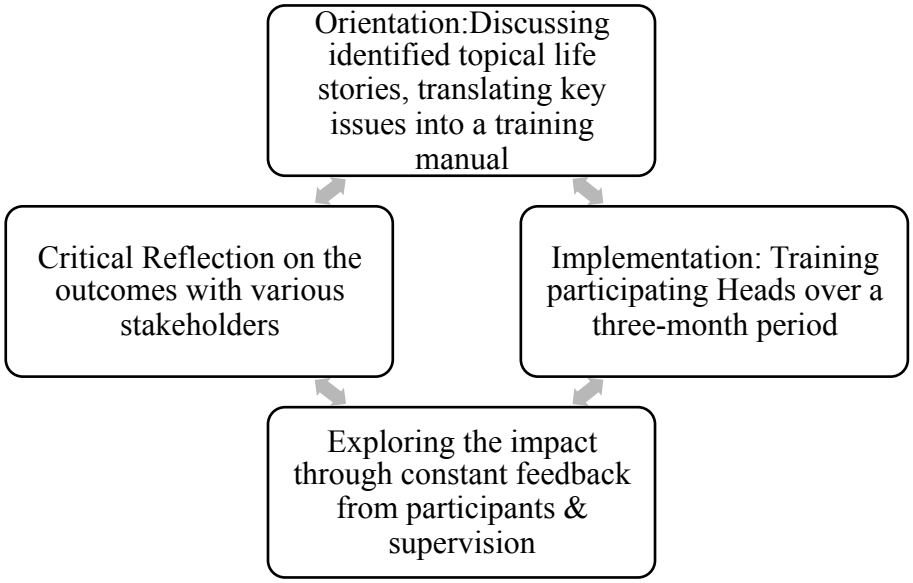

Figure 3: Action Research Spiral for Determining the Effectiveness of the Manual

Data Analysis: During the PCNA of the transcribed material topic-centered narratives, linked by themes were adopted (Reissman, 2008). Common patterns of meaning were identified, appreciating what fell out of this pattern and working with both. Data sets were placed into codes producing a thematic map. Narratives were deconstructed asking '*Which other voices need to be heard?* The synthesis, intertwined my interpretations of the descriptions, with my observations (Langdridge, 2009).

Findings

Participative-observation of CMTT sessions facilitated insight into the Heads' experience of ongoing change/implementation and outcomes of non-reflective facilitation. Exploratory interviews supported insight into Heads' underlying processes, training needs/preferred approaches and the outcomes of their non-reflective managerial interventions. Findings will be presented using the PCNA structure.

Participative-observation of CMTT sessions: Eleven CMTT sessions, were facilitated by CMTTF between June – July 2012. Heads nominated by administration[†] as their representatives, were tasked to create guidelines enhancing inter-employee and inter-entity communication. CMTTF planned to convince the Heads that it would benefit MNHCS to become a learning organisation, and introduce the position of Communications Coordinator at Director (CCD) level. One hoped some Heads would become "multipliers of the process" (Session #2, line 1). Stating that CMTT outcomes depended "on the personality of the leader" (Session #9, line 17) CMTTF set the canonical narrative as *hero who enters to turn the organisation around*. One appeared unaware that the Heads regarding CMTTF as representing MNHCS administration. They were cautious of embracing the prescriptive document, since they had to account for their actions to the absent decision-takers. Rhetoric included distancing through second- and third-person pronouns, and self-referentiality through the egocentric *I.* Verbalisations such as "people...do not like to see change" (CMTT10, Session #6, line 127), coupled with a wary tone of voice, indicated attempts to play for time until the picture became clearer, while appearing to support the communications document[‡] setting the counter-narrative as *change terrifies us into inaction; anonymity protects us*.

The MNHCS non-reflective change implementation processes involved: Senior management leading through *personality cult* (shadow narrative) created core groups to carry out their directions, precipitating a silo-mentality, *us v. them* culture. Reportedly, they adopted this style, to camouflage limited managerial skills, while controlling other Heads. Middle-management belonging to the core-groups, encountering an oppressive attitude, felt deterred from voicing their feelings/initiatives, as manifested when the CMTT Heads adopted very tentative language to describe potential initiatives verbalizing, *perhaps, if, maybe*. Heads responded from a perspective of fear of sanctions/self-gain, with underlying feelings more likely to be envy/spite: "Management wants an employee to...be creative, but when creativity does not work, [they] be-Head him with a scimitar" (CMTT2, Introductory Session, line 39). Living in constant fear of

[†] Senior management and administration are used interchangeably in this section.
[‡] Reference to *document* in the text means the communications document.

being shamed, mistrusting their staff's ability to maintain confidentiality, CMTT Heads shifted blame of limited efficiency onto sabotage carried out by subordinates: "The problem is when lower workers do harm on purpose" (CMTT9, Session #2, line 78). Heads, identifying with their oppressors became oppressive and/or infantile. "Good communication is that which gets you what you want" (CMTT11, Introductory Session, line 36). Apparently lacking self-reflexivity they *distanced from self-growth* - the shadow narrative. Lower echelons, excluded from core groups, reported resentment, with bottom-up rebellion and/or adaptation, joining their unions in an attempt to redress the power differential, severing communication.

CMTTF, infact, did not consult *with* the CMTT Heads. One deflected[§] their several warnings about how they felt, erroneously supposing that one could change their mind-set during the documentation process. One appeared unaware that the proposals, triggered the show-stopping overall narrative - *We will all do what we have to, so when change implementation fails, we all save face,* and predominant **theme** *MNHCS pièce du résistance, propose, stop (silence), wait (to gain time), abort (to safety)*. One gave the politically powerful Heads what they wanted to avoid conflict, so less powerful Heads, gained time through strategic requests for clarification, making counter-suggestions, until they gave rise to a scenario they could control. Discouraged by the percieved lack of collaboration, CMTTF, exclaimed that unless all agreed "we can forget it" (Session #11, line 34). CMTTF imposed the recruitment of a CCD deeming *him* necessary to create "a single perspective" (Session #7, line, 19). Heads voiced resentment that another Director could be given power to tell them what to do. CMTTF, negotiated the insertion of the term *cooperation* in the document, allowing them to collaborate if/when they deemed fit, rendering CCD dependent on individual goodwill. A diluted version of the original proposal was rubber stamped, *getting the job done but only on paper* – shadow narrative.

[§] In gestalt psychotherapy this means turning away either an internal stimulus or one from the environment, preventing awareness (Ginger, 2006)

The main obstruction to an effective outcome emerged in Session #3 when CMTTF asked the Heads to discuss their **identity**. Overwhelmed, most projected an image of competence, emphasising pride in their professional status: "We are those who are contributing to achieve the goals..." (CMTT5, line 5). In Session #7, asked to reflect about their **identity and values,** Heads reiterated that their sense of self emanated from "pride in the…professional state" (CMTT10, line 74). CMTTF gave up: "If we have a problem understanding *who we are*, we cannot go forward" (line, 43). Enjoying pride in their status Heads defended themselves from commitment to change fearing its loss: "This is ego" (line 104), verbalised CMTT5.

Exploratory Interviews: occurred between January – December, 2013 while participants waited for administration to either renew/terminate their three-year-term contract or re-instate/demote them after changes in political administration. Narratives evidenced anxiety, fear, anger, frustration, resentment and feeling irrelevant. Feelings were at times overtly expressed while at others camouflaged as over-composure and/or deflected into a bitter humour. Interviewed Heads also distanced from their narratives using second- and third-person, singular and plural, adopted the self-referential egocentric *I*, projected an image of excellence, hiding internal conflict. Distancing and detachment appeared to be MNHCS-wide coping mechanisms. Incoherence between verbal and non-verbal processes re-elicited the theme *public v. private selves.*

a) Heads Underlying processes

During Interview #1, Heads felt challenged by the research question "*What is your lived experience of change and transition?"* asking about their experience *of* rather than *how* they implemented change. Evaluating their impact on the enhancement of the quality of service provision, Heads assessed if they were *good enough* for re-instatement. They narrated adjusting to circumstances through a series of transitional crises, habitually *juggling* (shadow narrative) in a conditioned manner. Narratives echoed perused literature (Gilbert & Orlans, 2011; Thomas & Hardy, 2011). Viewing the inquiry as change agency senior management

belittled/ridiculed it*,* evoking an *expert – amateur interaction*: "You can't make the nervous calm." (H13, line 40) verbalised sarcastically. Middle-management tended to evoke a *dominant teacher – student interaction*: "Look, let me tell you!" (H2, line 11; H8, line 6). Caught in the same organisational shame/blame narrative as CMTT Heads, they also were reluctant to discuss their *private selves/***identity***.* To re-establish power dynamics some requested a copy of the methodology, others a list of references to ensure the research had *solid scientific basis.*

Proposing policy updates was viewed as an opportunity to "Increase consistent, reliable services..." (H1, Int, #1, lines 14) *enhancing quality, accessibility, and sustainability of service provision to the service user* (canonical narrative). Creative change was discouraged with "innovations… thrust upon you...most of the time, you just absorb the change" (H5, Int. #1, lines 14, 18).

Interviewed Heads echoed CMTT Heads narratives of non-reflective change implementation processes. Though senior management preferred adopting evidence-based research methods when attempting to implement change: "that does not happen much" (H9, Int. #2, line 28). Peers were approached with "scientific argument" (H2, Int. #2, line 26), however "personal psychology and the other person's psychology" (H5, Int. #1, line 73) were essential to elicit individual goodwill giving rise to the overall narrative: *It's not what or how much you know that matters but how well you get on with those who matter.* Middle-management, deemed "incompetent…[had]…to think like…" (H2, Int. #2, line 26) senior management. Lower echelons were approached through change agents adopting manipulative techniques. When persuasion failed senior management resorted to imposition setting the shadow narrative *power is in giving direction not in being of service.* Shifting blame onto lower echelons' resistance to change, Heads justified the need for autocracy, and lack of transperancy. They failed to acknowledge that the adoption of constraining communication styles, led to elective mutism (silence) and/or frustrated acting-out (unionisation), setting the counter narrative *striving for consensus orchestrates inaction.*

Heads also got caught in the MNHCS vicious cycle: "evolving and changing [not necessarily] into something better" (H4, Int. #2, line 88), becoming slowly but surely desensitized, detached and

alienated and/or leaving. They realized that going higher could entail meeting more constraints, precipitating frustration. The more distant Heads became from the core business, the more they risked **identity crises**: "It's…easier…to empathise…when you meet…the person…using the service" (H6, Int. #1, line 26). Speaking of their life as leaders, they took deep self-supportive breaths followed by silence. Self-actualisation slowed down spiritual-emotional regression, providing sufficient intrinsic rewards and energy to protect oneself: "Surviving is...*moment of reflection*...being happy doing what I do" (H3, Int. #1, line 116).

By Interview #2, having read the emergent themes from Interview #1 Heads felt they were losing control over the research. This precipitated further polite annihilation/ridicule as part of a *belligerent diplomatic argument.* While feeling displeased/furious at what emerged, they could not deny it: "I was taken aback…I was more of a guinea pig than I realised" (H5, line 8). To retain their top-down expert **identity** intact, participants *split* me into *bad listener* when I questioned and *good listener* when I empathised, being happiest when what I said was 'exactly, exactly' what they intended. The interviews ended on a relieved note for re-instated Heads, disappointment for Heads who accepted demotion with ambiguous grace and fury for Heads who experienced their demotion as narcissistic injury.[**]

Detached from their inner selves to survive MNHCS practices, hid frustration and anxiety under a veneer of over-composure and ego-centricity, living in fear of being shamed.

b) Managerial skills and values for change implementation

During Interviews 1# and #2 Heads disclosed encountering difficulty when practicing skills, they learnt during training. They acted *as if* they were following management theory but the intent was survival, the avoidance of shame and blame.

Active listening, acknowledgement, and equity aimed at ensuring loyalty, rather than understanding. Heads, disseminated information/knowledge about the organisation cautiously, disclosing even less about themselves, believing that this could lead to loss of power: "sharing

[**] A narcissistic injury occurs when a person reacts negatively to perceived or real criticism or judgment, boundaries placed on them, and/or attempts to hold them accountable for harmful behaviour (DSM-5, 2013)

inner feelings enough gains...trust, too much...becomes shaky" (H15, Int. #1, line 10). Heads noted that building good working relations with peers resulted in greater collaboration, however they set clear power distances between themselves and the staff, reducing the latter to a nameless mass; "…the staff has to benefit as well…give *him* a win-win situation" (H2, Int. #1, line 83). For Heads outcome evaluation was an ongoing exercise assessing whether one was attaining the desired results. This approach entailed being "able to accept, failures, mistakes" (H15, Int. #1, line 52), "...find[ing] ways of improving" (H1, Int. #2, line 12); saying "…'look, this didn't work,' we need to adapt" (H3, Int #1, line 17). Negotiation, persuasion, and organisation techniques aimed at achieving a win-win situation for as many stakeholders as possible; "I don't trust them and they don't understand me….so, you build trust" (H1, Int. #2, line 48, 53).

While acknowledging that being authentic and honest could generate trust, Heads noted that survival required flexibilty, shrewdness and opportunism, possibly also manipulation: "sometimes…you may need to say a half-truth (H13, Int. #2, line 49); "You can't, (triplicated) occupy certain positions and not have a thick skin" (H9, Int #1, line 30). Commitment and passion, involved owning a project which reflected one's cause: "If you don't succeed try and try again" (H13, Int. #1, line 11). When passion died one "moved on" (Int. #1, H3, line 116; H12, line 83). Patience, tenacity, perseverance and resilience, were essential given the slow, unfolding of change. Accepting the situation and, working in the here-and-now were related to lack of continuity rather than mindfulness: "constantly, understand the constraints...results take time" (H15, Int. #1, lines 56, 57). Self-control involved being logical, aware of negative feelings to retain clarity of vision and thought, focusing on what had to be done: "recognize that a situation is about to escalate…the circle of enemies needs to be converted into a circle of friends" (H1, Int. #1, line 84, 96).

Responding to the draft Training Manual sent between Interview #2 and #3, Heads noted that it was evident that the Manual had been written by someone who knew the field verbalising "you've invented…an adapter plug…we can *think* about changing our processes" (H14, Int. #3, line 28).

c) Training needs and desired approaches

During Intervew #3 declared training needs tended to self-referentially address the development of pre-existing predispositions, safeguarding positions of power. Skills required to function within the MNHCS were not found in managerial books/training as: “new managers do not even know what skills they are going to be needing” (H1, line 46). These skills could be imparted to chosen acolytes: “You cannot include...a day-to-day person in this...da” (H2, line 39).

However, when requesting further training about ethics, moral development, facilitating the emergence of the true-self, focusing on enhancing professionalism and increasing awareness of how far they had developed in these aspects, Heads exhibited awareness of their need to develop/rediscover their humanity: “the patient [as active participant] needs to become the ethos of the organisation” (H2, line 43),

Training approaches requested included interactive seminars/workshops wherein Heads could discuss issues, exchanging solutions. One-to-one coaching/mentoring sessions by: “someone… wiser…at the same level...to share grievances with” (H9, line 89), would “allow the situation to grow and develop” (H15, Int. #3, line 119), avoiding suffering associated with learning from one’s mistakes. Reflection as a form of personal development was highlighted: “It’s very difficult to bring about change when you yourself have not gone through *short stop of suspense* changes. Then you can say that you lead by example” (H9, line 67). Heads requested a “training manual [offering] sufficient flexibility for the person to revisit what one had learnt” (H1, line 44).

PCNA of Interview #3 highlighted that a reflexive-tool, could circumvent the organisational narrative *tell me what to do so I know what to resist*. This was added to the draft Training Manual.

Writing the Training Manual: Discussions with stakeholders indicated that it would be beneficial if the Training Manual drew on:- Gray’s (2006, 2007, 2010) executive coaching approach wherein training would focus on daily workplace interventions: Denham-Vaughn and

Gawlinski's (2012), coaching model, so training would be based on field-relational and gestalt theory: Nicholsen and Carrol's (2013) suggestions that the trainer/researcher, practicing self-awareness, would empathise with the leader who practices: a) self-observation, followed by self-disclosure; b) self-examination through reflection/feedback; and c) self-development through transformation by new knowledge: and Barber's (2012) multidimensional approach which facilitated engaging in five forms of interventions, helping participants develop forms of intelligence/skill at various levels. Table 1 outlines the facilitative skills, relationship levels, and types of intelligence addressed.

Table 1: Multi-Level Amalgamation for Holistic Inquiry

Facilitative Skill	**Relationship Level**	**Intelligence**	**Fostered Skill**
Engaging the physical-sensory environment. Facilitating awareness.	Negotiating the working alliance	Sensory intelligence.	Observation and listening.
Responding to sociocultural environment. Organisational dynamics and ethical boundaries are explored and recognised. Strategies are contracted/implemented.	As above.	Social intelligence.	Inquiry and communication
Acknowledging the emotional-transferential climate. Focusing on: client/organisation biography, resources, learning orientations, discovering emotional blockages.	Idealised dimension of relationship vs power politics; shadow side of contractual relationship.	Emotional intelligence.	Coaching and counselling.
Surfacing the imagined-projective shadow. Drawing attention to unconscious processes and dynamics.	As above.	Self-intelligence.	Mindfulness and self-awareness.

Locating intuitive-spiritual qualities. The attitude of listening without fitting what one hears into pre-packaged concepts.	Authentic relationship, accurate perceptions, willingness to be honest. Transformation occurs.	Intuitive intelligence.	Reflective and envisioning.

The Training Manual developed into three sections:

Introduction*:* - The concept of leadership and how synergistic learning supports self-development were discussed, exploring how the reader could adopt critical self-reflection during transition.

Self-Reflective Tool*:* - Replying to set questions, one could identify problems, seeking remedies, critically self-reflect, attaining behavioural clarity and awareness that one's practice is changing.

Self-Reflective Manual*:* - Supported the reader to learn from personal observation and critical self-reflection, facilitating the cultivation of a new sense of self/identity, and the development of transitional leadership skills/related roles. Conceptual frameworks and models upon which the tool was based, were discussed.

d) Training Outcomes and Evaluation of the Manual

Training commenced March 2014, with thirteen participating Heads and two new volunteering Heads – fifteen in all. During an initial meeting an up-dated version of the Manual was presented to them offering them a choice to read it on their own, or work through it with me. Five Heads opted to read it and meet for discussions. Ten Heads, identified areas they required training in and we worked together. This section will discuss results obtained from: training-in-activity; PCNA of Exit interviews and metaphor analysis. Exit interviews occurred one month following training allowing Heads time to work on their respective projects. Metaphors verbalised during Interview #1 were compared to those offered during the Exit Interviews

evaluating possible shifts in sense of self/identity, managerial skills/leadership style and/or learning style, not consciously verbalized, on a case-by-case basis. As projective techniques may reveal what participants do not necessarily know or want known about themselves, I asked them point blank which metaphor symbolised who they were, demystifying the process, increasing trust (Edgar, 2004).

Training-in-activity: Heads' projects were discussed during three/four meetings held over a three-month period. Process notes were kept. All Heads indicated that organisational issues arose when projects reached the exploration phase (Barber, 2012) - monitoring the impact of strategy implementation on stakeholders, possibly because adopting a top-down approach with subordinates rendered monitoring difficult. H14 noted that when building communication, the best plan was "coming down to earth, on level with the staff." H15 started having coffee in the kitchen, to give the message "I am a part of you at lower level." Training supported them to develop awareness so they could identify their values, and then support the development of awareness in others, so all could become aware which value they might need to change/adopt to successfully achieve desired outcomes.

Three Heads adopting guidelines explicated by the Manual commenced projects discussing the way forward with colleagues and subordinates. They found this exercise demanding, however agreed it, 'unexpectedly' facilitated the smooth flow of the project. Two Heads requested team-building for their entity. Though this achieved the desired managerial goal, it set subordinates on the path to differentiation. Feeling they were losing control over the staff, the Heads developed internal conflict. Notwithstanding, they reported that this activity left a positive impression on senior management, promoting managing-up. Heads seeking to enhance their interactions with subordinates, rather than their own self-development, became more effective.

Exit Interviews: Heads were asked set questions to evaluate the training outcomes:

Asked what they considered to be of significant learning for themselves and how they best learned from the meetings, Heads, voiced appreciation for the way the Manual integrated management with psychotherapy, logical thinking with empathy: "the way it is structured [and

the] questions [made you] reflect...rendering you more empathic" (H1, lines 5, 7); "It came at the right time...*he...he*... sometimes it's good to have something that...helps you filter your thinking" (H13, line 34). Heads, noted that they found the Manual time-consuming, requiring in-depth thinking prior to insight.

Asked if they were aware of any self-growth, due to the work carried out through the Reflective tool, Heads reported a limited increase in *self-awareness and self-reflexivity*, which they tended to intellectualise, justify and/or rationalise to some degree. Heads deemed the outcomes had commenced during the exploratory interviewing process, wherein 'hard' questions had "started self-reflection...maybe before I did not give it any attention" (H10, line 4). Focused on self-reflection, the Manual could not be used as a set of models/directions indicating what Heads were meant to think and/or how to reply. Heads lacking an internal locus of control found this difficult to digest. Sounding surprised H10 and H13 respectively verbalised; "That *thing* made me…stop, think and plan…I have a tool I can use" (H10, line 2); "You…make the time to actually…reflect" (H13, line 3). Blame for the increase in *undesired self-awareness and self-reflection* was at times shifted onto me, as author of '*the thing*.'

Other Heads, while appearing angry at *unplanned personal change,* reported feeling content when training supported achievement of managerial goals. This mirrored the CMTT narrative – *they want change*, *we do not want self-growth.* Self-reflection, while giving results might have precipitated *unblocking of shame* which Heads wanted to avoid: "It exposed me to my deficiencies...I think (H2, line 5); "I was finding it hard to adjust [to demotion]…*Long reflective silence*…Because I…I…never really thought about it" (H13, lines 4, 20). Other Heads yet used the Manual to serve their purpose: "The forms of thinking…helped…we can make a better team with each other" (line 11). *We* being H3 and myself, as H3 distanced from the staff who needed training; "You…need to resist the temptation that after things have reached full circle, you say 'Didn't I tell you?'...otherwise you get into trouble" (H6, lines 26, 29). These verbalisations implied that the main theme behind resistance was *professional narcissism.*

Asked if this work helped them develop their current form of intelligence and/or exposed them to other forms which they also developed and to what extent it did so, eight Heads

reported a shift in one of the various intelligences: self-, emotional-, social-, imaginative-, and/or spiritual; five learnt a new learning style, shifting either from abstract conceptualisation to active experimentation or vice versa. Active experimentation of the guidelines supported some Heads to discover individual needs for managerial training and others to observe that they needed to *stop, step back, and think prior to planning*, actively counteracting the MNHCS non-reflective change implementation process.

Eleven Heads claimed that the Manual helped them achieve their training needs; ten Heads claimed it helped their personal transition; thirteen Heads noted that the Tool supported their ability to self-reflect, enhancing awareness of who they were and who they wanted to become.

Identity work and Metaphor analysis: Metaphors chosen distinguished between male and female archetypes (Morgan, 2006) echoing CMTT and Exploratory Interview narratives: -

- male archetypes included: Gandhi, Mandela and Robin Hood: These counter-culture metaphors echoed the CMTT and Interviewed Heads respective narratives: *the hero who turns the organisation around, wants a personality cult* and *power is in giving direction not in being of service.*
- female archetypes included the old humped tree, the gnarled pine and the wise old *person*: Related to deformity and old age, the anti-thesis to Health *who is male,* these metaphors echoed the Heads' narratives *they want change,* we have to *juggle* around to survive.

Pre- and Post-metaphor analysis evidenced how Heads veered towards change that *maximized power*. H3 describing oneself as the captain of a boat with holes in it, gathering a team together to fix them, evidenced one's intent to extend one's personality cult. More frequently however change was carried out to *retain power*. Following demotion H15 shifted one's metaphor from a rider on a roller-coaster being mainly atop, to a wise old *person* adopting a low profile trying to blend with one's surroundings still exerting influence. Power retention also took the form of minimising shameful connotations by using euphemisms: *holes* rather than *shortcomings* (H3)

Some Heads found it easier to speak about their *private selves* through metaphor. The oppressed Healthcare administrators chose deformity a gnarled pine battered by the elements and a humped tree of wisdom which could spiral out of control to describe who they had become as a result of coping with senior management.

During the evaluation of the training manual some Heads appreciated the integration of professions, becoming more sensitive to the feelings of others, and more empathic with the pace of the changes one is carrying out with the other. The adoption of empathy, and co-creation was stalled by the *dominant, masculine archetypal orientation* of the existing culture and its underlying narratives which were introjected by other Heads. The discovery of this issue could only be carried out through dialogue and self-reflexivity (Chidiac & Denham-Vaughn, 2018). Heads agreed that despite being limited by time, their colleagues and themselves needed to stop and think, and that the Manual had facilitated that process.

Self-reflexivity: Supervision and keeping a journal, protected me temporarily from becoming ensnared in MNHCS practices, assuming the role of rebellious/adapted child and/or identifying with the oppressors (Evans & Gilbert, 2005). Finding myself trying to remain calm and composed, despite the ridicule, belittling and splitting, I gained insight that senior management's cold indifference could be a form of self-defence. Informed by Etherington (2004), that researchers need to delicately tread the pathway between their own possible narcissism and need for control, and that of their participants, I did my best to hold my presuppositions at bay, while adopting psychotherapeutic, active listening. The Heads, unused to this approach, apparently mistook it as a sign of weakness. As I did not act as an *expert*, I was an *amateur* to whom some Heads, imparted their skills. Being cognisant of the *as if* managerial tactics I began to recognise them when they were used by my direct line managers.

As an insider-researcher, I was surprised at the extent of the negative impact from the ongoing lack of continuity. Heads were given insufficient time to let their current sense of self/roles/identity go between one shift and another, so by necessity, they lived in the here-and-now, practicing secrecy as a survival tactic (Shapiro, 2013). This worldview precipitated a sense of insecurity, pervasive mistrust and fear of failure leading to *the shame-blame narrative*

resulting in the *alienation-demotivation process*. Consequently, Heads developed egocentric self-referentiality, personality cult leadership styles and core groups, limiting policy implementation at strategic level, decreasing the quality of service provision. This process resonated with the point raised by keynote speakers at the *Joint Action on Mental Health and Well Being: Driving Mental Health at Work in Europe* (2014), that even if policy were drawn following professional research and interventions respect ethical evidence-based best practice, implementation is not straightforward.

Synthesis: In line with Nicholsen and Carrol's (2013) conclusions, this research confirmed that the *undoing of power* is a difficult task for Heads. Finding it difficult to let their old grandiose identity go, even when this became necessary, Heads developed new identities to retain a semblance of their lost power. Adherence to the social contract, and self-transcendence was limited as Heads distanced from a professionally ethical identity for safety (Hamilton, 2008) resorting to egocentric self-referentiality (Langdridge, 2007). This is not restricted to the local scene. Encouraging management to involve employees at an early stage of the change process, Psy-ga (2013) advices managers to model on chameleons evoking the *hero that enters the organisation to turn it around* while appearing to merge with the background/company/employees. This resonates with the identity leader (Haslam et al., 2011; Steffens et al., 2014) who creates an image of *we-ness* to bring about change. This leadership style lacking self-reflexivity, led CMTTF to achieve limited outcomes. Deflecting feedback from the CMTT participants, CMTTF remained unaware that one was losing their trust and collaboration (Stetler, 2014). The concept of the *change implementer as change catalyst,* remaining unscathed by the implementation process, was and is still found in mainstream managerial training (NHS, 2010). MNHCS Heads might benefit from heeding Psy-ga[††] (2013, 105 - 109) that when "managerial staff expect from employees, conduct which they are not yet able to deliver, employees may simply feel overloaded." Leaders viewing human development as a value are more likely to achieve desired goals (Huppert & So, 2013: Leggett & James, 2016).

[††] Published under the auspices of the Federal Association of Company Health Insurance Funds and supported by the German Federal Ministry of Labour and Social Affaires under the New Quality of Work Initiative.

Post-Doctoral Work: Products and the wider professional influence of this research:

Following the Heads' suggestion, I went out and "explained [the manual] to [others]" (H1 Int. #3, line 18). H2's verbalisation that the Manual could "bridge between professions which are not necessarily within health" (Int. #3, line 13) foretold the Manual's future. Wanting to share their development in self-awareness and self-reflection MNHCS Heads asked me to start team-building sessions in their respective departments. Knowledge-sharing, meaning-making, self-actualisation, and critical self-reflection proved essential to create a collaborative environment in what was essentially a *dominant-submissive, shame-blame scenario.*

Moving beyond: Collaboration with the Commission for Domestic Violence, in 2017, led to the setting up of the Peer-to-Peer Case Study Research Group, promoting self-reflexivity, knowledge- and meaning-sharing and discussing evidence-based best practice within a related taskforce. Commissioners provided us with platforms to disseminate outcomes. We held a Workshop on March 2019 sharing our findings with peers and Heads of Departments. Workshops in self-reflexivity were also carried out with employees hailing from various Ministries including Home Affairs and Education as well as at the University of Malta where I am now employed as Head of Counselling Services.

Modifications in the training manual in light of more recent practices and learning: The Training Manual is being prepared for publication, and is the basis of a post-doctoral study to further explore the *role of self-reflexivity in transition-management training, supporting leaders to develop a hybrid practioner-researcher identity* (Barber, 2012). Armsby (2013) highlights that the integration of professional and academic identities is beneficial as one identity supports the other. This resonated with my doctoral experience when I found myself 'reflexively understanding as a person, expressing as a professional, repositioning my researcher stance into that of the acknowledged participant' (pg. 15). In hindsight, I realised that self-actualisation through the development of a doctoral identity protected me from embarking on the alienation-demotivation process, while my identity of practitioner protected me from getting *lost in a vortex of helplessness* upon losing sight of the core business, the client. The Manual would continue to train the leader in self-reflexive dialogue as a tool for transition-

management - the practitioner (Chidiac & Denham-Vaughn, 2018); while supporting him/her to develop research skills, particularly appreciative, holistic inquiry – the researcher (Breslow et al., 2015). This would distance from the problem-solving approach risking development of shame/blame, focusing on a passion-centred mindset, fuelled by the person's need for self-development and transcendence (Waters & White, 2015).

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Notes on contributors

Joan Camilleri

Joan Camilleri, M.Clin Psy. D.Psych.Prof.St is a researcher and practitioner working at the interface between psychology, wellbeing, and organisational development. She is currently employed at the University of Malta as Head of Counselling services.

Impacts Of Service User Involvement In Mental Health Nurse Training On Management Of Aggression: A Qualitative Description Research

JANE OBI-UDEAJA *

Department of Mental Health and Social Work, Middlesex University, London, UK

And

CATHERINE KERR

Middlesex University, London, UK

And

GORDON WELLER

Middlesex University, London, UK

The involvement of mental health service users in a Higher Institution prevention and management of violence and aggression (PMVA) team's training delivery is a recognition of the contribution that the unique insights of people's lived experience can make to the development of practitioners. This research aimed to determine whether or not their contribution to PMVA training delivery influenced the staff management of patients' anger or aggression on mental health wards. The qualitative description research design was adopted for the study. Focus group interviews were used to collect data from final year mental health students and new trust staff, while semi-structured interviews were employed to collect data from experienced trust staff. A sample of feedback from previous training records was reviewed. The findings showed that: the students and new trust staff were determined to translate lessons learnt into practice; the experienced staff were reflecting lessons in ward practices; the feedback records held expressed intentions to translate lessons into practice; there were hindrances in practicing as discussed with service users. The findings confirmed those from other studies claiming that service user involvement in the education of professionals has the potential to improve practice.

* **Corresponding author:** Jane Obi-Udeaja.Email: J.Obi-Udeaja@mdx.ac.uk

Key words: Mental health nursing, violence and aggression, training delivery, service user involvement, ward practice, insider research

Introduction

Restrictive interventions such as physical restraint (PR) are often used to manage challenging incidents in healthcare settings particularly in mental health inpatient wards. The obligation to use such interventions with patient care in mind is emphasised in literature and guidelines (Duffy, 2017; Knowles et al., 2015; NICE, 2015; DH, 2014). Nevertheless, the potential to cause harm and indeed to be abused by staff remains a concern. Hence, physical restraint is regarded as controversial (Moran et al., 2009; Irwin, 2006). McKenna (2016) and Brophy et al. (2016) consider the use of restrictive interventions particularly physical restraint as coercive violations of the 'human rights' of those affected.

The abuse of physical restraint and its potential negative effects trigger calls nationally and internationally to eliminate or at least reduce its use (Clark et al. 2017; CQC 2017; UN 2006). Most recently, the Restraint Reduction Network (RRN) training standards accreditation was introduced to monitor a systemic progression to restraint reduction in the UK (Ridley & Leitch, 2019). Furthermore, suggestions are made for healthcare organisations to attach high importance to and direct resources towards proactive and preventative alternatives to restrictive interventions (Riahi et al., 2016; Wisdom et al., 2015). Consequently, there is a growing body of literature reporting on alternatives to physical restraint. Authors including Bowers (2014) and Foster et al. (2007) are convinced that tuning into the reasons for patient's aggressive behaviour can facilitate ways other than restrictive interventions of dealing with the problem. Hence, Kontio et al. (2010 p72) suggest sensitizing staff to '*mindful reflection on patients' feelings and thereby enable understanding of the causes and prevention of aggression'*. Reinforcing, Clarke et al. (2017) explain that the behaviour support plans (BSP) aim to proactively reduce restrictive practices through an examination of factors that can affect patients' behaviours. It is noteworthy that activities regarded as routine hospital care can in fact constitute restrictive practices (Whyte, 2016).

Invariably, a genuine effort by staff to understand all possible causes of a patient's behaviour would require working closely and collaboratively with that patient. Reiterating, authors including Allen (2011) emphasise that achieving restraint reduction might require multiple strategies including consumer participation. Following his literature review Scanlan (2010) revealed seven key strategies for restraint reduction among which was again consumer involvement. These authors and many others are in agreement that a combination of multiple strategies could result in a reduction in the use of physical restraint. Of particular interest is the inclusion of consumer/service user involvement in every listed group of interventions that could reduce the use of physical restraint. For example, emphatically included on the list of 'six core strategies' for a systematic service-based approach to reducing the use of restrictive interventions by Huckshorn (2006 p2) is employing the expertise of service users/their families/advocates to work alongside clinical staff. This 'alongside' working is sometimes referred to as co-production or service user (SU) involvement. Explaining *co-production*, Ramsden (2010 p7) states that: *'... In practice it involves people who use services being consulted, included, and working together from the start to the end of any project that affects them'*. With reference to mental health and social work care, SU involvement in education and training is an acknowledgement that people who use services have valuable knowledge and expertise resulting from their lived experience of the condition … (Ryan and Carr, 2016).

SU involvement notion has driven government policies internationally (Dreissens et al., 2016; Speed et al., 2012). It has been reflected in numerous national guidelines, and initiatives including NICE (2015), Mind and NSUN (2015) and NMC (2010). For example, the involvement and participation of people with care and support needs, their families, carers and advocates is one of the key principles underpinning the guidance framework issued by the Department of Health (DH, 2014). There has been an expanding body of literature exploring the subject area of SU involvement in the education and training of health and social care professionals (McIntosh, 2018; Happel et al., 2014). However, there still seems to be a paucity of research with regard to its deeper impact on practice learning (Alida et al.,

2013). Morgan and Jones (2009) observe that this might be due to the challenges in determining the impact of learning on practice. Such learning they argue does not happen in isolation of other learning strategies, practice and nursing students' life experiences.

Background to the research

The principal author works within a Higher Institution (HI) team that provides training on the prevention and management of violence and aggression (PMVA) in healthcare settings. The training is delivered in a non-operational setting away from the ward environment. As trainers, the team recognize the potential rift between the theoretical principles emphasized in training and the staff practice on the ward. Jordan (1994 p.418) defines theory–practice gap as *'the divide between abstract possibly esoteric concepts and the real problems of everyday clinical practice'*. Theory–practice gap, for example, 'field modifications' of restraint techniques can occur for various reasons including fear as explained by Terkelsen and Larsen (2016) and by Paterson (2007). One of the ways the team try to bridge this gap is to invite mental health service users (living in the community) who have experienced being restrained while on inpatient ward to co-train with them.

The involvement of service users in the team's training is a recognition of the contribution that the unique insights of people's lived experience can make to the development of practitioners. While SU involvement in the training of social and healthcare practitioners in a normal teaching and learning setting has become a common practice and a mandatory requirement (NMC 2010), their involvement in PMVA training, a unique subject area, is still a new phenomenon. As a pioneer of the initiative the lead author started the co-training development in 2008. It has since continued and has consistently received very positive feedback from course participants. Furthermore, the team share their experience of working together in conferences and publications including: Obi-Udeaja, Crosby and Ryan (2017), Obi-Udeaja et al. (2010) and Obi-Udeaja (2009). The service users' contribution is powerful and has the potential to influence practice. This study sought to find out whether it actually influenced the staff management of patients' anger and aggression on the wards.

Research Question:

Can service users make a sustainable contribution to mental health staff practice in the prevention and management of violence and aggression through active participation in training and development?

Methodology

The qualitative description research design (Bradshaw et al., 2017; Sandelowsk, 2000) was adopted for this research because the research question identifies with descriptive approach in assuming that there is a contribution to practice that can be abstracted from data (Lopez & Willis, 2004). The approach is in line with the principal author's research aim to produce a straight description of the phenomenon under study using participants' language and staying close to the data. Furthermore, service user involvement in PMVA training delivery is a new initiative. Authors including Polit and Beck (2012) suggest that if we do not have adequate knowledge about a phenomenon, then it is best to use a design that would enable the description and understanding of it.

Method

Two focus group interviews of ten new mental health inpatient ward staff and ten mental health final year students were conducted. Semi-structured interviews of ten experienced mental health inpatient ward staff were carried out. A review of a sample from 111 records of feedback from previous PMVA training participants was carried out.

Ethical issues

An approval for the research was obtained from the HI Health and Social Care Ethics Sub-committee. The collaborative engagement with the trust managers at the hospital sites where the semi-structured interviews took place enabled helpful information, and the gaining of permission from the relevant hospital authorities. Reflexivity, criticality and collaboration (Ravitch & Carl 2021) enabled continuous monitoring in order to promptly identify and attend to potential impact of the study on any of the stakeholders (Parahoo, 2014). Written information about the study and further information as required was promptly provided. It was explained to research participants that participation was

voluntary, and that one was free to withdraw at any point (up to one month after data analysis) without explanation. Pseudonyms were used to effect anonymity of participants.

Sampling and data collection strategies

Purposive sampling was deemed appropriate and was used for data collection because the data sources participated in the PMVA SU session and could talk about the experience (Polit & Beck 2017).

The focus group interviews conducted at the HI location collected data from the students and separately from the Trusts' new staff. Each group comprised ten male and female in the age range of 20 to 50 and 20 to 35 years respectively.

The semi-structured interviews collected data from staff at two differently located NHS hospital sites. The participants comprised six male and four female in the age range of 20 to 50 years and with one to sixteen years of practice experience. Five of the participants were staff nurses, one a charge nurse, one a ward manager, one an assistant practitioner, one an activity worker and one a Nurse Assistant Band 4.

A random sampling of one in ten yielded eleven records of feedback in the past two years from the date of the record search. This was in compliance with the HI two years archiving policy at the time of data collection. The identified records were reviewed.

The adequate sample size for each category enabled a collection of rich, powerful and sufficient responses to the research question (Fawcett & Garity, 2009). Figure 1 illustrates the sources of data. Table 1 shows the inclusion criteria for the interviews.

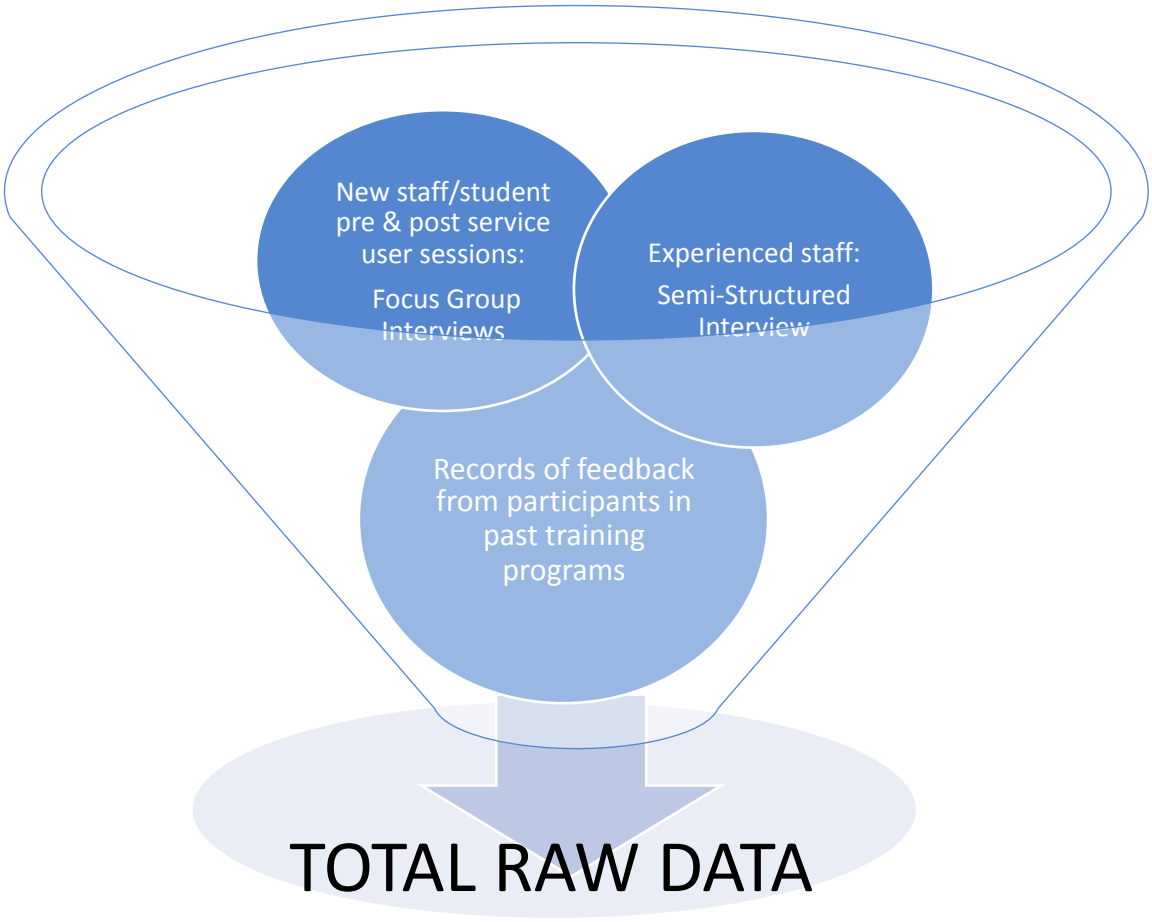

Fig 1: Diagram illustrating the sources of data collected

Table 1: Study Participants Inclusion Criteria

Focus Group Interview	Semi-structured Interview	Feedback Records
The NHS Trust mental health inpatient ward staff and The final year mental health students of a HI Who attended the 5Day PMVA training and participated in the SU	The NHS Trust mental health inpatient ward staff members Who participated in the SU session when they attended the 5Day PMVA training at least six months prior to data collection	All records of feedback from PMVA training participants Within the HI two years archiving policy

session Who were willing to participate in the interview	Who were still working on the ward at the time of data collection Who were willing to participate	

Piloting the research instruments

Pilot studies were conducted two weeks before the first actual interview session. Approximately forty minutes were adequate for a semi-structured interview and an hour for a focus group session. To make 'non coercion' obvious, a separate room was booked for the interviews. Also, to minimise bias and to avoid trainer-trainee influence, a moderator who had no prior acquaintance with the participants was engaged. The semi-structured interview schedule refreshed the participant's memory on the SU session prior to the key questions. This was considered important as the participants might have forgotten the details of their discussion with the SUs due to time lapse. The schedule is explained in Box 1. Permission was obtained from the participants to tape-record the interviews and for the principal author and a colleague to sit at a corner to take notes.

Box 1: Explaining the semi-structured interview schedule

- Engagement – the schedule tests how engaged the participant was during the SU session
- Did the participant identify any points of interest in the discussion?
- The schedule wants to know whether the experience resulted in practice change or modification.
- Could the participant please use incidents on the ward to illustrate such practice change or practice modification
- The participant may have opinions regarding the phenomenon. The schedule is interested in work related issues such as issues on the wards in particular and in

the establishment generally that may constrain or enable the implementation of lessons from the SU contribution to PMVA training • The participant is given the opportunity to share any other concern, work related or not about the phenomenon

Analysis

The tape recorded responses from the participants were cross-checked for consistency with their signed written responses. Driven by the research question and the theoretical assumption (Braun & Clarke, 2013; 2006), decision was made to use the thematic analysis (TA) method. The method captures patterns (themes) across qualitative datasets and is popular with interviews and focus groups generated data (Braun et al., 2018). The emerging information from the analysis was continuously compared for consistency with the detailed notes from the field work. In consideration of the qualitative description principle and the author's insider researcher position, she reflexively kept herself close to the data in order to minimise bias. Every identified category was acknowledged and given attention irrespective of number of appearances. In the spirit of collaboration (Ravitch & Carl, 2021) the independent analysis by the second author provided a valuable second opinion. Table 2 shows the process followed in deriving the themes. Table 3 displays the themes and sub-themes used in presenting the findings. And Table 4 holds the key to the quotes from data sets.

Table 2: Process of thematic analysis (modified from Braun et al., 2018)

1. Familiarization with data	Transcribed data, written responses and sampled records of feedback read over and over. Audio-tapes listened to again and again – ideas noted and compared with those from fieldwork.
2. Generating codes	Meaning units/essences were pulled out from participants' responses. These were categorised/ coded.

3. Constructing themes	Related categories/codes were grouped together into category sets to form candidate themes. The candidate themes and their category sets were scrutinised for emergent themes and sub-themes.
4. Revising and defining themes	On-going analysis and scrutinization to confirm, refine or rename themes and sub-themes
5. Reviewing and defining themes	Ensuring that theme names clearly, comprehensively and concisely capture what is meaningful about the data
6. Producing the report	Use themes and sub themes (Table 4) to present the findings supporting with quotes from participants. Underpin with relevant literature.

Table 3: Themes and sub-themes used in presenting the findings

Themes	Sub-themes
Service users' contribution to PMVA training	SU involvement draws attention to patient's perspectives
	It is useful for practice
Working with patients	Involve patients in their care
	Is PR always avoidable?
Challenges to implementation of SU contribution	Staffing issues
	Policies
	Environmental issues

	Allied professionals

Table 4: Key to quotes from data sets

RF	Record of feedback (from previous training)
FGT	Focus group (Trust staff)
FGS	Focus group (Students)
SS	Semi-structured interview (Experienced practitioner)
Rn	Row number
Service user PMVA trainers: Marta and Bob (pseudonyms)	

Table 14 holds the key to the quotes in the findings. Pseudonyms replace participants' names.

Findings:

Theme 1: Service users' contribution to PMVA training delivery

Service user (SU) involvement draws attention to patient's perspectives

SU involvement in PMVA training delivery meant that the participants in the training heard and discussed service users' views on physical restraint (PR), an exercise that could promote a reflection on practice. There was a keenness on the part of the study participants to hear what the SUs had to say.

> *I'm looking forward to the patient's session tomorrow because I think hearing from their perspective is so important because it's them who are dealing with it on a daily basis. Like I say, if there are things that we could improve or change to benefit patients, then that could reduce the amount. It's really important* **(Lisa: FGS)**.

The participants believed that discussions with SUs might provoke ideas of how to prevent patients' anger and aggression in the first instance or how to support and de-escalate patients when they were disturbed. That way, situations could be prevented from becoming full-blown incidents that required PR.

> *… And some of them can discuss … where maybe they are aggressive, the best skills to use to de-escalate the situation. What works for them or didn't work for them? … Yeah, if you can get a few of them discussing it, you can have a rough idea of what works and what doesn't work* **(Sam: SS)**.

Participants were impressed by the rich and balanced content of the service users' contribution. And particularly by the fact that they talked about restraint experiences that they considered as negative as well as those they perceived as positive. Apparently, this balanced view of the narrative whetted the interest of the participants and made them to engage actively in the discussion and to take seriously the lessons learnt.

> *… It was interesting that they also had a form of a good experience in being restrained as they underlined the fact that sometimes it may save lives. However it was very sad to see that restraint is also used with excessive force and unnecessary techniques; definitely at times a way to just punish. Very useful to hear their perspectives* **(Virgie: RF)**

Their contribution is useful for practice

Participants considered the contributions from the SUs as powerful, challenging them (participants) to understand and connect to patients' perspectives. The feedback from past PMVA training strongly acknowledged that the SU contribution could make a positive difference in the practice environment.

> *The SU session was the most interesting and helpful part of the whole training. … really ingrained the whole process of how to treat a patient with respect and dignity whilst keeping them safe, as well as the importance of attitude and communication especially after restraint. It is a thought I'll remember when working and I will encourage my colleagues to do the same.* **(Angela: RF)**.

> *The SU session was excellent as I really like his presentation about lack of debriefing and how staff lack relationship with patients. The presentation has broadened my knowledge and I hope to go and practice what I have learnt …* **(Tasia: RF)**.

The diversity of responses from the focus group participants indicated how personally and differently the experience touched them. They started to question their purpose for restraining patients

> *It (SU contribution) helps us to keep them in mind when we're restraining them because usually, when we do a restraint, it's more about the safety of us and keeping the patient in control and in the ward. But now, when you go in, you think, 'Are they alright?' or 'How are they going to experience this?* **(Ada: FGT)**

Following their discussion with the SUs, participants became convinced about the need to debrief everybody involved in a restraint process (patient, staff and witnesses) especially the patient.

> *For me, what I've taken from next door (SU session) is that definitely, after the whole restraint, I've always feared that the patient is probably still very angry from the restraint. So I never really try to have that conversation with them and I always try to avoid that conversation about how they felt but now for me, I feel that if after a couple of days, depending, I think I'll definitely approach them and just having that one-to-one and just ask them how they're feeling* **(Pat: FGT)**.

When an incident occurred particularly in a public area, those around were curious and most probably concerned. Participants talked about the need to reassure such witnesses.

> *And also in the service user session we were talking about if the restraint is done in a communal area so all the other patients are watching. It's just about going to the patient who hasn't been restrained and saying 'are you okay'? They might feel scared of the nurses like 'oh it might happen to me if I don't do something. … to reassure them* **(Lisa: FGS**).

The experienced study participants spoke subjectively and used their respective ward scenarios to elucidate how the lessons from their session with the SUs were translated into practice.

> *Meeting with the SUs changed the way I think about things* **(Kevin SS)**.

Clarifying with an example Kevin continued:

> *It's (PR) an intervention which as it is we have to provide information about medication to the service users. We have to provide information about psychosocial interventions. Why shouldn't we have … information on PR for the service user …?* **(Kevin SS)***.*

Helen, now an experienced staff member, accessed the PMVA training as a student. She talked about the impact of the service users' session on her early practice.

> *I wasn't really restraining before the training because I was still a student ... That's why it was useful to hear from the SUs because I didn't really have a clue. So, when I did start restraining I started to use those things …* **(Helen SS)***.*

Carrying on, Helen shared how the experience continued to influence her practice.

> *Yes, it has made me try to avoid using restraint. … like if someone's not taking their medication, maybe …talk to them a bit more rather than just saying, 'Okay we need to give this medication now' and then call the team. It's also the de-brief as well. I started talking to patients after restraint* **(Helen SS).**

Helen gave an example of her debriefing practice which according to her was useful in retaining patient's trust:

> *I've had to restrain someone and then I spoke to them afterwards and the trust wasn't broken. They still respected me as a professional. … I think because they understood why I had to do it. Instead of them thinking that I just did it because I could. There's a difference* **(Helen SS).**

Our approach with our patients determines the way they might want to relate to us in Susan's opinion. She shared how the session facilitated by Bob (SU) touched her:

> *I believe sometimes it's … the way we approach patients and sometimes staff we need to learn how to. Bob has stuck in my head ever since then honestly. I came back and I said wow what an experience! Because I was new then and no-one had ever told me anything like that. I'd never really had a chance to have one to one because we were normally short of staff all the time. So after having that meeting time with Bob, honestly, it really helped me* **(Susan SS).**

Similarly, Andy felt emotional about the experience. He shared what the SU suggested could lessen the trauma of PR experience:

> *He mentioned how to make it a better experience …, if you're having to restrain a person …, just letting him know what the process is, who you are and who the team is, and that has been what I have been doing …* **(Andy SS)**.

Reflecting on their discussion with the SU who said that it took six years for him to learn what his diagnosis actually was, Steve critically looked at their practice and shared his thoughts:

> *… We at times, don't explain to them what we think their diagnosis is. One of them (SUs) said it took about six years for a nurse to actually sit with him and say, 'Do you know what your diagnosis is?' and he said, 'Not really. I've just been given this label'. He was then told some of the symptoms that encompass this particular illness. … That's when he learned how to manage it and that's what kept him out of hospital. But before then,… He was in and out of hospital. That got me to understand that there are times when we need to ask patients … 'What's your diagnosis? Do you understand what it is?' I've been doing it since then. … I can see the effect it has in terms of trust, empathy and recovery. That's something I learned there* **(Steve SS)**.

The session with the SUs made one to take a critical look at the way one treated patients the participants said. They believed that problems could be resolved by talking with

patients. So, does that (the lesson from SU session) change the way you treat all your patients on the ward? Sam was asked.

> *It does quite a lot. I try and talk to them. … I tell them whatever I can to calm down the situation. … At least they see you've tried and the next time it builds up rapport and forms that kind of therapeutic relationship. …The moment you start restraining them, you sort of break the relationship that you've been building. …* **(Sam SS)**.

Further to Sam's opinion, some participants said that participating in the restraint of their patients might lead to a breakdown of the therapeutic relationship with the patient. The importance of rebuilding such relationship was stressed.

> *I think as staff, we need to just be very honest. Even if … we're part of that restraint and they might have a grudge against us. If you had that one-to-one conversation with them and let them know, 'It wasn't comfortable for me either'. Just be real with them. They can understand that* **(Kate FGT)**.

The above evidences show how contributions from SUs enhanced or could enhance practice. In the next session, the participants considered further ways to implement lessons learnt and took a more realistic look at physical restraint.

Theme2: Working with patients

Involve patients in their care

The session with the SUs provoked discussions on ways to reduce patients' anger and aggression such as: assessing patients on admission and maintaining an ongoing assessment, care plans based on the assessed needs and reflecting patients' preferences in the plan, all devised in partnership with patients.

> *Once you identify someone at risk of restrictive intervention like restraint, it's about building a care plan and doing it with that service user about if it ever came down to the point of you having to be restrained, do you have a preference for gender, for what happens afterwards …?* **(Andy SS)**.

> *It is important to engage with service users to avoid unnecessary restraints. And to look out for signals to violent behaviour and possibly deal with the situation, rather than leave the situation to worsen* **(Allop FGT)**.

Effective communication and therapeutic relationship with the patients were considered fundamental for a conducive ward environment with minimal need for physical restraint. Timely communication the participants said, could clarify issues and aid understanding:

> *… any situation has to be assessed according to its dynamics. If you feel that it doesn't warrant physical restraint, work around it. … it's communication basically ...* **(Kevin SS)**.

Emphasizing on therapeutic relationship and on allowing patients to speak with someone to whom they relate well, Nora shared an experience:

> *I have seen a situation where the plan was that this patient had to be restrained… Everyone turned up and then the patient said, 'Oh, you're part of the team. Are you going to restrain me? Okay, I don't mind. I can talk to you but I'm not talking to this nurse. I'll take the medication from you'. … Eventually, ... you don't even have to restrain anymore, just because of the relationship that the patient has …* **(Nora FGS)**.

Is physical restraint always avoidable?

The responses from the study participants indicated that their encounter with the SU trainers made them to look critically at what happened on the wards with particular focus on preventing or de-escalating incidents and avoiding PR. But, they also acknowledged that realistically there could be situations when PR may become inevitable:

> *… many times we face a chaotic client and so we need to have this training; otherwise, we are dealing with it without the knowledge and we are a danger to the patient and ourselves* **(Fab FGS)**.

Some participants who had been against the use of PR actually reconsidered their stance following their session with the SUs. Referring to the case of the SU with bipolar disorder who made to run into a busy road but was restrained by the staff one said:

> *… I've always been totally against restraint as well and I've always thought the way overall is to de-escalate … It's (SU session) just made me think that you can de-escalate as much as you like but there are some occasions when people are really out of control. As long as it's done in a safe and controlled way, then it's necessary* **(Rose FGT).**

The contributions from the SUs gave them food for thought the participants said, and challenged them to always consider ways to relate and work cordially with their patients so as to avoid or minimise the use of PR. But, there were work related challenges against practising as discussed with service users they said.

Theme3: Challenges to implementation of SU contribution to PMVA training

Participants considered issues that might hinder their ability to practise as discussed with the service users including:

Staffing issues

Problems directly linked to staffing at work places tended to undermine their effort to practice as discussed the participants said. Staff shortage was identified as the fundamental problem giving rise to other issues. Participants explained that their inability to give their best to patients was sometimes a direct result of staff shortage:

> *Yes, especially if there was a staff shortage. …maybe an escort cannot be done at the time that they want. That can cause huge implications with everyone. And that happening, we can't get somebody to try and maybe talk with them. Sometimes they're giving medication. Another person is maybe dealing with something else and it prevents the usual de-escalation. …* **(Sam SS)**.

Ultimately, staff shortage could sometimes mean working with agency staff or bank staff, an unfamiliar colleague, who might not know the patients.

> *Yes, people that you don't know* **(Lucy FGS)**.

> *In the session, they (SUs) were saying you should know your patient well. But if the agency came and they'd never met that patient and he was getting aggravated they might go straight into restraint. Whereas, another staff might just de-escalate that situation …* **(Lisa FGS)**

The unfamiliar staff scenario sometimes involved other challenges such as team members who trained differently and probably held a differing opinion on PR:

> *If all staff are not trained in the same way or have different approach about restraint, they may be likely to use restraint unnecessarily* **(Ada FGT)**.

There was also concern regarding the attitudes of some colleagues identified as 'stuck in their own ways'. Unfortunately such ways might be non-progressive and non-helpful:

> *Even if you want to do all the correct things and everyone else is stuck in their own ways, it can also make it quite difficult* **(Val FGS)**

Equally worrying was the attitude of colleagues described as the 'gung ho' type. The belief was that such people derived some weird sense of satisfaction from restraining patients even when it was unnecessary:

> *I think a lot of people in some mental health establishments like that 'gung ho', that's taking down. … They get their little bit of adrenalin going and it's like, 'Oh, we can take them down. I'm bigger than them.' …* **(Janice FGT)**

Some participants observed that the Response Team's role portrayed 'power imbalance' where an over powering number of personnel gathered at once to confront a patient whose behaviour was considered challenging:

> *I think that does unsettle people as well when you come in 8 and 10* **(Susan SS).**

> *The problem … when the alarm is called everybody just rushes in…* **(Ade FGT).**

On the other hand, the Response Team was viewed differently, even favourably when the team engaged the patient in a dialogue in order to resolve issues. As a result, the patient cooperated and no PR was involved.

> *… When we explained the steps as to what we were going to do, the patient said, 'Why do you have all these people here?' Just the fact that someone said … They're not here just to restrain but they're here for your safety'. That reassurance got them to take their oral medication …***(Steve SS).**

The conversation with the SUs appeared not only to have re-enthused the participants to be more patient sensitive in their practice of PR but also to question doubtful practices and to raise issues of concern:

> *… also like if I was restraining them to observe, like if another member of staff was doing that, maybe try and like raise it …* **(Nora FGS)**.

There was concern however that raising issues might attract negative responses from colleagues. Such could be discouraging especially when it was from ones seniors:

> *… I actually said, 'You guys are hurting him. You need to move off, because he was whimpering and he was pushed up against the wall. … It was my first job in mental health as a healthcare assistant. And I got a proper telling off from the nurse. … that really put me off saying anything about it ever again, especially when it's coming from a nurse* **(Ada FGT)**.

Policies

Policies such as smoking ban caused patients to push boundaries the participants said. Asked whether the ban particularly triggered aggression in patients? Roger responded:

> *Definitely I believe so … if somebody's really unwell it might not be the right time to go about doing smoking cessation. To them it makes them feel calmer, if they could just have one cigarette … But this could be a trigger for irritation, agitation for the whole day … which can escalate further to the point where the patient might damage property or assault somebody - just to*

> *try and get out to smoke. … that's where the main incidents are actually coming from these days.* **(Roger SS)**.

Environmental issues

In the participants' opinion, moving patients away from a stimulating environment could de-escalate an incident and prevent PR. This could be in the form of moving to a quiet de-escalation space some said. There was concern however that such facilities were not common in mental health establishments.

> *… this is not the newest type of building. It's not purpose built for mental health, so we don't have like secure gardens which people would go into. … People might want fresh air. …* **(Roger SS)**.

Patient friendly establishments with secure outdoor spaces for fresh air could enhance calmness in patients the participants said. Whereas the contrast could trigger frustration and aggression and ultimately endorse the use of PR.

> *I do think the environment plays a massive part in the reduction of violence and aggression. For example, … wards with gardens and open spaces, it's more therapeutic so I would imagine those have less restraints. And I think being in an enclosed ward where you can't go out at all, I can imagine it is quite frustrating* **(Andy SS)**.

Allied professionals

The non-involvement of allied professionals (Doctors, Activity Workers, Occupational Therapists (OTs)…) in patient restraint triggered a debate among the Trust staff focus group study participants. Some thought that participating in PR might negatively affect the therapeutic relationship of such professionals with patients:

> *I think the downside of allied professionals starting to restrain is that patients aren't used to them being on that side with the nurses. … I don't know how that would impact ...***(Kate FGT).**

But some questioned the fairness of it all where the allied professionals would shy away from patient restraint and the nurses are left all alone to deal with it:

> *… So, the activity workers weren't trained, the OTs are not doing restraint, doctors don't do restraint … and everyone says, 'It will take away our therapeutic thing,' but the people who have got the most therapeutic input with the patients are the nurses and yet the nurses are expected to do restraint* **(Allop FGT)**.

Making a crucial point, an activity worker stated that restraining in a caring manner did not negatively affect one's relationship with the patient. If anything, it enhanced it:

> *I've done a lot of restraints myself. Patients, they don't forget that you've given them helping to restrain them and they know you don't hurt them. But once they're restrained badly they'll probably say, 'I'm going to get you after this' …* **(Ade FGT).**

As if summarising, a registered mental health nurse said:

> *I think it should be compulsory for anyone that is working on a ward with forensic patients. We don't know our patients' backgrounds. They all potentially could be very dangerous people, especially when they're unwell. So anyone that's having any interaction with those patients I think, has to be trained, whether it's consultants, nurses, or other professionals* **(Rose FGT)**.

Summary

The diverse as well as subjective perspectives from the participants portrayed how relaxed the atmosphere was during the interviews. With confidentiality guaranteed, they freely shared their experiences, their practices and their intentions for future practice with regard to physical restraint. In theme (1) under '*Their contribution is useful for practice'* the resolve

to reflect lessons in practice was clearly expressed in the records of feedback and by the focus group participants. Meanwhile, the practising participants convincingly articulated how the lessons were being reflected in their practices.

Discussion

This research aimed to determine whether or not the contribution of service users to PMVA training influenced the way that participants in the study intended to manage or actually managed disruptive incidents that involved patients. The observations by Morgan and Jones (2009) about the challenges in determining the impact of learning on practice would apply in this case. However, the research instruments for the investigation were considered robust enough to have satisfactorily answered the research question.

The service users (SUs) sought to motivate the research participants to avoid physical restraint (PR) or to use it caringly if they must. The findings showed keenness on the part of the study participants to hear what the SUs had to say. The balanced views in the discussions apparently whetted the interest of the participants and made them engage actively in the session and to take seriously the lessons learnt. The contributions affected people in different ways according to the findings. The inexperienced participants including the feedback from previous training considered the SU session the most helpful part of the PMVA training. The narrations of real life experience of physical restraint apparently touched many of them and as they put it, ingrained in them how to treat patients with respect and dignity. They vowed to reflect the lessons from the session in practice. Meanwhile, one experienced practitioner said rather simply that the experience changed her. And yet another was sure that he did not need to change his practice because he was already practising as discussed. Nevertheless this individual thought that SU contribution gave a different perspective to what PR was about, especially he said, that in an aggressive and violent situation, emotions were heightened and nurses were looking at it from their point of view. This truth was echoed by another practitioner who said that in PR situations, one tended to automatically focus on the physical aspects of PR process. Similarly in Moran et al. (2009) staff reported that restraint situations could be emotionally draining and that

they (staff) suppress such emotions in order to get on with the job. Consequently, such suppression might lead to emotional detachment and inability to cater for the patient during the PR process.

The experienced practitioners used their respective ward scenarios to elucidate how the lessons from SU session were translated into practice. This included working closely with the patients in devising care plans for example, and engaging more with them in line with guidelines (NICE, 2015; DH, 2014; NMC, 2010). According to the behaviour support plans (Clark et al., 2017), working closely with the patient could proactively reduce restrictive practices. Resorting to PR could break relationship according to the finding. The importance of rebuilding such relationship was highlighted in the study. A participant shuddered at the thought of restraining patients and not speaking to them afterwards. It would seem like one was attacking them she concluded. Studies including Mackenna (2016) and Scanlan (2010) emphasise the importance of debriefing after PR. An honest examination of an incident by all involved could ensure the retention of relationship and perhaps even enhance it. However, an unnecessary and abusive restraint might result to the patient avoiding engagement which would make it difficult for the parties to repair the relationship (Knowles et al., 2015). Participants admitted that the contribution from the SUs challenged them to reconsider their practice. For example, some wondered why service users were not provided information on PR. This becomes a very pertinent question considering that the standards for pre-registration nursing education mandate the mental health nurses to ensure that patients receive all the information they need in a language and manner that allows them to make informed choices and share decision making (NMC, 2010).

The setting for the SU session encourages candour. So, the discussions sometimes reveal facts that potentially make the practitioners uncomfortable. Such was the case when the SU trainer shared how for six years he had no understanding about his diagnosis and was non-compliant with medication. Consequently, he was often in hospital admission, during which periods he repeatedly experienced PR. The practitioners in the session felt uncomfortable about such lapse by colleagues. In Obi-Udeaja et al. (2017) a service user believed that if the

clinicians were uncomfortable in a meeting with service users it meant that service user views were getting across. The reverse would be the case if they were comfortable.

The above findings showed obvious willingness, in fact enthusiasm to implement as discussed in the SU session. However, there were concerns about work related hindrances to practising as discussed. For example, shortage of staff was seen as the core issue that gave rise to other problems hindering their ability to give their best to patients. An example was an 'escort' that failed to happen at the agreed time due to staff shortage. Such an issue could trigger patient's anger and aggression. Staff shortage may also preclude adequate de-escalation process. The study found that staff shortage often meant working with bank/agency staff, probably an unfamiliar colleague who may not know the patient - a situation that could hinder both de-escalation and debriefing processes. The unfamiliar staff scenario might sometimes involve other challenges such as team members who might have trained differently and may hold a different philosophy on PR. There was also concern about colleagues stuck in ways that may be non-progressive or helpful. According to Beresford and Croft (1993), some professionals find changes to traditional ways of working daunting. Equally hindering was the attitude of colleagues described as the 'gung ho' type who derived weird sense of satisfaction from restraining patients even when it was unnecessary. Study participants in Knowles et al. (2015) thought that the reason staff would undertake jobs that involved PR was either for the money or they enjoy inflicting pain on others. These accounts reinforce the need for SU involvement in PMVA training, an initiative that could sensitise staff to be compassionate particularly in challenging situations like PR.

The experience of emergency response team could be unsettling for the patient and frightening when the team members are unfamiliar the study found. In Obi-Udeaja (2009) a study participant said that it felt like being restrained by two different teams of staff – the staff on his ward who knew him and whom he knew and the staff from other wards who didn't know him. He described these unknown staff as very judgemental and nasty. On the other hand, the response team was viewed differently, even favourably when the team engaged the patient in dialogue to resolve issues.

The discussions with SUs appeared not only to have re-motivated the participants to be more patient caring in their practice of PR but also to question poor practices of PR and to raise issues of concern. It was concerning however that raising issues could attract negative responses. It explains why bad practices still happen and justifies the need for initiatives such as SU involvement in PMVA training delivery that could trigger compassion in staff and motivate them to avoid restraint or to carry it out caringly.

Some of the policies that staff had to work by, example smoking policy were identified as triggers for patients' anger and aggression and the main reasons why patients push boundaries to get out of the ward. Whyte (2016) argues that inpatient routines and hospital rules could induce fear and uncertainty in patients who may respond by exhibiting challenging behaviours that sometimes lead to PR. Participants also thought that patient friendly establishments with secure outdoor spaces for fresh air could enhance calmness in patients. Whereas the contrast could trigger frustration and aggression and ultimately endorse PR. Wisdom et al. (2015) emphasise that administrators need to examine their environments, policies and practices in order to effectively integrate the core strategies into their situation.

The PMVA SU contribution aimed to inspire participants to avoid PR. But realistically, if PR became inevitable (NICE, 2015; Mind & NSUN, 2015), to carry it out with the care of the patient in mind. When such is the case, then it is irrelevant who carries out the process – Nurse or Allied professionals.

Limitations

Gaining access to the hospitals for the semi-structured interviews had to be organised well ahead of time with the managers. They decided date and time. This meant that only the staff who were there on the day were available to us. The interview data collection method relied on the participants' ability to recall restraint practices in retrospect. In reality, some of the facts may have faded over time, raising doubts about the accuracy of data. The use of prompts, the rephrasing of questions and asking several participants again and again were

attempts to minimise this weakness. My 'insider researcher' position raised the issue of preconception. Additionally, the trainer-trainee relationship may have resulted in participants telling me what they thought I wanted to hear. The adoption of reflexive and collaborative practices (Ravitch & Carl, 2021) throughout the research processes, the use of a moderator for the interviews in addition to locating my seat away from the respondents hopefully helped to mitigate these potential limitations.

Conclusion

The participants in this study found the contribution of the service users to PMVA training as profound and important; bringing a new reality and empathy to their work. It enabled new meanings for example debriefing to be derived. The participants took away numerous lessons from the experience including to proactively seek alternatives to PR. They appeared resolved to reflect them in practice or were already doing so in the case of experienced staff. There is now a national recommendation to involve mental health service users with lived experience of physical restraint in PMVA training delivery (Ridley & Leitch 2019). This development promises a transformation of the way that physical restraint is perceived and taught and a positive impact on practice. Furthermore, this study confirms findings from previous studies which claim that service user involvement in the education and training of professionals has the potential to positively influence practice (Turnbull & Weeley 2013, Spencer et al. 2011).

Recommendations:

- PMVA training providers should involve service users in their training delivery.
- Mental health inpatient staff must continue to resourcefully employ alternatives to PR.
- Ongoing research which should also seek patients' perspectives on the subject.

Acknowledgement

My heartfelt gratitude to the study participants and their managers whose active participation and assistance made the field work a huge success. Immense thanks to my service user colleagues Kate Crosby, Garry Ryan and to Steve Shelukindo for their unreserved support.

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A 360 degree learning environment for university online teaching

ANTHONY 'SKIP' BASIEL[*]

Queen Mary, University of London, London, UK

And

MIKE HOWARTH[†]

Middlesex University, London, UK

The paper is a sequence of methods to inform competent online video conferencing (webinar) teaching resources for universities rushing to meet learning effective provision in the current Covid crisis.

The authors consider Moore's Theory of Transactional Distance (1970), with the focus of the theory on developing autonomy in the learner, may still be relevant as a theoretical guide to a rapid growth in demand for online learning, despite originally being applied to traditional paper based distance learning.

Ensuring autonomy of learning in the theory's application, might need a WHAT, HOW, WHY, analysis to encourage the self-managed focus of webinar Presenters, Facilitators, Participants and stakeholders to be informed and aware from small PowerPoint projects to large-scale conferences.

The home-distance learning environment of the autonomous learner is now quite different to that envisaged in Moore's theory. Participants now have a broadcast studio in their home. The authors suggest a base level of hard skills of technical nature and soft skills of performance and engagement are required.

Managing complex online events are also not a feature of Moore's concept of the autonomous learner. Therefore a 'Fishbone' analysis is proposed to show the process of identifying key issues and quickly resolving solutions that may arise.

Looking to the future, the authors see the potential for a virtual online 360 Classroom. The Webinar could quickly evolve to use 3D Virtual Reality technology. One application might be to realise the traditional Socratic Method of higher level thinking accessible to many in a virtual online 3D environment. The conflation of technology and educational objectives are complex, but may now be managed with the methods suggested in the paper.*

[*] **Corresponding author:** Anthony 'Skip' Basiel. Email: abasiel@gmail.com

[†] **Corresponding author:** Mike Howarth. Email: michael.howarth@mhmvr.co.uk

Finally, a Transactional Distance Toolkit, is explored as a quick and easy method of planning the structure and organisation of a webinar and a with its inbuilt visualisations are away to assess the effectiveness learner autonomy.

Keywords: online learning, webinar, learning theory, virtual environments.

Introduction

Teamwork, we take the view, is the essential component in a crisis. Stakeholders quickly recognise the nature and degree of being self-directed in these situations. But, goodwill must be maintained and nurtured and at a distance. The methods in the paper provide a clear plan of research and development of webinar interaction guidelines based on a theoretical foundation tailored for an eLearning team working to these situations.

Transactional Distance

What is 'transactional'? Dewey (1949) explains 'transaction' in an education context, as the individual's pattern of behaviour in an environment. According to Moore (1997), the separation between these [stakeholders] is sufficiently significant that special [engagement] strategies and techniques are needed.

These theories were proposed in the context of analog technologies of radio and TV of the correspondence distance learning models of the time. However, they are very relevant to the virtual 2D space of the digital transactional webinar of the present: particularly the concept of learner autonomy, responsibility for owning the processes and of their knowledge acquisition.

WHAT elements comprise a successful event

The section begins with technical components and moves to examine the stakeholder's profiles. For example, is there a clear model of the expectations of the Participants? Is there an inherent expectation for the interactions to be identical to a face-to-face discussion, classroom lecture, seminar debate, role-play enactment, or unstructured brainstorming? These

expectation need to be explicit. They become the criteria and a benchmark in 'transactional webinar design'.

WHAT Webinar Components Affect Learning

General technical elements of most webinar systems includes sound, video, live text discussion, screen share, recording, and feedback or participation surveys.

Audio: The audio component is the most important part of a webinar communication. Without clear sound, Participants stop the software and revert to a phone call. The solution is to ensure they use the 'audio set-up wizard' microphone test to confirm the sound levels. The essential check must be done well before the live event to avoid the 'can-you-hear-me' problems. A headset with earphones and microphone may be a way to avoid audio feedback or echo.

Video: Video takes up bandwidth. Frequently it is not essential to see the speaker or the audience to add value to the event. Alternatives include facilities to only show visuals of Participants that speak, limiting views of Participants to two or four in a large group. A still image of the speaker in the corner of the PowerPoint slides as an alternative to the live 'talking-head' may suffice. Technically only one channel of audio can be transmitted at a time. It may be recommended that the audience is set on mute audio and video at the start of the session.

But what is the psychological effect go these controls. Because the Participants are not necessarily in control. A long meeting is extremely tiring. It is possible that individuals are exposed to scrutiny as never before.

Text: Text chat may be a safer, disciplined method. Certainly some Participants are disconcerted by break-out sessions if they are not familiar with the protocols.

The protocols for meetings might not be as casual and informal as the technologies suggest. For these reasons prudent 'Before the event' planning on the invitation webinar registration or email invitation the Q&A (Question & Answer) protocols. Will questions be addressed during the session or only at the end? The text chat discussion can be copied and pasted in-

to the event FAQ frequently asked questions resource page. Built-in caution such as silencing mic and hiding visual before sessions start are available.

Screen Sharing: Screen sharing is a powerful 'show and tell' tool. Unfortunately, the feature demands bandwidth, so action can slow or stall. A pre-recorded video may be a better. Also, an audience might be given an option to download the video prior to the event.

Recording Webinars: Event recording is an expected service for anyone wanting to review a session or who missed the live webcast. In a business meeting, a summary of the action points can be recorded for the next agenda.

Recordings can be edited to create a lasting training resource, tell a story, create marketing and publicity. Using more than one camera beside the screen capture allows the teaching resource to give a different perspective on the subject matter. The Presenter may do an 'over the shoulder' point of view (POW) recording of the webinar. The resource can take on a more engaging tone. New technology such as the Black magic ATEM Mini Pro (2020), makes live multi-camera conferencing while recording multi-camera.

Towards Autonomy: Awareness of Hard and Soft Skills

The discussion so far identifies the variety of media and potential for creative opportunities. Next are some suggested solutions for essential hard technical and awareness of soft personal skills for protocols from a simple online room set up and for expectations of Presenters, Facilitators or Participants.

Organising the home-distance learning environment

There are a series of hard skills, tricks of the trade, which help bring the webinar model alive. The organisation and layout of the home room needs thinking about carefully.

Figure 1 *Presenter set up - legend below*

Red: Visuals

1 Laptop at eye level, screen vertical, recording screen

2 Box or books on hand for raising the laptop during online sessions

3 Camera used for to-camera introductions which highlight key teaching points and for end of session summary.

Blue: Lighting Control

1 Curtain

2 Blind

Both create a slit of light onto the Presenter's face controlling available daylight

3 LitePanel backlight to lighten up background behind Presenter.

4 Main light for recording video at the big screen.

Green: Scripting

You may prefer to prepare in the form of scriptwriting using tables in Pages or Word to structure your message (2). The scripting process is very rewarding: reflective, an exercise turning written concepts into spoken English using visualised, graphic, language through several script iterations (3) ending in a bullet point list on a small card. But to maintain eye contact in your personal conversation with individuals, the card is under the laptop camera (1). Unless the screen is shared, use it as an autocue.

The spoken style of writing comes with practice. Most talk on radio and certainly TV is scripted in some form and flipping from writing formal to informal spoken English and back again is a very valuable skill. The ability of the Apple pen in Pages on an iPad Pro (2020) is to record video in a variety of situations such as creating figure 1 above. Adding audio commentary and annotations on top of text is now a possibility.

Black: Video production

Creating a simple video is now technically easier to achieve using Media Video Player and Quicktime. A lecturer can either speak to camera or use screen capture to record a PowerPoint with an audio sound track. But, to do both at the same time needs special software.
1) Note the thin green rectangle on the screen. This is the boundary of the recording area of the screen that can be defined of iShowU Instant Mac software (2020) used mainly in gaming. In education, the potential is much more exciting: inside the green area, the Presenter can record themselves full-frame, part frame, or switch to grab the screen view during recording. By setting a (16:9 aspect ratio) the output video will be in the right format for online transmission. But, significantly, a PowerPoint, a pre-prepared video or live extra visuals from an iPhone for example of close-up detail, can be dragged into the green area - all on the fly!
2) The video editing software is Final Cut Pro but any simple package will do to tidy up the components recorded in iShowU Instant.
3) A slope is for scripts. Narrations can be recorded to the computer camera and sound using the script on screen as an autocue. An alternative is reading the script into a smart phone. The iPhone using VoiceMemos, outputs a very good quality close up sound because of the microphones. The sound file can be imported into the video.

Figure 2 *Selfies become serious*

Soft Skills Screen presence is a subtle art. The assumption that giving a lecture online is a doddle compared to the college theatre needs careful assessment - unless you are really good at it: time disappears, cogent argument becomes endless waffling, your favourite edifying story may well become an in-your-face full colour flop, largely because soft skills that work in the confines of a small screen, are ignored.

It is easier to describe than perform, the five factors of height, distance from, horizontal position and angle of screen and your background all have a significant effect of the audience and illustrated in *Figure 2*. These are described in a series of embodied metaphors, the short hand language of the camera crew: headroom, falling out of the screen, having depth, being in the frame, the open door is the metaphor 'future opportunity'. Thinking space is the area to the side of the speakers when a more informal conversational level of engagement is required. This area, where 'minds meet', is space filled during the discussion of ideas in a restful visual scene. The example in *Figure 2* might be too busy. The lamp and bunch of flowers are standard 'props'. Your background is more important than you think. A warning, bed furniture is a big no-no.

These soft skills for lecturers as an actor or performer working online may appear irrelevant. There are many reasons why academics dislike anything to do with this approach. But Michael Caine's famous TV master class (1987), may provide insights for anyone contemplation a teaching career on the small screen.

Webinar Stakeholders: Key Actors in Transactional Distance

Who are the key actors in a webinar? Web video conferencing events may include: Host, Presenter, live text Facilitators, Participants as individuals small or large groups. We argue that the metaphor 'actor' is taken seriously.

The webinar Host owns the account on the software cloud platform. This may be in any of the current popular systems such as Microsoft Skype in Teams, Zoom, WebEx, Adobe Connect, Google Hangouts, GoToMeeting, Amazon Chime, etc. Two-way communication frees up the limitations of one-way live webcast seen in YouTube or live streaming services. The webinar Host has the flexibility to control the webinar space by setting access permissions,

and to unmute microphones and video. Some systems, such as Adobe Connect, have screen layouts that can be adapted for location of the Presenter's video slides or text chat inside the framework of the software window. In a lecture-style webinar, the Presenter speaks while showing PowerPoint slides. Experienced webinar Presenters can engage the audience by pacing the delivery of text and graphic content with opportunities to respond to questions via text chat or poling tools. The webinar Facilitator is perhaps the most important role by linking the Presenter and audience. The Learning and Skills Group (LSG 2019) of London, UK facilitated by Don Taylor demonstrates a good balance of content delivery with audience contribution.

It helps to consider the Facilitator and Presenter as Key webinar 'players' and treat them as 'actors' even in a remote location and no longer facing the lecture hall. Even though the audience falls into three categories: a) individuals b) small groups on location c) large groups on location, every participant actually experiences the event as a personal face-to-face encounter with the webinar players. Treat the audience as individuals, personally recognise their very first login with a greeting and include another identifier such as the business or organisation or location. A Facilitator working with the Presenter is helpful for following reasons.

1 The 'actors' at the keyboard suddenly have a heavy responsibility, the audience experiences the Presenter and the Facilitator talking personally to them in full screen reality a foot or two away. Any small movement expression glance is magnified.

2 We identify the Facilitator's role to include that of moderator or spokesperson for the group. The role then specifies a function that helps manage events such as a Presenter naturally glancing out of the screen window that can create concern for every participant.

3 Questions for the Presenter to be directed to the Facilitator, to ensure the emotional load of the Presenter is minimised. Questions might be handled by a still image or a voice or just text appear on the webinar screen.

4 The Facilitator should be fluent in the language of the Presenter.

HOW: Designing learning with transactional distance in mind?

The technology should not drive the pedagogy, Thorp (1989) reminds us. Our research frames webinar instructional design in a matrix linked to the level of transactional distance (range of structure and dialogue) towards the learner becoming more autonomous.

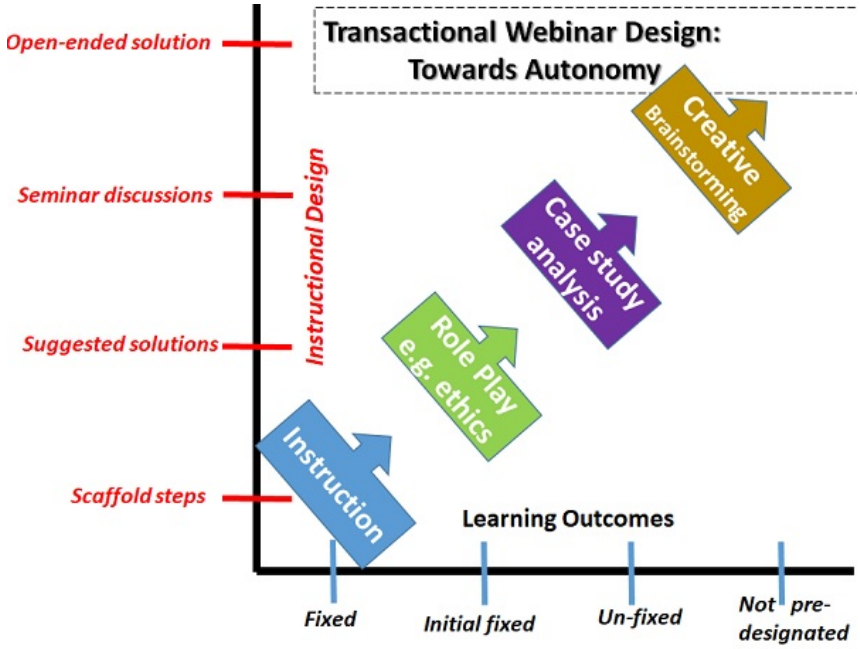

Figure 3 *Webinar Design Spectrum*

An Example: applying Toolkit guidelines for instructional design

A 'talking head' PowerPoint presentation with Q&A at the end, followed by an online quiz is a traditional design model. For example to train staff on using a fire extinguisher correctly there are detailed steps to follow and short-term recall is required for a specified conclusion.

The same task in a role-play webinar, with the Presenter and Facilitator providing audience members with a script to read, can act out a real-world situation.

A video of the task may portray errors or good practice with students discussing possible alternatives as a follow-up activity. Suggested solutions can also be given by the Tutor.

In small group discussions, the Presenter and Facilitator can create virtual breakout rooms to send Participants to analyse a case study. Each group may reach different or creative conclusions based upon their tacit and prior knowledge between the team members. Re-

cordings of meeting summaries can be available for review after hearing all of the solutions. The case study resource may have a sample resolution, but a multiple choice question with answer a combination (c) a + b) could address the factors under consideration. Negotiating with the team members and presenting recommendations supported by evidence in the webinar summary develops communication skills needed for virtual teams.

Finally, a key potential in webinar design is to promote autonomous learning. For example, using scenarios with no fixed outcome but a series of options requiring a creative approach. The webinar format provides a setting where team members may gain an understanding or each other's perspective. Each contribution to the argument leads to an innovative recipe of ideas and actions. Klaxon (2020), a French webinar software company, has an interaction model to foster smart teamwork. The sequence starts with a vote by team members on the project problem or research question. Through this first stage exchange, profiles of the group are established to identify any skill or knowledge gaps. Next, an ideas session provides opportunities for generating a resolution. Finally, a survey is done to gather evidence to assess the learning outputs of the webinar. All of these webinar models use a 2D interface to communicate real-life 3D audio/video data.

The next section is an exploration of a 3D environment as an immersive 360* 3D experience.

A Theoretical Underpinning for 360* Immersive Fishbowl Webinar Design

A Socratic discussion or 'fishbowl' model is proposed by the authors (Basiel et al. 2020) for the next-generation of webinar design.

Immersive webinars using a blend of 360* web video in conjunction with mobile smartphones create a virtual learning environment for the Socratic Method. The 360* software facilitates the Socratic method of cooperative argumentative dialogue between individuals, based on asking and answering questions to stimulate critical thinking and to draw out ideas and underlying presuppositions. The 'Socratic Effect' of the 'fishbowl' webinar design encourages the participant to rethink an idea after having their previously existing understanding discarded on the basis of their own answers to questions. The organisation is outlined in figure 4.

The 360* Immersive Fishbowl Webinar Design

The immersive blended learning model knits together: 360* video, mobile smartphone video conferencing, a local digital video camera, voice-to-text software for auto-transcription and a webinar Host platform.

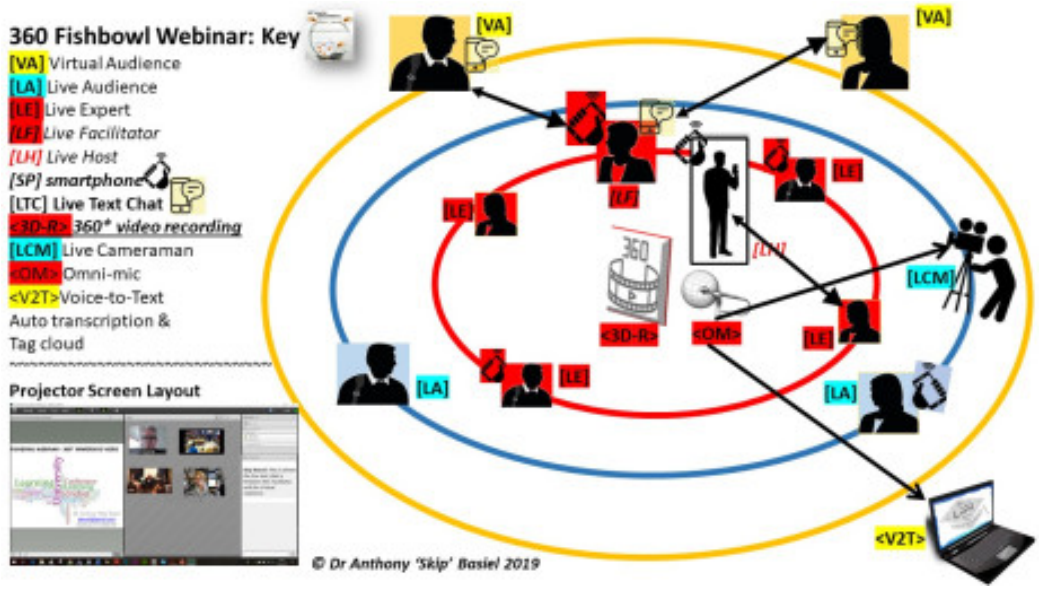

Figure 4 *the 360* Immersive Fishbowl Webinar Design*

The face-to-face 'fishbowl discussion' is a small central group of Local Experts [LE] sitting in an inner (red) circle with a Live Host [LH] using their mobile phone as a video camera and microphone to interview the Experts. The Host swaps the video camera from viewing themselves, when acting as Master of Ceremony, to showing the Expert speaking.

Webinar Participants using smartphones to record themselves using news journalism methods during the teaching event 2D 'Meta-Film' approach (Basiel & Howarth, 2017), now applied in a 3D situation. It sees the inner-and-outer circle actors [LA] being active Participants in a 360* 'unconference', using their mobile phones to record events from their own perspective. These videos are shared in social media platforms to promote the conference and develop an online community of learners.

In the centre of the circle, there are two capture devices:

1. 360* video camera <3D-R>– A device that first records the introduction before the live event. Then records the fishbowl discussion.
2. Omni mic <OM> – The device creates two outputs. First, the main audio for the Live Camera Man [LCM] who produces the main screen of the event. Second, the audio is fed into a live voice-to-text transcription <V2T>.

Text output creates a tag cloud summary graphic of the transcript. Text can be used as the database for an AI chatterbot dynamic FAQ resource.

The event Live Facilitator [LF] is a key player in the model. They sit in the inner circle and act as moderator for the Host and remote audience virtual [VA] members. This interaction is mediated silently, at first, by live text chat [LTC] discussion. As the Live Facilitator finds questions to add to the discussion, they give the VA member video access and turn off their [LF] self-video.

The projector screen layout diagram in the bottom left corner suggests how the event may look online to the virtual audience [VA]. The live event is projected on a big screen so the face-to-face actors can see the video of the entire group.

The event uses interactive webinar elements previously discussed such as whiteboard mind maps, voting, surveys, and polling. These activities promote evaluation of the event success. Next iterations of the 360* fishbowl model includes use of video drones (2020) and replaces the inner-circle people with a 360* monitors model (2020) when it is not possible to meet in person such as social isolation during the Coronavirus pandemic.

A 360* meeting during the Coronavirus in 2020 is may be a contribution to creative solutions to the situation of self-isolation.

A weakness of the open discussion model is that the webinar can become chaotic. The Live Host/Local Facilitator can juggle the flow of the interactions, but the larger the audience the more difficult it is to choreograph the online event. Let a physics principle called *py*[‡]*(2020)* be applied to guide us through the webinar mayhem. Entropy predicts any system will tend towards disorder, rather than develop a systematic structure. For example, if I

[‡] https://www.quora.com/What-is-entropy-4

have a container with 20 game dice that I throw across the table, the grouping patterns will be random, not tidy. The probability of the dice forming a pyramid is very low. Instead, there may be no evident pattern. Some of the dice may cluster together, while others are isolated.

An example of '*Learning entropy*' occurs in the unstructured nature of brainstorming in a webinar. The creative process can be steered by the Host/Presenter through the technical features of the webinar such as limiting participant video and audio transmission. Questions and comments can be redirected into the live text chat, but that can also become chaotic.

Is there a way to funnel the interactions of the webinar without too much control from the event organisers?

A fishbone or Ishikawa diagram (2020) is a way to conduct a *cause and effect analysis* for a brainstorming session. The diagram-based technique combines brainstorming with mind mapping to consider all possible causes of a problem, rather than just the obvious ones. According to Mindtools.com (2020), *'When you have a serious problem, it's important to explore all of the things that could cause it, before you start to think about a solution. Then, you can solve the problem completely, first time round, rather than just addressing part of it and having the problem run on and on.'* A fishbone diagram can:

- ➢ Discover the root cause of a problem,
- ➢ Uncover bottlenecks in your processes,
- ➢ Identify where and why a process is not working.

Step 1: Identify the problem

You can use a Soft Systems Methodology technique (SSM) from Checkland (2012) called CATWOE where the problem is examined from the perspective of Customers, Actors in the process, the Transformation process, the overall World view, the process Owner, and Environmental constraints.

Figure 5 *Fishbone Diagram - Identify the problem Mindtools.com*

Step 2: List the major factors

Next, identify factors that may be part of the problem such as systems, equipment, materials, external forces, people involved with the problem.

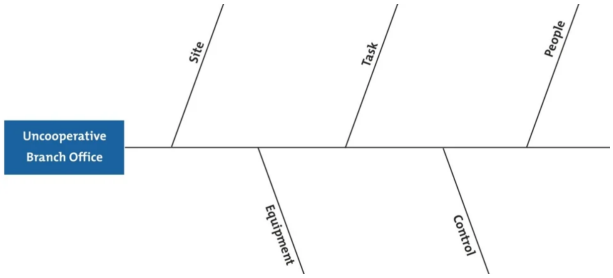

Figure 6 *Step 2 Fishbone diagram - Major Factors*

Step 3: Possible causes

Now, brainstorm the variety causes of the problem for each of the factors you considered in step 2.

Figure 7 *Step 3: Possible causes*

Step 4: Analyse the problem

Analysis involves setting up investigations, carrying out online surveys, and web video conference interviews. These techniques test the causes actually contributing to the problem and provide evidence to inform action. In the context of the Transactional Webinar Design, the same analytical processes take place easily and quickly in a short effective event or a series of webinars.

The manager in the example above may have assumed that people in the branch office were "being difficult". He thinks the best approach is to arrange a meeting with the Branch Manager. The decision allows him to fully brief her on the new strategy, and talk through problems she may be experiencing.

Why Transactional Distance Theory?

The final question, WHY would you want a webinar model that is informed by Moore's Transactional Distance Theory (1997)? Stepping back in time to the 1960s there are two dominant pedagogical traditions. Perhaps most of your webinar experiences have fallen into a Behaviourist webinar model. In this online learning event, the webinar audience is taken through a linear, systematic path of instruction based upon behavioural objectives. There is maximum Tutor/Presenter control of the resources, timing of the content delivery, media types used and opportunities for audience participation. Knowledge in this webinar design is a product metaphor. Mastery of a new skill or ability to recall short-term information may be a learning outcome linked to a standard assessment such as a written essay or presentation. The Behaviourist webinar model focuses on deliverables and not the process.

The Humanistic Tradition, on the other hand, has its roots in counselling and education psychology. Special value is placed in less formal, unstructured learning. The value of interpersonal, open-ended dialogue and creative brainstorming falls into this pedagogy. The creative webinar space may produce a bottom-up, learner-generated content experience with personalised learning outcomes. The Participant ownership of the learning journey is a key element. Moore was concerned with distance learning and responsibility for the learner to manage their learning from manuals radio or TV. Today the same process is live, active and

public in the digital environment with the students and the Presenter and Facilitator being more relevant than ever. They can be creative players on a stage.

Through the Transactional webinar model the participant has acquired a new skill, understood a new concept or mind mapped a path to an innovation or discovery. The next stage of the process provides the opportunity to apply that capability. The webinar or series of online events has the potential to bring a virtual community into action in the real world.

Key Components of the Transactional Webinar Profile Toolkit

Our research provides a software toolkit that guide the programme structure and learning dialogue to create a successful Webinar Profile (2020). A set of ten transactional factors are rated from your perspective as a webinar Host/Presenter or Participant. The next figures provide a summary of the analysis.

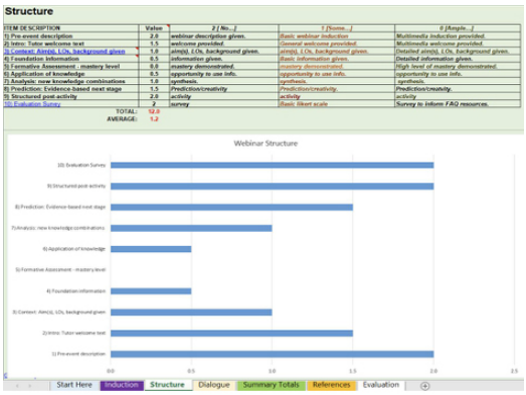

Figure 8 *Webinar Profile Toolkit - Structure*

Values are added to the Toolkit and appear as a visual bar charts. The assessment begins with establishing that the webinar has a pre-event resource induction or discussion. Next, is there an introduction of the Host or Presenter and Participants providing context to the webinar event? Are the stakeholders given appropriate resources or opportunities to create their own? Is any formative, self-assessment or reflection built into the webinar? Are the

webinar Participants given the opportunity to analyse, evaluate or create? At the end of the event, is evaluation data collected and analysed?

Figure 9 *Webinar Profile Toolkit – Dialogue*

The overall goal is not just review the webinar design and systems used to match the needs of the stakeholders, but the quality of learner autonomous, self-managed webinar Participants and stakeholders.

Evaluation

Evaluation should not be an afterthought. An online survey built into the webinar design from the start to quantify open-ended feedback and provide 'feedforward' evidence is needed. Each webinar event can use built-in polling tools and external systems to capture participant profile information. Some useful data may include:

1. Demographics e.g. geographic location, occupation, native language, webinar technology expertise
2. Expectations e.g. personal learning outcomes matched against the intended learning objectives
3. Human-Computer Interaction e.g. usability of the system

4. Pre-During-Post event sharing of knowledge and opinion, recorded as a score or tag cloud.

Web video recordings of the events can provide auto-transcriptions, text discussion exchange and whiteboard mind mapping evidence to support any modifications proposed to the webinar design.

Conclusion

The paper outlines practical methods for designing webinars for learning from an effective planning process to a 360* design for immersive learning experience with a simple way to assess participant performance. A theoretical framework is provided by Transactional Distance Theory (Moore 1997) adapted to current online distance technologies.

Training for the modern versions of distance learning is facilitated by asking organisers to assess: WHAT are the key factors of a successful webinar? HOW can webinars be blended with the interactive and transactional design? and WHY should you choose the transactional distance webinar model?

Moore (1997) at the time suggested that teachers need training to extend their traditional skills to embrace telecommunications for distance learning. Our paper provides a structure for that training by requiring stakeholders to assess their profile for technical and pedagogic blending. The spotlight on learner autonomy is a powerful reminder that end-user objectives are included in planning. The spotlight provides a focus towards Humanist creativity rather than the traditional instructional design Behaviourist model of webinar design.

Practical techniques such as the fishbone diagram maintain attention on learning despite the complexity of online events. The Transactional Webinar Profile Toolkit gives participants feedback guidance in aspects of the process from planning software to assessing effectiveness.

A glimpse into the future of a move from 2D technologies to a 3D immersive experience for participants suggests the benefit of shifting the balance from participants looking in to an event where looking out in terms of application of ideas in the world of the user. The So-

cratic Method may be achievable as an online experience using the technology. The result might allow participants to engage in higher levels of thinking.

The future is fast changing and ways to quickly collaborate to evaluate methods which are not platform dependent. The focus on the quality of online life in Higher Education is likely to be the norm not the exception.

The reader is invited to use the Transactional Webinar Profile Toolkit (2020) and test the guidance to choose software that applies Moore's Transactional Distance Theory in real-world webinar events. Test our webinar learning theory in online activity from basic lecture, discussion, large scale webinar or the 360* environment.

Please contact us with case study feedback on the results. The analysis of the case study examples inform the future designs of webinars. The authors predict a paradigm shift to more creative webinars that promote autonomous learners.

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The Dark Romanticism of Vivas: Practice Issues and Preparation

ADAM BARNARD[*]

Nottingham Trent University, Nottingham, UK

And

MATT HENN [†]

Nottingham Trent University, Nottingham, UK

This paper addresses three areas. The first is a discussion of the context for doctoral education and the use of vivas across higher education as the assessment method for doctoral education. The second area is a review of the data on submissions for doctoral examination across a post-92 university. The findings of the paper are based on a review and analysis of data concerning submission for examination and outcomes from viva examination across three colleges across a two-year period. A qualitative analysis of anonymised data was completed from three areas. The third part of the paper addresses the advice and guidance given to candidate in preparation for the viva. This informs the aspiration to increase the postgraduate research community of the university, increase the offer of professional doctorates (PD), and grow the post graduate intake for the Doctoral School.

Keywords; doctorates, qualitative analysis, preparation, vivas

Introduction

The dark romanticism[1] of the viva is the appeal and aspiration of joining a doctoral community of practice and the promise of entry into the academy as a fully-fledged, peer member of academia, accepted by authorities in the field of research, and judged on the quality of the doctoral thesis and performance in the viva voce. The darkness of the viva is a reference to the 'dark art' of vivas and the circulating narratives that inform the backdrop to viva preparation, provide the contextual 'wall paper' to the viva process and make available

[*] **Corresponding author:** Adam Barnard. Email: adam.barnard@ntu.ac.uk

[†] **Corresponding author:** Matt Henn. Email: matt.henn@ntu.ac.uk

the competing 'atrocity' stories of successfully completing the viva. The viva carries this Janus-faced dialectic of opening new doors, crossing new thresholds and providing a horizon of possibilities or leaving a permanent and indelible trace of an experience not to be forgotten (Carter & Whittaker, 2009).

Quality Assurance Agency (QAA, 2015) provides a set of expectations and indicators for higher research degrees with research defined as 'creative work undertaken on a systematic basis in order to increase the stock of knowledge' (OECD, 1993) or 'a process of investigation leading to new insights, effectively shared', through 'applied research' excluding routine testing and analysis and teaching materials (www.ref.ac.uk). Hoddell (2002: 62) states '[a] Professional Doctorates is a programme of advanced study and research which, whilst satisfying the University criteria for the award of a doctorate, is designed to meet the specific needs of a professional group external to the University, and which develops the capability of individuals to work within a professional context'.

In the UK, the oral examination is usually a 'closed' examination, where only the candidate, examiners, and any independent observer or chair is present. An External Examiner is appointed according to quality assurance processes of the University with an Internal Examiner consonant with internal processes. Many Universities permit the supervisor to be present to observe the examination with the candidate's and examiners' permission, but they do not play an active role in the final decision-making process. This differs from some non-UK European oral examination models involving a public defence, where the candidate may invite family and friends to join the audience in what is considered a celebration as well as a defence of the thesis, and where the outcome of the award is usually already known. Where UK universities are offering joint programmes with other European partners the public defence is sometimes used rather than the 'closed' UK model (QAA, 2015) with considerable variation and some mystification (Morley et al., 2002).

The QAA (2015) suggests whether the candidate is being examined on a 'traditional' thesis, portfolio, artefact(s), clinical practice or other outputs the critical evaluation in answer the research question(s) and performance in the oral examination is the point at which a decision in made in the award of the doctorate. The dominance of vivas as the final

assessment method is under scrutiny given the proliferation of professional doctorates and the various forms of assessment they require. For example, practice based doctorates, work based doctorates, doctorates by public works all require different forms of assessment and creative and performing arts require artefacts or creative products accompanied by as critical commentary.

The postgraduate context

The postgraduate landscape is 'neglected' (The British Academy, 2012) and in crisis, overlooked and undervalued, muddied with transitions (Wakeling & Hampden-Thompson, 2013), motivations (HESA, 2013; Mellors-Bourne et al., 2014) and recruitment and selection processes (CRAC & Vitae, 2014) determinant on funding (Lindley & Machin, 2013; NUS, 2012) in an international field (Clarke & Lund, 2014).

The issue of funding for postgraduate taught students has come into focus with the announcement of the Government back loans scheme for the foreseeable future with BIS (Department of Business, Innovation and Skills) overseeing its implementation. The needs of distance learning and part-time postgraduate research students awaits sustained discussion.

Vivas

Researching the proceedings of doctoral viva is difficult (Burnham, 1994) although generic guidance on viva performance is provided (Cryer, 2006; Churchill & Sanders, 2007; Philips & Pugh, 2005; Rugg & Petre, 2004; Sharp & Howard, 1996). The process of examining doctoral thesis is surrounding by different agendas, ideologies and practices (Carter & Whittaker, 2009) and the very notion of 'doctorateness' has received continued debate but unsuccessful resolution. Trafford and Lesham (2008; 2009) have suggested preparing for the viva, at the start of achieving a doctorate, is an integral part of achieving 'doctorateness'. 'Doing a doctorate' is in the production of the written thesis and the oral defence of the thesis in the viva. The literature surrounding vivas is often confined to generic guidance on students' projects or guidance manuals (Philips & Pugh, 2015; Jackson &Tinkler, 2015).

The received wisdom on the viva process is that it is at best 'traditional'. At worst, the viva

is the dark arts of doctoral study. The UK doctoral assessment (thesis and oral examination) provides evidence of equivalence of standards across different institutions, doctorates and candidates (QAA, 2015). The question of providing cohesive, comprehensive and helpful learning materials and support for candidate preparing for vivas has triggered the need to review viva outcomes. This also contributes to the monitoring and review of quality assurance mechanism on doctoral programmes.

Methodology and Data collection - Review of the data on submissions for doctoral examination across a university.

Using archival research methods, the data is thematically coded for rich detail and flexibility (Braun & Clark, 2006; Nowell et al., 2017) and below is a review of preliminary report forms, external examiners comments and recommendations to candidates that have been reviewed over a two-year period in a school of a Higher Education provider. The most desired outcome of the viva is a straight pass with no recommendations from an unusual 'word-perfect' thesis with the necessary rigour for doctoral work. Most results of vivas, fall into the category of pass, pass with minor amendments, major amendments or resubmission. The results of vivas resulting in resubmission usually fall into with or without a viva, an acceptance of an MPhil or the worst-case scenario: a fail. The following section investigates the minor, major and resubmission.

The University Research Regulations state that the award of PhD/PD subject to minor amendments is the Recommendation 10.2. This recommendation "*should be used where the requirements of the degree have been met, except that minor typographical and/or minor editorial amendments are needed and a re-examination is not required*". Three months is permitted for submission of amendments.

Typical comments and conditions specified by examiners within the cases reviewed follow the format of the thesis and include: change title ; re-word abstract (e.g. to cover contribution to knowledge/ add sample size) ; summaries necessary for end of each chapter; address inconsistencies in use of "I" and "We"; re-word aims and objectives; divide large chapter into several chapters; strengthen aspect of argument in an identified chapter and re-organise discussion in an identified chapter/

The combination of the early part of the thesis (title, abstract, summaries, aims and objectives, purpose, strength of argument and organisation) are overarching themes that apply to the production of the thesis. The critical literature review was assessed with corrective attention needed for: greater critical evaluation of selected aspects of the literature; clarify lack of recent papers used in the discussion and include brief discussion/ expand identified section, e.g.: ethics; limitations of study; short reflective section in methods chapter; explanation for choice of items included in a particular table; more detail re: reliability and validity in methodology section; include details of ethical procedures followed; clarify decision for focus on an identified key concept; note (but do not explore) an identified parallel literature; clarify meaning of a particular approach (e.g. mixed methods"); rationale for particular aspect of method(s) / approach(es); more detail re practical/ implementation of methods for data collection and include information on the sample.

The literature review contains elements of methodological discussion and care needs to be exercised to control and marshal the material into navigable and coherent sections that have a continuity and consistency of argument. The depth and detail of the thesis comes under scrutiny to include all collected data, formatting and presentation issues, stylistic issues, flagging work forward and proof-reading are all identified.

Comments for minor changes include: qualify small aspects of the discussion; deeper explanation of some identified results; omitted, but already collected and available data to be included in thesis; re-format diagrams and tables / reduce tables and peripheral findings; add appendices to two chapters explaining a particular issue or method (e.g. derivation of equations - minor amend); minor amends such as *Acknowledgments* section. These stylistic changes include tonal changes to soften tone to minimise impression that candidate is dismissive of a particular approach; re-fashion conclusion in light of new aims and objectives; highlight potential future work; provide list of conferences attended; check references in main to ensure they match those in the main reference list and conduct thorough proof-read and correction of grammatical and typographical errors.

These comments fall into three categories. The first are presentation issues. The second are process issues and the third product issue. Presentation issues concern the process of delivery of a topic to an audience, to inform, persuade or convince and compel on the quality and veracity of the argument produced.

These presentation issues include: title change; reworded abstract; summaries; consistencies in presentation; reformatting diagrams; minor amendments to targeted areas. Process issues relate to the conduct of the research. These include: re-worded aims and objectives; brief descriptions and expansions; qualification of discussion; deeper explanations; softening tone of argument. Product issues relate to the satisfaction of the needs of 'doctorateness' and a set of deliverables to provide solutions to thesis production. Product issues include: strengthening arguments; reorganising discussions; greater critical evaluation; clarity; inclusions of data; adding appendices; potential of future work; contributions to conferences. Although there are fluid and debatable boundaries between presentation, process and product, the conceptual delineation provides a scaffold for engaging with the thesis and revisiting amendments.

The award of PhD/PD subject to *substantive* amendments occurs, according to The University research degrees regulations, when there are changes that are more substantial. The regulations state substantive amendments *"should be used where the requirements of the degree have been met except that the thesis contains limited deficiencies which the examiners consider can be corrected by the candidate without the need for re-examination of the thesis*". Six months is permitted for submission of major amendments.

Typical comments and conditions specified by examiners within the cases reviewed, include:

- Re-structure the thesis in a series of identified ways (eg., to reflect the value of a selected research site to the research, collect findings in a single section, review quantify of data set in thesis)
- Re-write of introduction – more sign-posting and clearer focus for thesis
- Expand introductory chapter and signpost conceptual framework, need for study, potential contribution to knowledge / Re-write chapter two and three in line with suggestions made by external examiner in additional report (not supplied)

- Refine the research question
- Amend claims re contribution to knowledge
- Extend discussion in literature review chapter / at times over-reliance on limited range of sources/ over-reliance on web-sites/ greater reference to primary rather than secondary sources required
- More critical evaluation with literature
- Ensure consistency of philosophical grounding of thesis
- More sustained development of theoretical underpinnings
- Greater explanation of, and justification for, conceptual framework
- Re-interpret some key (qualitative) findings
- Development of conclusions required (double length of concluding chapter), and more critical reflection / Short concluding chapter required (5-10 pages)
- Brief overview of the comparative method (3-5 pages)
- Include diagram for conceptual framework
- Synthesise findings – refer back to conceptual framework
- Provide more detail regarding the process of data analysis
- Inclusion of additional data
- Correction of grammatical and typographical errors
- Over-length of thesis is noted – condition set to reduce length of thesis.

The majority of requirements and recommendations for major amendments fall into the process category of the activity and conduct of the research. These are structuring, expansion, and clarity. For example, restructuring to reflect value of selected site of the research; expanding discussion on conceptual frameworks; need and contribution of the research; refining research questions; claims of contribution to knowledge; discussion of literature review and its critical evaluation; more refined conclusions; and greater synthesis. The processing issues also demand further work such as consistent philosophical grounding; theoretical underpinnings; greater explanations of key areas; re-interpretation of presented data; overview of comparative methods; and detail of process of data collection. The presentation issues are of lesser concern and the inclusion of diagrams and correction of grammatical and typographic errors. Similarly, the product issues concern rewriting

introductions and conclusions and the overall length. Substantive amendments demand more and sustained work to satisfy the Examiner's criteria.

The third category is for re-submission for PhD/PD. The University research degrees regulations state that this recommendation should be used in cases "*where the candidate's performance in the first oral or approved alternative examination and /or the thesis was unsatisfactory*" and has in general not reached the standard required for the PhD/PD. Twelve months is permitted for submission of revised thesis. Often, given the challenge of full-time workloads, this result allows the candidate a year to rework to the satisfaction of the nominated examiners.

Typical comments and conditions specified by examiners within the cases reviewed, include:

- Statement of originality is only tentative (and needs to be addressed more fully)
- Significant re-organisation of material required throughout / restructure thesis/ major re-thinking and re-organisation of the literature review
- Major re-write of two early chapters (including literature review)/ Re-write and expand conclusion / include methodology chapter
- Introductions and conclusions required for each chapter
- Absence of hypothesis
- Number of misinterpretations of literature identified for reflection and amendment by student.
- Considerably more needed by way of synthesis of literature/ connections between key identified literatures and between key concepts require clarification/ clarify conceptual framework
- Relevance of key literature for the research study needs clarification / some of the literature identified as key is out-dated / over-reliance on a literature that is too narrow in scope
- A key theme is left underdeveloped
- Research endeavour is very inefficient (20 overseas interviews in 11 trips)/ weak (e.g. sample size very small)

- Some methodological matters not dealt with in sufficiently robust or sophisticated manner
- Insufficient justification for, and characterisation of, choice of research design/ methods/ case studies
- Research methods issues – discussion not sufficiently accessible/ more detail required regarding implementation/ additional readings required
- Analysis lacking in sufficient depth and rigour/ analyses need to be more systematic / data not fully exploited or inferences drawn-out
- Greater engagement with theory in the analysis/ implications of theory and data need elaboration
- Ensure claims follow from the data
- Strengthen conclusions with greater emphasis given to the original contribution to knowledge
- Conduct thorough proof-read and correction of referencing system as well as grammatical and typographical errors
- Over-length of thesis is noted – condition set to reduce length of thesis.

These more challenging requirements and recommendations are focused on product and process issues. Product issues of originality; reorganisation; rewrites; hypothesis construction and testing; and length are required. Process issues include misinterpretations; synthesis; relevance; key themes; insufficiencies; methodology; justifications; research design; implications; analysis; engagement; and substantiated claims. Interesting the more serious concerns requiring resubmission are process and product driven with more latitude in interpretation conveyed to the candidate. The depth of changes required also increase in magnitude and significance.

The award of MPhil subject to amendments is in cases where the candidate has in general not reached the standard required for the PhD/PD, they may be awarded the degree of MPhil subject to the presentation of the thesis amended to the satisfaction of the examiners. The period permitted for submission is not specified within the regulations.

Typical comments and conditions specified by examiners within the cases reviewed, include:

- Re-write abstract and more clearly emphasise key findings of the thesis
- Clear statement of research topic, purpose and hypothesis/es
- Research questions need clearer articulation, and to be related to the hypothesis/es
- Extend background discussion to place study in context
- A more critical engagement with relevant literature, including more recent literature and that which is appropriate to the research / integration and discussion of literature vis-à-vis the focus of the research
- (Minor) restructuring of thesis (eg move statistics and other data to appendices)
- Main thesis to engage closely with statistics and other data in appendices
- Re-write (identified) chapters with a clearer focus on the purpose of the research study
- Student to demonstrate a more comprehensive understanding of methods and techniques applicable to the research / a more explicit justification and critique of research design
- More detailed engagement with key research methods issues – eg., the nature of 'insider' research, research ethics, objectivity, validity
- Compile a properly assembled bibliography / correct format and order of reference list and ensure that all citations have a reference entry
- Correct all typographical errors / Correct all errors in figures, graphs and tables
- Full proof-reading and writing to the required standard in English

These conditions and recommendations fall into seven substantive areas. These are firstly, presentation issues; secondly research aims and questions; thirdly literature review, fourthly theories and conceptual framework; fifthly methodology; sixthly data collection, processing, analysis and discussion; finally, contribution to knowledge and further work. They follow a line of the general construction of a thesis.

Discussion

The lighter touch of conditions for 'minor amendments' are overwhelmingly represented by presentational issues of wording, formatting, shape, structure and layout of the thesis. The

recommendation of 'substantive' or 'major' amendments are characterised by a change in focus on the conditions towards the literature review, conceptual framework and data collection and discussion and involve process issues particularly structuring, expansion and clarity. The third category of 'resubmission' is characterised by a fusion of conditions. For example, reorganising material, restructuring and rethinking and reorganising literature review covers the literature review and presentational issues and contributions to knowledge. Greater development of key themes, analysis and implications cut across a number of the themes identified. The conditions also highlight omissions such as the need for the inclusion of research aims and hypotheses, original contribution to knowledge and dissemination strategies.

These assessments of viva outcomes can be clustered in presentation, process and product issues. They also follow the structure of the thesis from title page, research question, abstract, literature review, ontological questions, epistemological questions, methodology, methods, data collection, discussion, limitations, conclusion and contribution to knowledge. Further evidence of assessments in vivas is presented by external and internal examiners feedback. These cluster around the structure of the thesis. Title page have been criticised for a mis-match between the title and the actual content of the thesis or the title should accurately reflect the methodology used. Research aims and questions should address the specific context of the research and so should not be framed too widely. For the abstract, comments refer to formatting appropriate to discipline and the need to strengthen content to concisely and accurately detail the content and advances made in the work. Similarly, abstracts should be concise, but clear, to provide the reader with a 'way into' the thesis.

For the literature review, Examiners were critical of a literature review that focused too heavily on a limited number of journals. Significant contributions in the relevant area were not considered or discussed as a result. Literature may be strong in relation to, say, the content focus of the thesis, but may be weaker in relation to the chosen methodology. It is important to address literature relating to all aspects of the study. Literature needs to be current, which may mean some updating is necessary as between the final thesis and the earlier drafts of the literature review. 'Currency' may be a particular issue with statistical data or official reports, where it might be reasonable to expect very recent data to be

available. Ontological positions were required to be spelt out, epistemological issues such as a clearer explanation/rationale of research process, sample choice/selection and a clear articulation were required to explain and illustrate the limitations of the methodology.

Methodologically, Examiners wish to see a central theoretical focus within a clear conceptual framework and research design. Projects that incorporate multiple theoretical concepts, or extraneous philosophical discussion, have been less well received. Examiners also highlighted limitations in methodological reflexivity. A sufficiently clear rationale was not always given for the chosen methodology; candidates did not always (a) identify positive benefits of the particular methodology and (b) explain why obvious alternatives had not been chosen.

Candidates need to address any obvious tensions or inconsistencies between the articulated methodology and the selected research methods e.g. in one thesis, an interpretative, qualitative approach was taken to data collection and analysis that did not align to the core theory or methodology. In another thesis, an emphasis was placed on grounded theory in a methodology section, but only elements of this were then evident in the actual study and data analysis. Conversely, another thesis indicated that a grounded theory approach had been taken during data analysis, but no explanation had been offered as to how this was reflected in the research design.

Data collection / processing / analysis / presentation including results and discussion were further areas of concern with a step by step detail of the approach taken to data analysis being important. A sample of the data should be included as an appendix to the thesis e.g. a transcript of an interview, perhaps annotated to illustrate the approach taken by the candidate to thematic coding. Care needs to be taken to ensure that charts or figures are readable and clear e.g. by including percentages on columns and by selecting titles that show how one chart builds upon an earlier chart, with an awareness of what claims can be made and what cannot, so more detail on analysis that has been undertaken is clearly shown. Ethical position/processes need to be clearly stated with the procedure followed (note that there could be ethical implications of using Social Media as a data collection tool).

The contribution to knowledge and contribution to practice for practice-based research, needs care in construction so that too much emphasis is not be placed on the individual's professional role and identity and consequently the impact on their specific practice, at the expense of the scholarly nature of doctoral study and wider impact. The thesis requires a clear explanation of the contribution to knowledge.

Examiners expect the thesis to be clearly structured around a delimited research question, with a careful and critical unfolding of the argument required to pursue and answer that question. Too much 'signposting' was an issue, as was not enough. A balanced and stylistic judgement needs should be made to add to the 'elegance', flow, direction and purpose of the thesis. A strong thesis will get to the heart of the argument more directly. Examiners consider that the thesis should be viewed as a professional document that will be read by a public audience, with appropriate care taken in respect of presentation, layout, fonts, referencing, anonymisation of research participants and typographical accuracy. The presentation of the thesis includes presentational issues of typographical and grammatical errors - including US spellings, line spacing, over word limit. The quality of the articulated argument in the thesis is needed to avoid poor written English including the need for editing, proof-reading and sense-checking. These aid avoiding referencing errors (adhere to style guidelines for discipline) and adopting a suitable writing style that includes a critical approach. The presentation of tables and figures within the thesis - including introducing tables in the discussion, should explain how tables relate to each other and the arguments being constructed. Clear definition of key terms used in the thesis, abbreviations need to be explained, and the inclusion of transcript, interview schedule or other data capture tool in appendix are all necessary inclusions.

Having discussed the contextual landscape of postgraduate education and specifically UK doctoral education, the review of viva outcomes has shed light on the reception and assessment of theses. This provokes the question of how best to support students and candidates in their preparation for vivas.

Guidance to candidates.

The final section of the paper is the support offered to the candidate to prepare for the viva. It is encouraging that the conditions identified by External Examiners are consistent with the guidance provided on constructing the thesis during the process of instruction on professional doctorate courses and provision offered to PhD candidates. Professional doctorates provide supportive research workshops cover the main aspects of presentation, literature review, conceptual frameworks, methodology, data collection and analysis, evaluation and original contribution to knowledge in professional practice. This evidences the 'doctorateness' of professional doctorates and their significance and their parity and equity with PhDs. Candidates are further supported in preparation for the viva by conducting 'mock' vivas where these areas are significantly identified and addressed and a 'dry run' of the conduct of the viva is experienced and explored.

The advice and guidance given to candidate in preparation for the viva.

The final section of this paper examines the advice and guidance offered to doctoral candidates preparing for viva examination. Silverman (2010: 397) suggests the process of viva preparation requires that you revise your thesis, particularly the concluding chapter, prepare a list of points you want to get across, be ready to explain and defend any changes to your original research questions, read up recent work in your field, find out about your external/internal examiner's work and practise with others in a mock viva.

Whisker (2012: 477) recommends how to prepare for the viva or oral examination (viva voce) in many ways but there are common themes. These are practice presenting and discussing your work at conferences and dealing with questions and find colleagues/staff who are willing to read parts of the thesis and then ask questions. Candidates are advised to make a systematic summary of the thesis so you know the contents of every page, talk to colleagues who have gone through their oral examination successfully and ask for their advice and make sure that you have read the thesis and are thoroughly familiar with it, immerse yourself in the material, particularly with the whole argument, the main findings and major contribution of your work. A simple sentence statement of the contribution you are making should reflect the title, summarise the argument, identify the original contribution to knowledge and to professional practice. Further suggestion it to write a book proposal

based on your thesis, thus requiring you to present your work and to justify to a prospective publisher why it should be published, what is original, what are the competitors in the market, where is the market, and who is the audience.

As well as the viva preparation, there are sets of questions that it is helpful to anticipate that follow the 'normal' structure of the thesis. Earlier questions are often used to enable a candidate to 'settle in' to the viva, to tell the story of the research, and to make clear opening claims.

Questions to be asked in the viva process are general, aims and research questions, literature review, theory, methodology, data collection and analysis and further work. General questions ask of motivation: what made you do this piece of research? Why did you choose this topic? Why do you think it's important? Why is timely and current? Your own position (professional and personal) in relation to this field and these research questions? These questions have become increasingly central to doctoral education.

Research aims and questions normally involve the story of the research, the timeline of when it was conducted, contextual (personal, professional, academic) and the contribution in terms of originality and novelty. Questions of the literature review usually ask 'What shaped or guided your literature review? Why did it cover the areas that it did? (And not others?) Why did you/did you not include the work of X in your study? Have there been recent significant works that have not been included? How does your project contribute to the literature?'

Theories and conceptual frameworks ask of the main framing device used in the thesis, what theories informed the study, what ontological positions did you draw to inform your project and the limitations of this theoretical framing.

Methodological questions concern why did you employ the methods you used? Why not others' for example X? What informed your choice of methods? What would you do differently, with hindsight? Is there a key recommendation you'd give to colleagues working in this area? Why did you select this sample? Can you see problems with it? If it is a small-

scale study, can you justify why so few were involved? Are there improvements that could be made with the sample? What would you do differently? Received wisdom suggests that methodology is the pivotal moment in a thesis and if used well defines the outcome of the assessment.

Questions regarding data collection, processing and analysis normally asks of anomalies or surprises, how the data was analysed or categorise, why it was analysed in this way and not another and what was the most significant finding. Broader questions such as did themes emerge from your data (a posteriori) or did you 'bring them to the data' (a priori) cross-cut ontological, epistemological and methodological areas.

Connections and linkages of how are the findings related to the literature review, are findings consistent with your methodology and what are the linkages that can be made to the literature review add cohesion, consistency and self-referential strength to a thesis.

The final area of discussion usually surrounds further work, the original contribution to knowledge, the contribution to professional practice, which aspects of the work could be taken further, and which elements are worthy of publication and/or presentation at a conference. Plans for publication and dissemination and if any of the work been published or presented already?

Generalise from the work, lessons learned for practitioners/ policymakers/ other researchers professional practice address the 'so what' question of what are its key messages and implications of the research.

Often an open forum includes reflections on the process (thesis), its strengths and its limitations or weaknesses. Viva should end with 'Is there anything else you would like to say or discuss that we have not asked you about?' to allow questions to be asked of examiners by candidates.

It is also recommended that the candidate can take control of the process and provide prefaces and thinking time. For example, "that's a good point", "does that answer your

question(s)?", "do you mean" and re-presenting questions to ensure clarity in what has been asked and what answer is to be given.

A viva voice is both a dialogue with experts and an oral defence of the thesis. It is an opportunity to engage with the research community and a 'testing moment' to explore, clarify, discuss and defend the thesis. There are a range of anecdotal and apocryphal stories about vivas (e.g. taking two days, falling out with the external, examiners not understanding the thesis format or examining process) (Delamont & Eggleston, 1983; Hartley & Jory, 2000). Independent Chairs are becoming increasingly popular to ensure fairness, equity, and consistency following policies and procedures.

Whisker (2012: 744) suggests knowing your thesis very well and develop a brief outline of the main argument, conceptual conclusions, key points you would like to make. Responses to common questions and knowing the abstract and conclusions well and that you are able to articulate them. Find out about your examiners, rehearse with friends and supervisor, manage stress before and during the viva and know the abstract and conclusions well. Post-it notes highlight particular areas for you to focus on and make quick reference to. Candidate are also coached on the ability to managing fear and anxiety particularly the feeling of seeing an External Examiner with a host of marked pages at the viva.

During the viva, Wisker (2012) suggests, you sit down and place the thesis in front of you. Feel secure about it being there. Thank the examiners for the opportunity to talk with them about your work. These people are key figures in your field/methods, and they have spent time on your work. Answer questions clearly and concisely throughout, ask for clarity when needed but remain focused and direct. It is not the time to digress. Use the arguments, ideas and examples you use in answering questions. Feels secure with them. Focus on linkages, justifications and rationales. Make is clear who the conceptual framework links questions, themes, methodology, methods, fieldwork, findings and conclusions. Be able to refer to texts you have used and demonstrate critical awareness and ability by criticising, disagreeing or agreeing with texts and explain your position. Use eye contact throughout – appear confident and positive, comfortable and relaxed. Do not fumble through the thesis, use markers to move quickly and easily to key pages.

There is an increasing move towards greater openness and transparency in the conduct of vivas and a focus on fairness, and equality of opportunity in the proceedings of the final exam. Vivas are the end of a sustained period of work, the 'capstone' project to the research conducted, and the crossing of a threshold to a community of academic practice.

Conclusion.

This paper has discussed the context for doctoral education and the widespread use viva as the final point of the doctoral process. Reviewing the results of external examiners comments and preliminary reports provides guidance on how candidates can and should prepare for the viva.

The paper has discussed the University regulations for postgraduate research degrees provide formal statements on the award of the degree and/or the recommendations for successful completion. Mayer and Land (2003) discuss 'a portal of understanding' and coined the term 'threshold' as a portal of learning-gain which passage through transforms capabilities in conceptualisation that has four characteristics, irreversibility, integrative, bounded and troublesome. Firstly, irreversibility since new perceptions and understandings cannot be unlearned. Secondly, thresholds are integrative since interrelationships previously not anticipated become clear, comprehensible and potentially usable. Thirdly, they are bounded through application to specific sets of ideas or concepts. Finally, thresholds are potentially troublesome in raising new that maybe quite unfamiliar or which raise new issues that might be concerns (Mayer & Land, 2003). The engagement with the viva process is a capstone project that consolidates years of work and research. It has the transformative capacity to open new portals for understanding as well as qualifying for the title 'Dr'.

Acknowledgements

The authors are very grateful for reviews provided on earlier drafts of this publication.

Notes

1. The dark romanticism is attributed to Michael Löwry's Consumed by Night's Fire – the dark Romanticism of Guy Debord, *Radical Philosophy* 87:31-34 (1998).

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