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**A qualitative exploration of environmental and
relational factors affecting service user
involvement from the perspective of
community mental health nurses**

**A thesis presented in partial fulfilment of the requirements for
the degree of Master of Philosophy in Nursing
at Massey University, Palmerston North Campus,
New Zealand**

Vicky Keryn Brown

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Abstract

Mental health policy and clinical guidelines require service user involvement principles within clinical practice and service provision, yet few national studies exist to examine Mental Health Nurse's (MHNs) viewpoints about its implementation. This qualitative research project asks the question 'What are the environmental and relational factors which affect service user involvement in community mental health team settings from the perspectives of community MHNs?' The research aims were: (1) Explore how the practice environment supports service user involvement; (2) Explore how they include, or not, service users in the provision of care; and, (3) To discuss how the group of community MHNs recognise and describe service user involvement. Central ethics approval was gained and eight community MHNs in two District Health Board's (DHBs) with over 5 years experience were interviewed. Participant's discussion was audio taped, transcribed and then analysed utilising a thematic analysis approach.

From this analysis, two predominant themes arose. Theme one highlights the 'relationship dynamics of practice' through exploration of concepts of historical changes; conflicting relationships, influential attitudes and powerlessness. Theme two explores 'strength based approaches' from the participants perspectives and includes recovery; inclusive practices; challenging stigma and beliefs towards service user involvement. Mutual agreement about the benefits of service user involvement was identified. However, changes to funding, hierarchical mental health organisations, nurses' education, stigmatising attitudes and lack of nursing identity have impacted on the implementation and support of service user involvement. Recommendations for further research and suggestions for nursing practice are offered through building nursing capacity, capability, quality and strengthening the profession.

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Chapter One: Introduction

"Every path to a new understanding begins in confusion." (Mason Cooley cited in www.bizcommunity.com)

1.0 BACKGROUND TO THE STUDY

As a mental health nurse (MHN) for the last 9 years, interest in service user involvement is founded in my nursing experience within both acute inpatient and community mental health settings. I have worked alongside service users in a number of settings and often felt ethically and professionally challenged by health professionals' care and decision making processes for service users. These challenges led me to question what my colleagues perceive service user involvement as and whether service user involvement is a reality within current mental health nursing practice in New Zealand. Reflection of my own beliefs, values and practices in regards to the therapeutic relationships and interactions I have with service users has enabled greater introspection and analysis of my practice to occur. Throughout my post graduate studies I have been exploring and examining discriminative practices that occur on a personal, organisational, societal and governmental level for service users. This current research, examining MHNs attitudes and perceptions towards service user involvement, has been a progressive journey from those initial studies.

Within practice I have observed habitual behaviours and prejudices towards services users that have challenged me ethically. Alongside this I have been privy to dynamic nurses who embrace service user involvement whole heartedly and advocated for the establishment of service users driving their recovery. The inconsistency of practices between nurses working in the environment of mental health care has confused me, leading me wondering how variances in attitudes exist, and what factors contributed to differing views of service user involvement.

More recently I have been employed within a community mental health setting working on a one to one basis with service users. My current role involves acute assessment of service users who present to adult community mental health settings in crisis or routinely via the police, community organisations, general practitioners, emergency department, medical department or through self referral. This exposure to outside organisations has been ethically challenging at times as I have observed not only the attitudes and perceptions of my colleagues but also the wider public. This experience has awakened my desire to further examine individual, organisational and societal views of the involvement service users having in the planning and delivery of their own care and wider services.

My passion for examining service user involvement was initially driven through reflection of my personal values and beliefs towards recovery from mental illness. I acknowledge the naivety I held when beginning my nursing career. As a new graduate I envisaged recovery to consist of service users being free of signs and symptoms of mental illness. With gained experience I recognised that this was not the lived reality of mental illness. At this time I became somewhat disillusioned and questioned the validity and purpose of my interactions with service users. However I found resolve through utilising self reflection, peer discussion, supervision and further studies which enabled me to examine my way of thinking towards delivery of future nursing care. From that I recognised the impact of my preconceptions about mental illness and recovery and how that is played out in practice.

I now believe that service users have the right to determine their own sense of meaning in recovery, rather than me imposing my perceptions of mental illness upon them, in order for self determination to occur. My part to play in service user recovery is as a facilitator. This incorporates meeting with service users, building rapport, listening, acknowledging and addressing concerns (as and when they arise), facilitating problem solving and planning care in a holistic and hopeful manner. Through stepping back and allowing service users to drive their recovery, I have become a partner within a therapeutic relationship, formulated

purposeful alliances and improved trust which has led to clinical and recovery goals being achieved.

1.1 RELEVANCE TO NURSING

One of the unique features and strengths of mental health nursing is the therapeutic relationships that can exist with service users (Hurley, 2009; van Dusseldorp, van Meijel & Derksen, 2010). In order for MHNs to develop meaningful alliances with service users and improve outcomes they must focus on working alongside service users in planning and delivering healthcare rather than trying to contain and fix them (Hannigan & Cutcliffe, 2002). A therapeutic, trusting relationship can greatly assist service users to overcome emotional adversity especially when “values are respected as the nurse listens to the patient’s concerns, provides information and advice, relieves distress by encouraging the expression of emotion, improves morale through review of established outcomes and encourages the patient to practice self help” (Moyle, 2003, p.103). However, if sporadic contact with service users occurs, MHNs run the risk of becoming distanced and the therapeutic relationship focus changes, from acknowledging the their individual needs, to the monitoring and assessment of symptoms and incorporation of pharmacological treatment (Moyle, 2003). Therefore focusing on service users as ‘objects’ or ‘illnesses’ rather than ‘people’ increases their distress, leads to feelings of abandonment and can negate the nurse-service user relationship.

In order to facilitate recovery and promote social and community inclusion for service users nurses can assist them to identify and overcome barriers that exist through the formulation of “supportive environments that facilitate integration and acceptance” (Russell, & Lloyd, 2004, p.272). Inclusive practice is outlined throughout literature as a fundamental aspect of recovery for service users. Socially inclusive practice aims to ensure that mental health service users not only live within communities but are part of communities (Mental Health Commission (MHC), 2007b). Bradshaw, Armour and Roseborough (2007) identify the foundation for inclusion being: addressing issues of accommodation;

employment; education; and, developing a sense of belonging. Furthermore supportive people who promote hope, encouragement and opportunities are essential to ensure socially inclusive practice and service user recovery occurs and it is neither a treatment nor an intervention, rather it is ideals and beliefs that enlighten cultures, policies and practice. Socially inclusive practice should be of prime concern to MHNs and is demonstrated through information and knowledge sharing, viewing all options, and empowerment, therefore enabling self determination over health care decisions (Stickley, 2005).

Surveys undertaken with service users highlight the value that is placed on the relationships between MHNs and service users. However, underpinning this research is the lack of expertise and knowledge that many nurses hold in regards to mental health care (Coffey, Higgon, & Kinnear, 2004). Furthermore paternalistic attitudes by MHNs can limit service user self determination and decrease involvement in treatment planning (Harris, Lovell, & Day, 2002). Given that mental health service users often experience exclusion from clinical decision making, effective therapeutic engagement which focuses on education and the development of a therapeutic relationship is paramount (Gray, Rofail, Allen, & Newey, 2005). For example, to enable truly autonomous decisions regarding treatment options to be made by the service user, honest, open and informative dialogue must occur whereby the service user is able to comprehend, seek clarification and formulate treatment goals with health professionals (Harris, Lovell, & Day, 2002). MHNs play an important role in assisting service users to develop strategies to manage their mental illness, this includes collaborative interactions and through this understanding and recovery of mental illness can occur (Coombs, Deane, Lambert, & Griffiths, 2003).

MHNs have a responsibility to assist service users to become self-determined participants of their healthcare through the use of advocacy, education and health promotion (Harris, Lovell, & Day, 2002). From a nursing perspective, therapeutic relationships which promote positive outcomes involve: knowing the service user; striving to understand their lived experience of their illness;

providing a safe environment to open and honest discussion to occur; education and careful monitoring of treatment; advocacy; and, the building of trust and rapport (Dearing, 2004). A key component of therapeutic relationships is the nurse's ability to promote service users individual growth through the use of self, in a manner that demonstrates "warmth, empathy, genuineness and unconditional positive regard" (Hewitt & Coffey, 2005, p.563). This suggests inclusive professional relationships are fundamental to empowering service user self determination.

In contrast Lysaker and Buck (2006) propose that a therapeutic relationship should focus less on the assessment and maintenance of mental health stability. Rather emphasis on recovery principles and the lived experience of mental illness should be the primary focus. It is clearly documented in research that MHNs play a fundamental role in assisting service users in decision making about their mental health and minimisation of relapse (Hurley, 2009; MHC, 2007; Russinova, Rogers, Ellison & Lyass, 2011; Te Pou o Te Whakaaro Nui (Te Pou), 2009). However nursing in a directive manner may limit service user's ability to make informed choices. Therefore socially inclusive practice promotes the opportunity for all to participate fully in care planning and interventions.

The need of service users to participate in treatment planning and decision making does not differ from any other health area. However due to unfounded beliefs that mental health service users lack capacity to be involved, involuntary detention and treatment can be administered leaving service users feeling resentful, disgraced and discouraged (Roe, Chopra, Wagner, Katz, & Rudnick, 2004). In order to promote independence, MHNs need to move beyond merely assessing symptoms of mental illness and readily explore individual service user perceptions, strengths and coping strategies so that inclusive care can be facilitated (Roe et al., 2004).

1.2 RELEVANCE TO MENTAL HEALTH SERVICE PROVISION

In regard to national policy, the MHC (2007, p.21) defines recovery as “an individual, empowering process for people with mental illness and/or addiction and is a journey as much as it is a destination”, and through recovery, service user unification and strengthening of values and beliefs occurs. Recovery involves more than symptom alleviation, as it focuses on service users finding individualised tenacity, ownership and embracing of their experiences of mental illness through self acceptance (Meddings & Perkins, 2002). However the concept of recovery is mystified not only due to its association with medicine and a cure but also due to the diverse interpretations that exist in literature (Davidson, 2005). The reality for many service users is that no cure exists for their experience of mental illness, rather their tools and strategies for obtaining wellness expand. Therefore understanding and participation play a fundamental role in facilitating service user choice and individualised recovery.

Mezzina et al. (2006) view recovery as being three dimensional. This comprises of personal (service users gaining control for decision making through self determination and making sense of their own and others perceptions of mental illness); interpersonal (recovery is facilitated through others being there, doing more and/or doing something differently for the service user); and, social spheres (foster recovery through engagement in social groups, employment, education and housing which can promote service users feeling a sense of belonging). Whilst Mezzina et al. (2006) research suggests concepts and relationships that guide recovery, Masterson and Owen’s (2006) viewpoint of recovery holds a more singular view. That is, self determination occurs within service users when they take ownership of their recovery, rather than relying on clinicians or mental health services (MHS) to drive their recovery.

In comparison, Davidson (2005) asserts that recovery orientated practice involves the intertwining of current recovery principles of: social inclusion (removing barriers that inhibit recovery); service redesign (initiating appropriate services to meet the needs of people); transforming conceptual understanding

about mental illness (Like Minds project, Hearing Voices workshops); and, emphasising individual resolution (increased interest in spirituality, individual coping mechanisms). The publication Te Hononga 2015 (MHC, 2007, p.22) concurs in that they view that the future of mental health care be based on recovery values of “self determination, social inclusion, hope and choice” which enables service users to actively participate and formulate recovery in their own way in the context of their chosen relationships. Clayton and Tse (2003) suggest that recovery concepts can be further expanded to include the Treaty of Waitangi principles of partnership and participation, therefore ensuring a culturally sensitive recovery approach is achieved.

Recovery is a unique multi-dimensional process that involves transformation of service users attitudes, beliefs, opinions, abilities and roles to a point whereby life satisfaction, hope for the future and feelings of value and contribution to the community can occur (Lapsley, Nikora, & Black, 2002). Arguably acceptance of recovery models cannot be achieved by service users themselves, rather its success relies upon educating society and altering individuals’ preconceptions about mental illness (Masterson, & Owen, 2006). Further caution is given that if the advocacy of recovery models is contained within MHS alone it may lead to a power differential whereby wider health and social services are hesitant to be involved.

Recovery models are underpinned by principles of service user/carer involvement, social inclusion, person centred planning and self management (Davidson, 2005). However the experience of recovery is at odds with traditional psychiatric models of care (Wilson, 2007). McAllister (2007) concurs with Wilson (2007) that medical models utilise bio-medical treatments rather than focusing on the holistic needs which acknowledge personal strengths, abilities and capacities. McAllister (2007) further suggests that a recovery model of care enables nurses and other health care professionals to play a vital role in working therapeutically with service users as they experience and implement changes.

An outcome from this may be service users verbalising greater understanding, participation and less barriers to accessing the care they want.

Barriers such as discrimination and paternalistic attitudes clearly impact on service user involvement within current MHS (Peterson, Barnes & Duncan, 2008). Whilst mental health policy promotes service user involvement and advocates for recovery principles to underpin MHS, little study into how nurses report the effects of such in their practice has occurred. This gap in research has led to this study into nurses attitudes and perspectives of factors that affect service user involvement within mental health and addiction settings.

1.3 RESEARCH QUESTIONS AND AIMS

The research question identified is “What are the environmental and relational factors which affect service user involvement in community mental health settings from the perspectives of MHNs?”. This was then broken down into three aims of:

1. Explore how the practice environment supports service user involvement.
2. Explore how nurses include, or not, service users in the provision of care.
3. To discuss how the group of community MHNs recognise and describe service user involvement.

1.4 A REFERENCE TO TERMINOLOGY

The terminology ‘service user’ was chosen after extensive analysing and reviewing of various nursing and government literature exploring the historic unpinning of the consumer user movement and current literature outlining future directions for MHS. Amongst this literature a variety of terminology were used to identify people who utilise MHS. These are ‘consumer’, ‘client’, ‘person’, ‘patient’ and more recently ‘service user’. Given that recent literature used the terminology service user I felt it was important to use this terminology within this research.

1.5 ORGANISATION OF THE THESIS

Chapter one provides background information to this study and the current New Zealand context of recovery policy. Further, this chapter justifies the need for research into service user involvement and outlines the qualitative research question and aims of this project.

Chapter two examines literature regarding service user involvement. Historic influences such as the service user movement are presented alongside the barriers to involvement. Whilst there appears to be a number of barriers within current literature I have chosen to focus on key concepts of discrimination, stigma and paternalistic attitudes for the purpose of this research as it is a particular focus in the New Zealand literature. Literature suggests that service user involvement can counter stigma and discrimination, however there is a lack of recognition and understanding of the importance of service user involvement within mental health nursing practice.

Chapter three explores the qualitative research design utilised in this research project. The methodology and process of thematic analysis are described in depth. Following this ethical considerations and reflections of the research process are presented.

Chapter four presents data in relation to the first aim to explore how the practice environment supports service user involvement. From this discussion the first theme of relationship dynamics of practice and sub-themes of: a history of change; conflict in the caring relationship; influential attitudes; and, powerlessness is 'risky' are discussed. This chapter explores participants' attitudes and perceptions towards service user involvement through considering the relationship dynamics existing within current nursing practice.

Chapter five addresses the second and third aim of the research project. How nurses include, or not, service users in the provision of care is discussed, followed by how MHNs recognise and describe service user involvement. The second theme of strength based approaches and sub-themes of: beliefs in service user involvement; insight on recovery; working with inclusion in mind; and countering stigma are presented.

Chapter six presents discussion of the findings extracted through examination of the two themes and subsequent sub-themes. This chapter concludes with the implications of the research for nursing practice and explores avenues for further education. Service user involvement within the context of mental health settings is discussed along with reflection of the research and recommendations for nursing practice and further areas of exploration.

1.6 SUMMARY

This chapter has provided an introduction to the research project. It has also provided background information about the reasons why the topic of service user involvement is of interest to me. It has detailed the research questions and aims for the research project and given a brief synopsis of the chapters to follow. Chapter two will provide a more in-depth literature review on the topic and the themes that underpin service user involvement. Discussion regarding the barriers to service user involvement that have been gleaned from nursing literature will be outlined within this chapter.

Chapter Two: Literature Review

“Literature is where I go to explore the highest and lowest places in human society and in the human spirit, where I hope to find not absolute truth but the truth of the tale, of the imagination and of the heart.” (Salman Rushdie, cited in www.proverbia.net)

2.0 INTRODUCTION

This chapter reviews historic and current literature on service user involvement. A search of social science databases including Medline, CINAHL, Discover, EBSCO, PsychINFO, Web of Science and Google Scholar was undertaken for relevant references and literature. Key words of ‘service user involvement’, ‘recovery’, ‘social inclusion’, ‘collaboration’, ‘mental health nursing’, and ‘psychiatric nursing’ were searched to explore service user involvement as a concept within mental health related literature. Additional websites accessed were the New Zealand Ministry of Health (MoH), Mental Health Commission (MHC), Nursing Council of New Zealand (NCNZ) and Te Ao Maramatanga New Zealand College of Mental Health Nurses (NZCMHN) to gather publications about service user involvement from a New Zealand perspective. Review of these articles enabled a theoretical perspective of service user involvement within mental health nursing to be examined.

The literature review identified multiple issues that have shaped and influenced service user involvement within mental health and addiction nursing care. It became apparent that service user involvement included concepts of: historical influences; service user stories; stigma and discrimination; recovery and MHNs role. The following is an overview of these key concepts relating to service user involvement.

2.1 HISTORICAL INFLUENCES

Service user involvement evolved before and during deinstitutionalisation¹ (Rosenman, 1998; Tomes, 2006). History records the roots of service user

¹ Deinstitutionalisation – this involves replacing long-stay psychiatric wards (institutional care) to care within the community (www.merriam-webster.com).

movement stemming back to the 1620's in London where the first protest movement by 'psychiatric patients' is recorded (Connor & Wilson, 2006; Lakeman, Cook, McGown, & Walsh, 2007). Significant change occurred in the 1960's with psychiatrists Cooper, Laing, Szasz and Basaglia challenging traditional psychiatric care, whilst scholars Foucault and Goffman critically argued against traditional institutional psychiatric care (Rissmiller & Rissmiller, 2006). This reportedly led to significant change fuelled by lobbying, protest and public enquiry within MHS (Lakeman et al., 2007; Tomes, 2006).

The service user movement in the 1960's evolved due to anger towards psychiatry and institutional care (Tomes, 2006). This opposition was in part due to the practice of Electro Convulsive Therapy (ECT), major tranquilisers and the detainment of patients through the law (Hopton, 2006). The 1970's and 1980's anti-psychiatry and human rights movements are reported as catalysts for driving service user involvement through advocating for individual rights, reporting abuses and reform toward reconfiguration of psychiatric care (Lakeman et al., 2007). The 1990's saw 'recovery' visions and principles which influenced mental health service delivery throughout America, the United Kingdom and New Zealand (Gawith & Abrams, 2006). The World Health Organisation (2005) highlight user involvement as a human rights issue, the importance of service users being involved in managing their own mental health (Happell & Roper, 2007; Nestor & Galletly, 2008).

Gawith and Abrams (2006) identify the Mason Inquiry Report² (1996) as being the foundational national document that drove service user involvement movements within New Zealand and acknowledge that dissemination of this report led to establishment of the MHC with the aim to "improve mental health and addiction... services and to influence society's overall response to mental health issues" (MHC, 2011, p.1). The MHC has been fundamental in developing mental health service policy documents and establishing a new direction for the

² Mason Inquiry – inquiry into mental health services which recommended a public education campaign to reduce discrimination of mental illness (www.teara.govt.nz).

future development of MHS (MHC, 2011). Initially, in 2002 four categories of service user involvement decision making within mental health and addiction services were identified: *no involvement*; *limited involvement*; *joint decision making* and *autonomous decision making* (MHC, 2002). Currently their core functions are: advocacy; promoting and facilitating collaboration; monitoring of the mental health strategy; encouraging and supporting policy makers and funders in system development within mental health and addiction services; and research on mental health matters (MHC, 2011).

Within New Zealand the MHC (2002) viewed MHS future as service users being active participants in their treatment, planning and care. However in 2007 they report service users being involved in planning their care and treatment is mere tokenism (MHC, 2007). Research concurs through identifying user involvement as tokenistic and rhetorical with the reality being that service users campaigning for self determination have a limited impact on policy and procedures formulation (Connor & Wilson, 2006; Ion, Cowan & Lindsay, 2010). To combat this MHC in 2007b recommended staff training about social inclusion, discrimination and barriers to inclusion needed to occur if staff attitudes were to be improved. Following this Let's Get Real³ (Te Pou, 2009) outlines essential attributes for clinicians working with MHS settings. The more recent publication of Blueprint II⁴ (MHC, 2012) is driven by recovery and resiliency models of care which aims to improve accessibility and increase participation for service users by improving environments enabling MHS to be strengthened through doing “more with the funds, workforce, infrastructure and energy”(MHC, 2012, p.3). In order to achieve this Blueprint II advocates for improved interactions, communication, involvement and education within primary, secondary and non government organisation providers (MHC, 2012b).

³ Let's Get Real – framework describing essential knowledge, skills and attitudes to deliver effective MHS (www.tepou.co.nz).

⁴ Blueprint II – document providing the pathway for the future delivery of MHS (www.hdc.org.nz).

In keeping with this Doughty and Tse (2005) identified a marked increase within New Zealand of services run by and for people experiencing mental illness. A service user led organisation is defined as “a programme, project or service planned, administered, delivered, and evaluated by a service user group based on needs defined by the service user group” (Doughty & Tse, 2005, p.4). In regards to challenging discrimination and promoting recovery internationally, MHC (2004) reported New Zealand implementing social inclusion initiatives of Like Minds, Like Mine⁵, employment support, human rights, de-stigmatising campaigns, culturally sensitive programmes and legislative requirements enhances mental health outcomes. The governmental and organisational targets in place are to involve service users in the planning, implementation and delivery of care aiming toward improvement in clinical outcomes, better services and resources, and challenging discrimination (Barnes, 2011; MHC, 2011b). However, some suggest that mental health legislation negates this aim through the exertion of power and control over service users (Borg, Karlsson & Kim, 2009; Soffe, Read, & Frude, 2004).

The service user movement endeavours to highlight the valuable contribution that service users can make within treatment and disability teams and in all aspects of mental health care (Lammers & Happell, 2003). It has been found that research exploring service user participation has frequently involved discussion about user participation yet has not sought to involve service users as participants (Ion et al., 2010; Lammers & Happell, 2003). Given this, one might question the validity and reliability of such studies to inform mental health nursing practice.

2.2 SERVICE USER INVOLVEMENT

Mental health vocabulary frequently uses the terms: user involvement, participation, perspective, control and empowerment to describe service user roles in the receipt and delivery of MHS (Borg et al., 2009). Despite subtle

⁵ Like Minds, Like Mine – public education programme to reduce stigma and discrimination of mental illness (www.likeminds.org.nz).

differences in terminology these terms are often used interchangeably and frequently in discussions by researchers and clinicians. Furthermore, a lack of consistent and acceptable terminology to describe individuals who utilise MHS exists (Telford & Faulkner, 2004). For the purpose of consistency in this project the definition of service users is “individuals with mental illness who have been users of mental health services and who identify themselves as such” (Doughty and Tse, 2005, p.11).

Whilst involvement in policy by service users appears to have increased over the past few years, MHS continue to be welcome to participate “only to the extent that it serves the purposes of other better-organized stakeholders” (Tomes, 2006, p.726). Participation by service users within MHS is often dependent upon professionals and policy makers determining the terms in which they can participate (Cleary, Horsfall, Hunt, Escott & Happell, 2011; Rush, 2004). Whilst it is noted that service user groups are essential in unveiling gaps in MHS, even in countries where service user involvement is an established and embraced part of policy development, research shows service users continue to express frustration about the lack of consultation, diminished involvement and dissonance that they feel occurs in mental health and addiction nursing practice (Horrocks, Lyons & Hopley, 2010; Rush, 2004; Tomes, 2006).

The MHC (2011) argue the way forward for MHS is through increased participation of service users in service improvement and facilitating experiences from exclusion to inclusion. The MHC (2004) view service user participation as being paramount in enabling understanding about discrimination and stigma. Doughty and Tse (2005) assert that service users that engage or work within educational or support groups, demonstrate strong self-determination, proactively engage in recovery practices and establish meaningful community participation.

2.3 LEGISLATIVE INFLUENCES

Despite legislative and governmental guidelines promoting least restrictive care and recovery focused health services, literature continues to highlight that MHNs maintain paternalistic power and control over service users, through the use of coercion and alliance with the medical model (Austin, Bergum & Goldberg, 2003; Bertram & Stickley, 2005; Cutcliffe & Happell, 2009; Roberts, 2010; Rydon, 2005). In order to fully understand the power dynamics within MHN care, further analysis of influencing factors of paternalism and the medical model needs to occur.

Paternalism is identified as the use of power or authority placing restriction or limitation on the autonomy or liberty of others (Roberts, 2004). Despite governmental legislation recommending increased service user involvement and professional collaboration, mental health culture remains “steeped in a discourse of treatment and care, control and compliance and professional expertise” (Warne & Stark, 2004, p.654). It is suggested that nurses need to view user involvement in a positive manner and value the experience, rather than keeping a watchful eye over them to ensure they don’t fail (Diamond, Parkin, Morris, Bettinis & Betteworth, 2003). Thus the extent that service users participate in mental health care is dependent upon nurses’ ability to communicate with them and their family in a way that invites participation (Roberts, 2010). It is suggested that nurse’s take a lead in creating a therapeutic relationship between service users and them (Piippo & Aaltonen, 2004). Schauer, Everett, del Vecchio and Anderson (2007) argue that service user choice of interventions that suit their individual preferences increases personal understanding, satisfaction, quality of life, and promotes self-determination and recovery.

Mental health and addiction services have undergone a multitude of changes in recent years and despite this apparent change of focus of include service users in decision making, coercion within inpatient and community settings remains, particularly for those subject to compulsory treatment orders (Ion et al., 2010; Lind, Kaltiala-Heino, Suominen, Leino-Kilpi & Välimäki, 2004). Emphasis is given

to Mental Health (Compulsory Assessment and Treatment) Amendment Act (1999) (MHA) legislation enabling coercion to occur through the enforced hospitalisation and treatment of service users (Berry, Gerry, Hayward & Chandler, 2010). Mental health reforms have attempted to release clients from paternalistic control, however mental health policy has failed to promote service user autonomy through the use of compulsory treatment orders (Szasz, 2005).

Some argue long term mental illness can morally reverse the duty to care if overwhelming distress limits the service users ability to make autonomous decisions about their healthcare and proposed treatment (Doyal & Sheather, 2005). Nurses' viewing service users in a 'sick role' run the risk of transforming them to a compliant recipient of health care determined by professional control and expertise therefore creating a power imbalance (Barker, Jackson & Stevenson, 1999; Roberts, 2010).

Promotion, encouragement and support of user involvement provides an opportunity for much need change to occur within MHS as the users knowledge, expertise and experience of distress is explored. Individuals are enabled and empowered to achieve their personal understanding of recovery (Diamond et al., 2003). Schauer et al. (2007) maintain that recovery is a reality for most mental health service users if care is planned and delivered, in a collaborative manner that incorporates family and community.

2.4 SERVICE USER INVOLVEMENT

Serious mental illness can affect quality of life due to the exclusion that occurs, potentially impairing confidence, self worth, sense of identity and belonging (Verhaeghe, Bracke & Bruynooghe, 2007). Exclusion can occur on many levels, including: impaired access to employment, housing and educational and civic opportunities (Verhaeghe et al., 2007; Wahl & Aroesty-Cohen, 2010). In regards to employment Woodside, Schell and Allison-Hedges (2006) suggest people with serious mental illness have difficulty acquiring and maintaining employment with an inflated 80-92% unemployed.

Reasons for this high unemployment rate include symptomatology of the mental illness; sporadic relapse and recovery; and the financial impact of being on a government benefit. This is concerning given studies in Canada demonstrated that high numbers of service users experiencing mental illness verbalised finding employment as high on their list of needs in order to ensure they felt included in society (Woodside et al., 2006).

The Human Rights Act (1993), Equal Pay Act (1972), Parental Leave and Employment Protection Act (1987) and the Employment Relations Act (2000) within New Zealand ensure employees are punished if they engage in discriminatory or inconsistent behaviours that counteract equal opportunity principles (Human Rights Commission, 2004). However despite legislative requirements being in place, research has shown that the majority of employers pay little attention to the implementation and monitoring of equal employment opportunity policy unless they face fine or penalty for not doing so (Human Rights Commission, 2004). The reality is that employment opportunities are “less advanced than they should be. As a result, current employment outcomes for traditionally disadvantaged groups remain poor relative to overall outcomes” (Human Rights Commission, 2004, p.24). The Mental Health Foundation (MHF) of New Zealand (2004) study shows 34% of the 785 respondents believed they had been discriminated against when looking for employment and 31% being discriminated against whilst in employment.

Evidence shows that service users with serious mental illness who are employed are at significantly less risk of relapse and hospitalisation (Like Minds, Like Mine, 2007). Furthermore, employment enables service users to increase control over their lives through the provision of meaning and purpose. Employment can also increase social networks, access to resources and assist in dispelling myths about serious mental illness through enabling interaction between people to occur without diagnoses or disability.

Terminology utilised within MHS has been suggested as a factor in furthering exclusion. Categorisation and labelling of diagnostic criteria maintains psychiatry's power and restriction over service users (Cutcliffe & Happell, 2009; Mason, Caulfield, Hall & Melling, 2010). Therefore nurses critically reflecting on their communication and use of labelling mental illness, can legitimate user participation in treatment planning (Roberts, 2005).

2.5 STIGMA

Psychiatric diagnostic labels create stigma, in part due to public perceptions of dangerousness associated with them. Four dimensions of stigma include: (a) interpersonal interactions (diminished social interactions with family, friends, public and organisations, along with negative effects of medication); (b) public perceptions (stereotypes, negative media reports); (c) structural discrimination (prejudice within social, political and legal arenas); and (d) social roles (barriers to employment, relationships and parenting) (Beecher, 2009; Schulze & Angermeyer, 2003). Of concern Ross (2009) research shows service users reported stigma as their main reason for lack of engagement with MHS.

The stigma service users experience correlates to the amount of knowledge that society possesses about mental illness. This knowledge (or lack of) informs public attitudes towards people experiencing mental illness (Wallcraft et al., 2011). Additionally, experiencing stigma can affect service users psychological wellness due to internalising shame or feeling flawed for having been diagnosed as experiencing mental health illness (Hinshaw, 2005). The impact of stigma on service users is "often deleterious, and may be disabling concerning an individual's self esteem and chance of recovery" (Knight & Moloney, 2005, p.499). In contrast Bagley and King's (2005) research reported stigma as phenomenological in nature with some clients experiencing serious mental illness denying feeling stigmatised and able to rebuff or ignore stigma when it occurred. They suggest "the nature and degree of felt stigma often varied dramatically between members of a generally stigmatized group" (Bagley & King,

2005, p.345). Implying, personal coping strategies affects the ability to overcome stigma.

2.6 DISCRIMINATION

From a New Zealand perspective Peterson et al. (2008) research acknowledges that despite legislation and public awareness campaigns to reduce discrimination it remains problematic with the majority of discrimination occurring from client's friends and family. Particularly of interest is the small minority of complaints from service users experiencing serious mental illness made to the Human Rights Commission, they argue due to apprehension, especially as "fear prevents people from lodging complaints, that they would rather put up with discrimination instead of complaining in a potentially very public forum" (Peterson et al., 2008, p.23).

Masterson and Owen (2006) assert that social inclusive services that promote recovery can only exist when fair and equitable division of power occurs between service users and nurses. Entrenchment of mental health discrimination at governmental levels exists, and is evidenced by worldwide psychiatric budgets being disproportionately small in comparison to medical budgets, therefore reinforcing system discrimination to occur (Lauber and Sartorius, 2007). In collaboration, Schulze and Angermeyer's (2003) acknowledge that shortages in quality care occur due to MHS having restricted funds and being disadvantaged in allocations of health care expenditure. Others argue service user involvement is adversely affected as a direct result of financial constraints within health care settings (Rush 2004; Tomes 2006; Wand, 2011).

2.5 SERVICE USER INVOLVEMENT AND THE MENTAL HEALTH NURSING ROLE

The attitudes of health professionals and the general public towards service user involvement can be major barriers to fostering inclusion within MHS (Berry et al., 2010). Furthermore professionals' having a poor understanding of the concept of service user involvement, perceptions of limited impact and feeling threatened or distrustful of the potential benefits all contribute to scepticism to

occur (Hansen, Hatling, Lidal & Ruud, 2004; Lammers & Happell, 2003; Stromwall, Holley & Bashor, 2011; Summers, 2003). In agreement Woodhouse (2010) identifies a lack of knowledge within nursing about service user involvement in legislative and policy directives as contributing to the burden of mental illness.

Nursing practice embodies aspects of political action, clinical practice, research and education with the aim of enhancing public interest and health advancement within communities (Kagan, 2006). Nurses deliver nursing care being mindful of professional codes of conduct and ethical codes of behaviour that oversee their practice (NCNZ, 2005; NZCMHN, 2004; Wolf, 2012). MHNs are a cultural group due to “shared common meaning concerning taken-for granted knowledge about how things are understood and done” (Street, 1992 cited in Cleary, 2003, p214). Literature highlights the ambiguous nature and structure of mental health nursing philosophies, practice and theory which in part is due to the myriad of complicated roles they undertake (Lawn & Condon, 2006; Rydon, 2005; Teng, Hsiao & Chou, 2010).

Examining MHN perceptions regarding service user involvement is timely and in keeping with government initiatives advocating for increased involvement and participation by service users (MHC, 2012; Ross, 2009). Anthony and Crawford (2000, p.426) identify that a lack of research currently exists regarding nurses perceptions of service user involvement and that it is “essential that attempts are made to identify and explore factors influencing user involvement in order to effectively promote the concept within the reality of clinical practice”. They suggest that through examining MHNs perceptions of service user involvement possible barriers and hindering factors can be identified. Cody (2003) advocates for MHNs developing increased awareness of historic and current influences to advance the current practice. Promotion, encouragement and support of service user involvement in service provision provides an opportunity for much needed change to occur within mental health and addiction services as the users

knowledge, expertise and experience of confusion, distress and social exclusion is explored.

A role of community MHS is to assist client's integration into the community in an inclusive manner through enabling "consumers to become independent, effectively manage their illness, and participate in community life" (Lemaire & Mallik, 2005, p.125). It is argued that community MHNs have considerable autonomy within their roles which is deemed as vital to cope with professional, legislative, administrative and managerial demands they need to undertake (Hannigan & Allen, 2010). A New Zealand study of MHNs identified essential skills as: being professional; optimistic; respectful; partnership focused and containing personal and practical knowledge and skills about mental health and service user involvement (Happell, Palmer & Tennent, 2011). In a broader sense, mental health clinicians' need to appreciate and incorporate clients rights including acknowledging self determination and autonomy, ensuring informed consent and ensuring service users have the right to refuse treatment (Read, 2003). Nurses can facilitate recovery and promote social inclusion by assisting people to identify and overcome barriers that exist through the formulation of "supportive environments that facilitate integration and acceptance" (Russell, & Lloyd, 2004, p.272).

The attitudes and behaviours of MHNs towards services users can impact on treatment outcomes and quality of life experiences (Wahl & Aroesty-Cohen, 2010). New Zealand research clearly identifies service users reporting MHNs "should be professional, convey hope, know and respect the client, work alongside the client, privilege human quality and be able to connect with clients (Happell et al., 2011, p.903). However MHN overexposure to service users maladaptive behaviours and problems can lead to feelings of burn out and stress which affects their ability to form collaborative relationships (Van Dusseldorp et al., 2010). Through nurses acknowledging how their personal anxieties and stress levels impact within their professional relationship they can "become facilitative rather than directive in nature, hope inspiring rather than pessimistic,

and autonomy enhancing rather than paternalistic” (Cleary & Dowling, 2009, p.540). Therefore it is vital for MHNs to reflect on how their personal attitudes, assumptions and beliefs impact on service user experiences within MHS (Roberts, 2010). Literature identifies barriers such as time and resource constraints leaving nurses feeling unsupported and isolated, lacking trust, feeling overwhelmed and questioning their ability to care (Cleary et al., 2011b; Hurley, 2009; Loukidou, Loannidi & Kalokerinou-Anagnostopoulou, 2010; Thomas 2003).

2.6 SOCIAL INCLUSION AND THE WAY FORWARD

Social inclusion is a fundamental aspect of recovery which aims to ensure that mental health service users not only live within communities but are part of communities (Mental Health Commission, 2007b). Social inclusion is neither a treatment nor an intervention, it is ideals and beliefs that enlighten cultures, policies and practice. The promotion of social inclusion should be of prime concern to MHNs and is demonstrated through information and knowledge sharing, viewing all options, service user freedom and self determination over health care decisions (Stickley, 2005). Bradshaw, Armour and Roseborough (2007) identify the foundation for social inclusion being: addressing issues of accommodation; employment; education; and, a sense of belonging. Further acknowledged is how supportive people who promote hope, encouragement and opportunities are essential to ensure social inclusion and service user recovery occurs.

The MHC (2012b) view the way forward for MHS as being through utilising a person centred approach whereby responses are tailored to meet service user needs rather than service provider driven. They suggest that through the tenacity of resiliency approaches, service user personal power and social inclusion can occur. In conjunction, recovery philosophies enable “hope, self determination, full citizen participation and a broad range of services and resources for people with mental disorders” (MHC, 2012b, p.11). Mental health service user organisations and their participation are paramount in furthering recovery approaches by enabling understanding about discrimination and stigma

that mental health service users experience (MHC, 2004). Furthermore research shows that service users that engage or work within treatment services or support groups, demonstrated strong self-determination, proactively engaged in recovery practices and established meaningful community participation (Doughty & Tse, 2005). The future of service user participation should involve people across the spectrum of society.

Mental Health disorders can occur at an early age which negatively affects young people's ability to productively engage within society (McInnis & Merajver, 2011). School environments are identified as fundamental areas in which to promote mental health awareness (Kidger, Donovan, Biddle, Campbell & Gunnell, 2009). New Zealand research identifies that schools are failing to address issues such as bullying which contributes to anxiety, depression and poor mental health, therefore it is vital that mental health programmes be introduced at an early age (Cushman, Clelland & Hornby, 2011). It has been proven that mental health promotion lessens relational difficulties, increases functioning, improves behaviour and lessens positions young people to be more able to cope with development stress (Walter et al., 2011).

In conclusion, Horsfall (2003, p.381) asserts: "A truly mature mental health system would be one in which it is taken for granted that consumers/survivors are included and actively involved at all levels of mental health service delivery." Given that service user involvement is outlined as a key direction to MHS, the ambiguity and uncertainty that exists about service user involvement needs to be addressed. Service users have a vital role in formulating, implementing and directing their own recovery. Nurses need to embrace this challenge and work in partnership and shift the nursing culture from one where decisions are based on professional values to one that supports, encourages and incorporates service user values (Tee et al., 2007). Service users being seen as experts in managing their own care can occur. Read (2003, p.1) reiterates this point by stating:

"Living well with mental illness involves service users finding their own definitions of living well, and then making the decision to respond and

work towards what is important to them: psychological, spiritual, intellectual, emotional, physical, and cultural well-being. Thus, living well can bring emancipation.”

2.7 SUMMARY

Literature highlights a lack of a definitive definition of service user involvement which results in health professionals continuing to exclude service users in their own care and in the provision of service planning. The term service user is multi faceted and incorporates a number of concepts including involvement, empowerment, participation, control and perspective. The literature details how historic influences, the medical model and discriminatory attitudes have shaped and guided current service user involvement initiatives. Literature suggests current barriers to effective service user involvement and identifies that effective service user involvement can occur when mental health nursing care is delivered in an inclusive, collaborative and recovery orientated approach.

The next chapter examines the qualitative methodology approach utilised in this project to explore MHNs perspectives of environmental and relational factors affecting service user involvement. Chapter three offers an explanation of the selective method, recruitment, data collection and analysis process, as well as exploring ethical considerations, reflexivity and soundness of the research.

Chapter Three: Research Design and Method

To do research is always to question the way we experience the world, to want to know the world in which we live as human beings (van Manen, 1990 cited in Tappen, 2011, p.46)

3.0 INTRODUCTION

The purpose of undertaking this qualitative study was to explore what environmental and relational factors affect service user involvement from the perspectives of community mental health nurses working in mental health settings. In this chapter the qualitative methodology chosen is outlined along with an explanation of the selected method. Next participant selection and the data collection process is discussed. Following this the process of thematic analysis is outlined along with ethical considerations and reflexivity in this project.

3.1 QUALITATIVE METHODOLOGY

Data gathered for qualitative research usually derives from analysis of text, rather than numbers. Qualitative researchers focus on society's comprehension of a subject, and they are interested in participants' perspectives of their lived reality (Flick, 2007). Qualitative research produces descriptive data in the form of written and/or oral language and visible behaviour (Taylor & Bogdan, 1998). All qualitative research approaches share a similar goal "in that they seek to arrive at an understanding of a particular phenomenon from the perspective of those experiencing the phenomenon" (Woodgate, 2000 as cited in Speziale & Carpenter, 2007, p.23). Understanding how the social world impacts on the reality of individuals is vital when developing science. Qualitative research provides opportunities for in depth analysis to occur through "finding answers to questions centred on social experience, how it is created and how it gives meaning to human life (Denzin & Lincoln, 1994 as cited in Speziale et al., 2011, p.4).

Crossan (2003) identifies qualitative research varying from quantitative research due to its naturalistic and holistic approach and the great deal of researcher involvement that is required. The nature of qualitative research is post-positivistic whereby “reality is not a rigid thing...it is a creation of those individuals involved in the research...its composition is influenced by its context, and many constructions of reality are therefore possible” (p.52). In agreement Blaxter, Hughes and Tight (1996) emphasise that qualitative research focuses on non-numeric data collection and the analysis is focused on depth, rather than breadth, of research. Thus, qualitative approaches in data collection involve viewing the world as “variable, fluid, and changing over time and place” (Cutcliffe & Goward, 2000, p.591). Bailey (1997) suggests that qualitative researchers’ ability to view reality through a socially constructed lens enables meaning and the creation of further questions regarding the topics under investigation.

In addition, qualitative research examines individual beliefs and values in an attempt to create research which is from participants’ perspectives, rather than the researchers’ (Carr, 1994). The contextual examination of phenomena through participant and researcher involvement enables theory identification to occur (Corner, 1991). Schultz and Cobb-Stevens (2004, p.221) suggest that the process of qualitative research is both an art and a science, whereby “researchers take a presuppositionless stance at the outset of the study to allow the more abstract, non-independent ‘moments’ of concern to present themselves”. The flexibility and situated nature of qualitative research enables issues and topics to develop in line with the experiences and values of those involved (Carr, 1994).

Qualitative designs synchronise effectively with mental health nursing due to both being viewed as involving interpersonal relationships through the sharing of stories and listening (Foster, McAllister, & O’Brien, 2006). Cutcliffe and Goward (2000) agree that the uniqueness of mental health nursing lies within the collaboration and closeness between the nurse and service user as equal participants in the therapeutic and interpersonal alliance. Harper & Thompson

(2012, p.3) identify that many of the competencies of mental health nurses are able to be transferred to the research setting due to mental health nurses innate ability for “‘collecting data’ and ‘making sense of’ peoples’ complex and rich personal histories and experiences in order to deliver care and support”. Further suggested is that the use of qualitative designs in mental health nursing research enables enhancement of mental health practice to occur. Given that ambiguity continues to exist about the concepts of mental health and illness, Cutcliffe and Goward (2000) suggest that qualitative paradigms are closely aligned to mental health nursing philosophies and highlight viewing the interpersonal world of the service user enables further areas for mental health nursing inquiry can emerge.

The lived experience of recovery more suitably aligns to a qualitative approach enabling the researcher to capture thoughts, beliefs and experiences of those being interviewed (Cutcliffe & Goward, 2000). The post-positivistic approach that qualitative inquiry offers enables greater flexibility and is guided through incorporating and acknowledging social issues such as culture, gender, attitudes, beliefs, behaviours, socio-cultural issues and external issues (Crossan, 2003). Qualitative researchers view the world they are examining as unique, changeable and consisting of multiple realities in that “what might be the truth for one person or cultural group may not be the “truth” for another” (O’Leary, 2006 cited in MacKenzie and Knipe (2006, p.3). Therefore, a qualitative research approach is suited to explore the concepts under investigation in this study, such as nursing attitudes and beliefs about service user involvement.

3.2 METHODOLOGY

Methodology is a two-fold approach which examines “the collection of methods or rules by which a particular piece of research is undertaken” and the “principles, theories and values that underpin a particular approach to research” (Somekh & Lewin, 2005, cited in MacKenzie & Knipe, 2006, p.5). Methodology refers to the decisions made about the phenomena under investigation including the data collection and analysis undertaken in the research (Silverman, 2001).

An interpretivist approach enables researchers to “explore the different ways in which people experience and understand their world and their relationship with others and their environment” (Maltby, 2010, p.68). The theoretical viewpoint of interpretism is based on individuals’ behaviours. These behaviours, in turn, are determined by their experiences from interacting with those phenomena. Human beings interpret and attach meanings to different ideas and actions, therefore new experiences are constructed during interaction with certain phenomena (Dash, 2005). The interpretivist researcher relies on participant viewpoints of the issue being studied and recognises the potential bias their own background and experiences could bring to the research (MacKenzie & Knipe, 2006). Through the researcher developing empathetic understanding of individuals’ interpretations towards the phenomena (under review), a deeper understanding of the feelings, motives and thoughts behind the actions of others can be examined (Dash, 2005).

An interpretive approach enables the researcher to be open to ideas emerging from verbal discussion and observation of participants, as well as enabling introspection about personal pre-conceptions and ideas to occur (Maltby, 2010). The process of inductive reasoning “starts with the details of the experience and moves to a more general picture of the phenomenon of interest” (Liehr & Smith, 2002 cited in Speziale et al., 2011, p.10).

My aim, during this research was to investigate the opinions and beliefs towards service user involvement of nurses working within the mental health arena. I sought to explore how nurses ascertain and describe what service user involvement is and if any environmental and/or professional issues impact on service user involvement at a professional and/or organisational level.

3.3 INTERVIEWS

Interviews are commonly utilised in qualitative research and include data being collected through conversation involving open and/or closed questions, with individuals or within a group (Hek, Judd & Moule, 1996). The researcher’s

primary aim “is to generate data which give an authentic insight into people’s experiences” (Miller & Glassner, 1997 as cited in Silverman, 2004, p.126).

Dilley (2004) suggests qualitative interviewing involves three factors, these being: understanding (participants using their own words to relay their lived experience); interviewing (obligations and interpersonal relationship between interviewer/ee); and, philosophy (identifying ethical issues, reviewing interviewing relationship, research quality, standards and research accuracy). Further suggested is that interviews enable researchers to not only critically investigate participant’s beliefs and experiences in order to gain understanding but also to gain insight into their own (Dilley, 2004).

Minichiello, Sullivan, Greenwood & Axford (2004) informs that qualitative in-depth interviews are often unstructured due to the data gathered guiding the direction and questions that the researcher undertakes. The questioning of issues which may arise during the interview process allow rich data (that may not otherwise be obtained through questionnaires and/or observation) to be attained (Blaxter et al., 1996). From the conversational focus that qualitative interviews allow, participants can feel encouraged to disclose richer and deeper information regarding their experiences to the researcher (Roberts & Taylor, 2002).

3.4 THEMATIC ANALYSIS METHOD

Thematic analysis enables researchers to expose varying viewpoints of interest from the participants (Speziale et al., 2011). A theme is defined as “an abstract entity that brings meaning identity to a recurrent experience and its variant manifestations”, therefore capturing and unifying experiences to a consequential whole (Speziale et al., 2011, p.46). The uncovering of patterns from participants accounts of their experiences involves theme analysis of recurring patterns (McLeod, 2011). Braun and Clarke (2006, as cited in McLeod, 2011, p.146) see thematic analysis as being the foundation for qualitative analysis as it “fulfils most of the functions of grounded theory and other methods of analysing the

meaning of interview transcripts, but with a minimum of theoretical baggage". Thematic analysis enables discernible themes of a more hidden and inferred nature to be identified (Harper & Thompson, 2012).

3.5 METHOD

Specific research techniques are called methods (Silverman, 2001). Method refers to the systematic modes, procedures or tools used for the collection and analysis of data (MacKenzie & Knipe, 2006). The following describes how participants were selected and how the data was collected and analysed. The first step in exploring the research question is to determine who will comprise of the participant sample.

3.6 SAMPLING

Sampling involves identifying the research participants to be involved in the study. Qualitative research participants are identified due to their personal experience of the phenomena under investigation (Flick, 2007). This is called purposive sampling. Purposive sampling occurs when participants are specifically chosen because they share common traits that the researcher wishes to explore more in depth (Maltby, 2010). Parahoo (2006) identifies that purposive sampling is frequently used in qualitative studies with the size and selection being determined at the onset of the study.

This study aimed to recruit 8 -10 Registered Nurses who were employed in adult community mental health and/or addiction settings. Two New Zealand District Health Boards were approached and both gave permission for recruitment within their organisations. The sample group comprised of 8 participants.

3.7 ETHICAL ISSUES

Ethical approval for the research project was gained from Central Ethics Committee (Appendix F). Additionally the two DHB's gave approval for me to recruit community mental health and addiction nurses within their organisations. The Massey University Code of Ethical Conduct for Research and Teaching Involving Human Subjects (Massey University, 2010) guided the research process. This code sets out eight major principles to ensure research procedures are appropriate to research participants. These principles are:

Respect for Persons – This principle involves recognition participant's individual dignity, autonomy, beliefs, culture and privacy. This principle ensures participants have the right to participate or withdrawal in the research project. This principle was upheld in the research project by participants approaching the researcher and requesting to be part of the research (Appendix A). Participants were educated about the consent procedure verbally and then given the option of signing the consent form if they wished to continue to participate in the research (Appendix B; Appendix C). The participants identified a suitable interview time and were advised they could withdraw from the research project at any time. Following the transcribing of the interviews, participants were offered a copy of the transcribed notes to peruse and were asked if they wanted to continue participating in the research project (Appendix D).

Minimisation of Risk of Harm – this principle ensures no risk of harm to participants occurs. It ensures researchers make every attempt to identify and minimise harm to research participants occurring. Minimisation of harm also includes risk of harm to Maori through their inclusion in the research process. I ensured I took every effort to avoid harm of a spiritual and psychological nature occurring to research participants. This included ensuring participants were advised that the tape recorder could be switched off at any point should any issue discussed raised concerns for them. I ensured participants were aware of the Employee Assisted Programme that provides counselling within their DHB and also discussed with them the use of internal supervision if the research

project raised any concerns for them. All participants were informed of the right to refuse to answer any question if they felt the question caused them distress. The possibility of unsafe practice being discussed during the interviews was captured in the consent sheet whereby mention was made that such disclosures would need to be referred to the Clinical Manager and my Research Supervisor. No such disclosure was evident in the research questions. Prior to the research being undertaken I met with Maori Mental Health staff to discuss the research proposal and to identify if any cultural issues were raised. Flyers inviting participation in the research were also sent to Maori Mental Health Community Teams.

No risk of harm to researcher occurred through me ensuring my private address was not listed on research proposal flyers and giving my mobile telephone number on all correspondence. All interviews were undertaken within the DHB's offices during day time hours (following approval from the DHB's to undertake the research on DHB premises).

Informed and Voluntary Consent – this principle ensure all participation in research is done so in a voluntary manner and done so after with a full understanding about what participation will involve. This principle ensures participant consent is obtained of a verbal or written nature prior to the research commencing, no pressure for participation is given, and that participants have the option to withdraw from the research at any time. All participants in the research contacted me requesting to participate in the research following my dissemination of recruitment posters and the information sheet. Participants contacted me either via email or telephone indicating their willingness to participate in the study. A copy of the information sheet, consent form and semi-structured questions was sent to them via the post prior to setting up an interview time. This allowed them to make an informed decision of whether to participate in the research prior to me contacting them to arrange an interview time. A mutually agreeable interview time and date was set up and prior to the interview commencing a discussion regarding informed consent occurred.

Written consent was obtained from each participant prior to the interview commencing (Appendix C). Participants were sent a copy of the transcribed notes to check for authenticity.

Respect for Privacy and Confidentiality – this principle ensures the privacy of participants, communities, organisations, ethnicities and minorities is respected and that no identification of participants can occur without their consent. All interviews occurred in the participants' homes in a private and quiet location. All participants were given a letter of the alphabet as a pseudonym to conceal their identity and provide anonymity and confidentiality. All information gathered was safely stored and managed in the strictest confidence. My supervisor and I were the only people to have access to the transcription equipment, tapes and transcribed notes. The tapes, consent form, transcriptions and field notes will be stored in a secure manner for five years and then disposed of.

Avoidance of Unnecessary Deception – this principle ensures no deception of participants occurs as this is in conflict with informed consent. This principle ensures that any withholding of information for the purpose of the research is clearly identified and discussed with research participants. This research was not deceptive or covert. All aspects of the research were outlined to the Central Ethics Committee and participants of the research. Participants were aware that tapes and transcriptions were being held for a period of 5 years for audit purposes. All correspondence and discussions with participants was done so in an honest and truthful manner.

Avoidance of Conflict of Role/Interest – this principle ensures researchers do not put themselves in a position where their research conflicts with their position in society. Researchers must ensure they are not put in a position of power over participants or declare if they have any financial interest in the project. No power differential existed between the participants and me. Although

I do work for the same institution as the participants, no power differential existed nor do I have any financial interest in the outcome of the research.

Social and Cultural Sensitivity – this principle ensures cultural diversity to Maori and incorporation of the Treaty of Waitangi principles are maintained in the research and that the researcher anticipates any consequences of the research finding on indigenous people and ethnic groups. Respect for participants' social and cultural needs was maintained at all times. Whilst this research study was not specifically targeted for Maori, it is acknowledged that a number of service users within mental health services are of Maori descent. Prior to the recruitment posters being distributed I met with Maori Mental Health Clinicians to discuss the research proposal, the aims and the semi-structured questions to ensure cultural sensitivity was maintained and my research was in keeping with Treaty of Waitangi principles. Nurses from all cultures were invited to participate in the research. Ethnicity of the participants for the research is not discussed therefore maintaining anonymity and confidentiality.

The principles of the Treaty of Waitangi are incorporated in all stages of the research. The researcher and the participant entered in to partnership. The partnership was protected by the researcher and the participant retaining rights, values and confidentiality through the informed consent process. Participation was open to all nurses that met the inclusion criteria outlined in the recruitment poster and information was disseminated to participants prior and post interviews to ensure they were fully informed and included.

Justice – this principle ensures fair distribution of benefits and burdens within the researched population. Justice ensures that no neglect or discrimination occurs to those who may benefit from the research and ensures that research is undertaken with the intention to benefit those whom participate in the research. For this research justice was maintained through allowing any one within the inclusion criteria to participate. Recruiting within the two DHB's enabled variation within the research results to occur. Through ensuring the same semi

structured questions were asked in each interview reliability and equality was achieved. The Central Ethics Committee approved the research as being ethically sound.

3.8 THE PARTICIPANTS

The participants had varied life and professional experiences. All participants were over the age of 30 years and had worked in the area of mental health nursing for 5+ years. The areas that the participants worked in included: adult community mental health, adult alcohol and other drug, service delivery and assertive outreach⁶.

The interview comprised of semi-structured questions which had been prepared prior to the interview occurring (Appendix E). The questions were consistent in all the interviews undertaken. Semi-structured interview questions allowed for flexibility within the interview as well as providing the opportunity for participants to fully describe their experiences (Speziale et al., 2011).

Each interview lasted approximately 1-1½ hours in duration and all interviews were audio taped. Consent for audio taping was also obtained prior to the interview commencing (Appendix C). Tapes were transcribed verbatim by me. Once completed the written transcript was sent to the participants to check for authenticity.

I keep field notes which were taken at each interview outlining areas of interest that emerged for me along with my thoughts and feelings. My research supervisor provided the opportunity for me to discuss and reflect upon any issues that arose subsequent to the interviews occurring.

⁶ Assertive outreach services support service users in the community who find it difficult to maintain contact with mental health services.

3.9 DATA ANALYSIS

Utilising a thematic analysis approach, concurrent data collection and analysis occurred until no new themes emerged from interviews. Following the interviews and collection of data I utilised Attride-Stirling's (2001) six step thematic analysis. These were:

Step 1: Coding the material. This aims to condense the data into controllable and consequential sections through using a coding framework. A coding framework is attained based on the conjectural interest which guides the research questions and the significant issues that arise within the research. Following on from this framework is the dissection of text data to text segments whereby codes are assigned to the data gathered from the interviews. I immersed myself in the data both as I was transcribing and reading and then later re-reading of the transcripts.

Step 2: Identifying themes. This refers to extracting themes from the coded text segments that have been identified in Step 1. Through extracting salient and common themes and re-framing of the text, the identification of underlying structures and patterns occurred. Further refinement of themes enabled further reduction of the text to a manageable set of themes to concisely summarise the text.

Step 3: Constructing the networks. This involved arranging the themes and assembling them into two major themes to formulate the thematic networks, or sub-themes.

Step 4: Describe and explore the thematic networks. This allows a further level of abstraction to occur through describing and exploring the text segments within the networks to explore any underlying patterns that appear. Step 4 is vital in bringing the data, interpretation and analysis together in preparation to present to the audience.

Step 5: Summarising the thematic network. Following full description and exploration of the network in Step 4, Step 5 presents a summary of main themes and patterns. The objective being to summarise principal themes that emerge from the network and identifying emerging patterns.

Step 6: Interpret patterns. This is the bringing together of summaries of all networks identified. The aim being to return to the original research question and utilise the patterns emerging within the exploration of the text to address them.

3.10 SOUNDNESS OF THE RESEARCH

Whilst qualitative studies are viewed as compatible and applicable with nursing practice and goals, criticism regarding the qualitative studies rigour continues to exist (Priest & Traynor, 2006; Roberts, Ryan-Nicholls & Will, 2009). In order to demonstrate credibility within qualitative research Fereday and Muir-Cochrane (2006) recommend clear identification of evidence pathways be shown. In addition, Jootun, McGhee and Marland (2009) describes reflexivity as being fundamental in qualitative research through ensuring examination of research data to determine if any intentional or unintentional influences of the researcher exist that may impact on the findings. In agreeance, Sandelowski (1993) argues that qualitative research validity occurs through 'trustworthiness' being demonstrated throughout the research process, as 'trustworthiness' is evidenced through the researcher outlining the decision making process undertaken leading to auditable findings. Trustworthiness was achieved throughout this research project through the accurate recounting of participants narratives. The rich and diverse narratives of participants along with the vast nursing literature accessed to complement their stories all contribute to the research project and inform the findings. This projects value will be dependent on nurses, managers and providers perceptions of its usefulness and applicability within their current practice environments. It is hoped this research will facilitate reflection on personal attitudes and beliefs towards service user involvement through

acknowledgement of any environmental and relational factors affecting its implementation.

It is acknowledged that this research offers a snapshot of the environmental and relational factors impacting on service user involvement from the realities of the participants interviewed and offers a starting point for further research to expand on. Throughout this research project, examination of my values, beliefs, conduct, and presence and those of the participants interviewed and how they may influence the research has occurred in order to ensure credibility. In order to critique this research through qualitative means I have utilised Sandelwoski's (1986, cited in Rolfe, 2006) four concepts of trustworthiness which aim to ensure the research is auditable. These being: credibility, dependability, transferability and conformability.

Credibility

Credibility is achieved through the 'fit' between participant's viewpoints and the researchers understanding and account of them (Tobin & Begley, 2004). Ryan-Nicholls and Will (2009, p.76) identify that measuring credibility ensures "'truth' of the ethnographic account is assessed in terms of the researcher's reflection on the research process and the participants' ability to recognise their experience in the research account." This project maintained credibility through returning participants receiving copies of their transcribed narratives to check for accuracy. Participants were given the opportunity to confirm accuracy of their transcripts by notifying me if alterations were required. Accurate and verbatim data outlining participants' narratives is included in chapter four and five in conjunction with nursing literature outlining national and international findings in regards to factors affecting service user involvement.

Authenticity

The strength of this research lies in it being a situated investigation of the participants' perceptions and attitudes towards service user involvement within their area of practice. The data allows the authenticity and veracity of

participant's dialogues to be explored and their thoughts and awareness towards service user involvement to be made known. Whilst every effort was made by the researcher to remain objective and impartial, it must be acknowledged that this research is influenced by my own perception of service user involvement and my understandings as a MHN. Potentially also having bearing on the research was the professional relationships I had with the participants in my role as colleague prior to the research. This prior relationship potentially may have strengthened the research allowing more open and frank discussion as participants verbalised feeling comfort and ease in undertaking research with an individual they knew.

Dependability

Dependability involves the researcher demonstrating an auditing process that ensures the research process is clearly documented in a logical and observable manner (Tobin & Begley, 2004). Graneheim and Lundman (2004, p.110) expand on dependability to include "the degree to which data change over time and alterations made in the researcher's decisions during the analysis process". Consent approval was obtained from the Central Ethics Committee prior to the research project beginning. The interviews were all audio taped and undertaken by me and ensures dependability. All transcription and checking for accuracy of the interviews was undertaken by myself. All interviews were undertaken using the same semi-structured questions.

Conformability

Conformability enables objectivity to occur through ensuring all data and research findings are derived from the data and not from the researcher's perceptions and/or imagination (Tobin & Begley, 2004). Conformability is evidenced through my utilisation of Attride-Stirling's (2001) six step thematic framework which enabled a logical process for data collection and analysis to occur. My supervisor reviewed the transcripts and identified her viewpoint of the themes that arose. My understanding of the themes and hers were then

discussed and common themes were identified. Field notes were written after the interviews which contributed to the decision making process.

3.11 SUMMARY

This chapter has explored the qualitative methodology and method undertaken to explore the research question. This exploratory qualitative research project was undertaken using a thematic analysis approach to view the data. The justification for using this methodology and method has been discussed, including the presentation of ethical issues, data collection, and research soundness.

In the next chapter I present the participant data and provide discussion concerning the first theme of which arose from the data analysis. The first major theme and subsequent subthemes is derived from participants experiences and understanding of service user involvement. The theme of **environmental dynamics of practice** explores how the practice environment supports service involvement through the examination of environmental and relational factors impacting on service user involvement within nursing.

Chapter Four: Environmental Dynamics of Practice

“The real voyage of discovery consists not in seeking new landscapes but in having new eyes” (Marcel Proust, cited in Stuart, 2012, p.360)

4.0 INTRODUCTION

In this chapter I focus on the first aim of the research project. The first aim of this project was to explore role and relationship dynamics affecting MHNs practice. Nurses’ narratives are presented in conjunction with relevant research which addresses the primary aim of this research project. The primary focus being examining the environmental and relational factors affecting service user involvement from the perspectives of nurses working in community mental health settings.

In this chapter the current environmental and relational factors that impact on service user involvement are explored. From this, the four sub-themes identified were: context of the service user and nursing environment; ideology and service user positioning; attitudes and paternalism. The first sub-theme of ‘context of the service user and nursing environment’ examines the historic and legislative influences identified in participants’ narratives that have guided their view of service user involvement movement and nursing practice. The second sub-theme ‘ideology and service user positioning’ explores power dynamics identified by participants as they exist within their nursing practice and the relationship of these dynamics to service user involvement. The third sub-theme ‘attitudes’ examines participants’ viewpoints of the attitudinal factors deemed as necessary to work in mental health and addiction settings and explores the impact of these attitudes on service user involvement. The last sub-theme of ‘paternalism’ examines participant’s viewpoints of paternalistic practices within nursing.

4.1 CONTEXT OF THE SERVICE USER AND NURSING ENVIRONMENT

Significant change has occurred within MHS delivery as a result of lobbying, protest and public enquiry. The 1970's and 1980's anti-psychiatry and human rights movements are reported as catalysts for driving service user involvement through advocating for reform and radical reconfiguration of MHS (Lakeman et al., 2007). The 1990's brought about recovery vision and principles which developed and influenced MHS delivery throughout America, the United Kingdom and New Zealand with literature citing the 2000's as heading towards a socially inclusive MHS (Gawith & Adams, 2006).

The establishment of the New Zealand MHC in 1996 aimed to increase support and access to MHS with the purpose of developing and implementing mental health guidelines and service models to drive future mental health care delivery (MHC, 2011). The most recent guideline '*Te Hononga 2015*' (MHC, 2007) reports by 2015 New Zealand society will be inclusive and value the diversity and potential in all people to generate a shift in attitudes towards mental health whereby "rights are upheld, stigma and discrimination are rare, and exclusion is unacceptable" (MHC, 2007, p.13). Therefore implying increasing knowledge and attitudes towards mental health within society can promote service user inclusion.

Participants in this project had a varied understanding of available legislation and guidelines that guided New Zealand MHS. However, they acknowledged literature about service user involvement existing internationally but suggested national literature as lacking. Participants identified the MHC as a point of reference to specific service user involvement guidelines but cited time constraints, unachievable goals and feelings of invalidation towards their contribution as limiting their interest and impacting on their learning.

As one participant suggested, the length of documents and who was involved in writing them made a difference, she said:

...I went to the commission...they weren't interested, so I'm not. I haven't read much of their stuff. For one thing it's long winded, its verbose and it says nothing...To engage my interest, you've got to be honest, you've got to make good reading and you've got to have a goal...They might have a goal but it's that long, or the goal is unrealistic...They want us to achieve the unachievable and I think that puts a lot of pressure on the mangers up there because in turn it flows down to us, so I'm not a fan I'm afraid. I, um, find them wrong and just verbose. (Participant Green, p.13).

Another participant cited a top-down push of ideas, which for them, meant a loss of interest, he stated:

...It's not obvious...stuff comes through and I think move on, they post far too much stuff, you know, and you think I can't, I'm not going to read through all that seriously. You know focus on one really important or two really important things but don't try to change everything all at the same time. (Participant Pink, p.12).

Some suggest health professionals having a poor understanding of the concept of service user involvement, that their input has little impact and feeling threatened or distrustful of the potential benefits which contribute to scepticism on the concept (Happell, 2009; Summers, 2003). Nurses' lack of knowledge regarding service user involvement policy potentially contributes to the continuation of mental illness due to a lack of visibility, voice and credibility within communities which impedes implementation and promotion of service user inclusion in practice (Woodhouse, 2001).

Whilst policy development has increased over the past few years (MHC, 2012; Te Pou, 2009), MHS continue to be under funded and fragmented leaving service user involvement dependent upon the professionals running services to determine the terms in which they can participate. Financial implications cause constraints on service user involvement through adversely affecting service user

outcomes and mental health care delivery (Butcher, 2012; Rush, 2004; Tomes, 2006). Schulze and Angermeyer (2003) suggest shortages of quality mental health care exist due to services having restricted funds which disadvantage the allocation of health care expenditure. Whilst the MOH policy states the need to provide for service user consultation and involvement, participants reported the contrary. One nurse stated:

...the buck can only go so far...it will just decrease they will find it harder to function...I think a cold hard light of day is that there isn't going to be the buck as there use to be...we have been asked to tighten our belts...I think we have to find the place to carry on and do that work without having all those bucks around (Participant Yellow, p.12).

Furthermore, another participant suggested continued restructuring diverts resources from intended policy, as summarised here:

...when we have a change in government often we have a slash and burn occur and management is changed...nursing staff or community staff are getting more stretched and stressed...and it's like less quality time that the service user has with the clinician, so it puts back the recovery time (Participant White, p.6).

Additionally, limited finances and resources are identified as a hindering factor:

...Basically it comes down to finances and lack of resources...I personally think that they are cost cutting in all the wrong places and I find it extremely frustrating and infuriating when I see blatant wastage in other areas (Participant Violet, p.9).

Alternatively another suggested that prioritising funding toward non-MHS provision overrides the policy:

...I think there needs to be an alignment so we can provide the best possible service for our clients...you know we've only got 50,000 dollars to spend and we need a new incubator for the neo natal unit or we need to...pay...for a group of clients to become involved in MHS development...I know what the

money's going to be spent on, it's not going to be spent on the clients (Participant Pink, p.9).

Time and resource constraints leave health professionals questioning what client care they are required to deliver, and “like the character in the fairy tale Rumpelstiltskin who was put in a room full of straw every night and told to produce gold” (Thomas, 2003, p.6). Global studies concur that psychiatric budgets are disproportionately small when compared to non-psychiatric budgets (Butcher, 2012; Lauber & Sartorius, 2007). Inadequacies lay in part, with health care institutions experiencing dramatic changes in health care delivery, for example, structural changes, nursing position consolidation and decreased staffing levels and these “competitive and pressured organisations, set the stage for structural imbalances of power” (DeBel, 2003, p.2). There is increased concern that MHS are unable to meet the current demands of new policy initiatives due to disparities between national ‘growth in demand’ and ‘supply of MHS’ due to constraints in workforce and resources. Particularly concerning is the reduction in public expenditure within the current political environment which has meant the revenue for the MHC for 2011/2012 is 25% less (MHC, 2011). This has caused the Commission to reduce staff numbers and projects planned which impacts on the implementation service user involvement guidelines (MHC, 2011, p.1).

Whilst service user groups have been identified as being instrumental in identifying gaps within mental health care, research continues to show they express frustration about the lack of consultation, diminished involvement and dissonance (Borg et al., 2009; Nestor & Galletly, 2008; Tomes, 2006). The organisation leading promotion of service user involvement identifies service users’ participation and planning of their care and treatment is mere tokenism within New Zealand culture (MHC, 2007). Of the same opinion, participants in this project cited tokenism towards service user involvement initiatives. One said:

...they [the organisation] continue to receive funding from the Ministry of Health because they've ticked their box...I don't think it's actually about the welfare of the consumer at all...its lip service (Participant Orange, p.20).

Tokenism of service user involvement in MHS exists due to the political correctness driven by bureaucratic requirements (Nestor & Galletly, 2008). Little improvement to service user involvement occurs through tokenistic acts in some organisations, as “professionals can congratulate themselves on being seen to have done their bit in terms of user involvement” (Ion, Cowan & Lindsay, 2010, p.5). Whilst service user inclusion talk is frequently mentioned, research shows that user involvement is tokenistic and rhetorical and the reality is that service users who campaign for self determination have a limited impact on policy and procedure formulation (Borg et al., 2009; Connor & Wilson, 2006; Stromwall et al., 2011).

Jervis (2002) identifies a foundational pyramid shaped hierarchical structure in healthcare settings as contributing to tokenism, with small numbers of individuals existing at the top in managerial positions of power, and large numbers of workers lying at the bottom undertaking the work. Jervis (p.14) define this as “You’ve got your royalty, you minor nobility, and your peasants. Everybody is trying to get in with the royalty, and the peasants are getting screwed”. This reinforces the chain of command approach, with orders passed downwards from management and problems and issues directed upwards from workers. However, rather than a chain of command mentality being a barrier, one participant suggested a kind of lack of understanding at managerial levels for service user involvement initiatives. She said:

...I think sometimes the barriers are management. They [management] don't provide us with the service. I think a lot of the time, management don't particularly care, all they care about is numbers and stats and HONOS⁷...I think a lot of these people just don't see people as we see them. It's almost like you become and manager and that's it... (Participant Green, p.8).

⁷ HONOS is a Health Of the Nation Outcome Scale. It is a routine clinical outcome measure used in MHS internationally (www.rcpsych.ac.uk accessed 24/04/12)

In contrast another identified a lack of accountability within MHS management as negatively impacting on moving initiatives forward. She said:

...I think nursing leadership needs to be more accountable, not just to the Ministry of Health but actually to service users and their staff... (Participant Orange, p.11).

Also highlighted was a lack of visibility and understanding about management's beliefs and goals as disempowering. He stated:

...I don't know what the service managers would understand of service user involvement...my experience recently is that they tend to only focus on things that they are told they have to focus on from the Ministry rather than anything else... (Participant Pink, p.10).

Nurse leaders and managers can contribute to disparities in healthcare through a self belief that they are more superior than other nurses (Stromwall et al., 2011; Roberts, 2000). In keeping with this, evidence shows that historically the basis of employment promotion has been due to clinical and technical proficiency, not effective management skills, with the financial survival of the organisation seen as more important than employee and service user needs (Kimura, 2003; Nestor & Galletly, 2006; Wand, 2011). This in part may be due to hospitals originating "on the principles of servitude and dedication with a rigid hierarchy which breeds authoritarian beliefs" (Hampshire, 2000, p.10). Waitere (1998) asserts that within New Zealand society, dominance is maintained through the mechanisms of control, reward and buyout within health sectors. This indicates that whilst organisational and financial demands impact on service delivery, nurse leaders and managers can also limit initiatives by MHNs.

Influential factors of "being socialised to follow orders, futility of past actions, fear of losing their jobs, self doubt, and lack of courage" all impact on nurses abilities to take a stand against paternalistic and coercive practices (Austin et al.,

2003, p.178). One participant identified her workplace demands, causing her to question how she could deliver quality nursing care. She said:

...how can you make any difference when we've got to do these ITP's⁸ every 2 months, we've got to do these risk assessments every 3 months, we've got to attend all this training, we've got to go to our own in-house meetings...there's all these commitments but at the end of the day what difference are you making with that client by not being with them, by not being there for them... (Participant Blue, p.4).

Another participant identified excessive paperwork as adversely affecting her relationship with service users. She states:

...now you've got the Honos, the Chips⁹, the Assessments, the reviews, the MDTs...It's like the paperwork feels up here (raises hand above head) and I'm down here somewhere (lowers hand towards knees)...if they want people to be seen they need to give us time to see them and also time to do the paperwork... (Participant Green, p.11).

Nurses have reported time limitations as severely impacting on their ability to deliver high quality care in a holistic manner (Hurley, 2009). Due to a large amount of mental health nursing time being spent either on paperwork requirements or interacting with multi-disciplinary health care professionals, limited interaction between service users and nurses occurs (Loukidou et al., 2010). This in turn can leave nurses feeling overwhelmed with feelings of isolation, and a lack of trust in management especially when their expertise is perceived as undervalued and their contribution is minimised (Cleary et al., 2011b).

⁸ ITP's are Integrated Treatment Plans are developed to identify generic interventions and recommendations for clients experiencing mental illness (Mueser, Noordsy, Drake, & Fox, 2003).

⁹ Chips – Community Health Information Processing System which gathers statistical information for the Ministry of Health to gather funding information (Retrieved from www.stats.govt.nz).

Current MHS have a multidisciplinary decision making process about service user treatment and care. These teams are influenced by managerial and political factors that may differ from individual nurses ethical perspectives, however nurses are expected to work within the team regardless of the ethical discomfort they are experiencing (Leung, 2002; Lützen, Blom, Ewalds-Kvist, & Winch, 2010). Decisions on service user care being made by others not directly involved in delivering nursing care was identified as a barrier by one participant. He states:

.. suddenly somebody comes along and says I've got a really neat idea let's do something differently, and low and behold, happens to be one of the people I'm working with and how can they judge?... (Participant Pink, p.2).

This suggests nurses may feel powerless in environments where the power to make decisions about service users treatments and care are made at times by members of multidisciplinary teams excluding nurses and service users. This may leave nurses feeling unable to make autonomous clinical decisions and truly engage with service users due to multidisciplinary team decisions lacking “a good understanding of the nature, value and implications of nurses’ collaborative work with consumers” (McCloughen, Gillies & O’Brien, 2011, p.53). Awareness of the institutional restraints that promote non-therapeutic environments is essential for MHNs, due to these factors negatively impacting on their ability to act in an ethical manner (Roberts, 2010; Ross, 2009; Schreiber & Lützēn, 2000). Through this awareness and critical analysis into the power differentials that exist, alternative approaches to care delivery can be examined.

4.2 IDEOLOGY AND SERVICE USER POSITIONING

The ‘care versus cure’ dichotomy (Cutcliffe & Happell, 2009; Loukidou et al., 2010) has been identified as a contributing factor to service user disempowerment with ‘care’ being the major focus of nursing whereas ‘cure’ being medical provision and systematic approaches (Hastie, 2002). Such contradiction exists in mental health guidelines and government legislation with service user involvement being promoted (care) yet legislation such as the Mental Health Amendment Act (1999) restricting service user freedom and

limiting full user involvement (cure) (Berry et al., 2010). This over-emphasis of 'cure' which focuses on biological causes for mental illness can lead to minimisation and oversight of the social, cultural and emotional factors that have contributed to service users current mental illness (Beecher, 2009; Tarrier & Barrowclough, 2003). Foucault (1977, as cited in Hopton, 2006) suggests that psychiatry focuses on surveillance and social control of clients rather than showing compassion and empathy to their mental distress.

The conflict between caring and curing for service users was identified by one participant. She stated:

..nurses are always put in this position of having a tension between service user involvement and our organisational requirements to provide what the organisation contracts to, such as safety, risk management and budgetary ideals... (Participant Orange, p.4).

In contrast stereotypical nursing images by society were seen as blurring the reality of nursing within mental health. One participant stated:

...I do think that there are some people that really do think we are just like Florence and that we are all just all caring, all kind, all considerate...But I believe that we need to go quite a few steps further then Florence...we actually have hard conversations with people at times and actually say your behaviour sucks... (Participant Gold, p.7).

Whilst caring, holism, promotion and advocacy are championed as key roles of the nursing profession, over emphasis of the medical model and task orientated practice belittles the caring relationship between nurse and service user (Ross & Goldner, 2009). With the concepts of caring and promoting wellbeing being intrinsic to nursing practice, contradiction arises in modern nursing practice due to restrictive clinical environments and as such limit nurses' attempts to delivery therapeutic care (Happell, 2009; Schreiber & Lützén, 2000).

A close relationship exists between 'care' and 'control' within mental health nursing, as any intervention introduced that imposes restrictions "includes a risk of misuse of power and perceived punishment, even if the expressed purpose is good" (Lind et al., 2004, p.381). Further argued is that traditionally nurses engage in coercive acts that are physical (restraint), verbal (threats) and psychological (manipulation) interventions to ensure service users comply with ward rules and structure. Lind et al. (2004) view coercion as an imposed part of MHNs job description, despite the discomfort. Participants themselves identified power differentials and paternalistic attitudes existing between nurses and service users impacting on the ability to promote service user involvement. Ownership over service users was identified by one participant as a hindering factor. She stated:

...there are some clinicians that don't work in recovery and want to own the service user... (Participant Lime, p.1).

Another participant identified individual nursing egos as contributing to disempowering practice. She states:

... I think that is sort of sacred cow stuff...whether we like to admit it or not, we perceive ourselves as experts and, um, we aren't actually but we like to think that we are... (Participant Orange, p.19).

Stuart (2012, p.364) agrees with the above, she identifies that as nurses "we all have our ingrained ideas, notions, and conceptualizations and it is easy to think we are right and those around us are wrong". Given that nurses spend a vast amount of time with service users they can assume knowing what is in their best interest, therefore asserting professional control over the service user through taking control and responsibility for recovery (Barker et al., 1999). By viewing users of MHS as being in a 'sick role', nurses transform service users to compliant recipients of health care that is determined by nurses' professional expertise, therefore reinforcing power imbalances in the relationship dynamic (Roberts, 2010). In order for service user involvement to be embraced, the relinquishing

of nursing power over them must occur to enable the lived experience of service users expertise in their own mental health to be valued (Cleary et al., 2011b).

Terminology evident throughout the interviews was a 'them' and 'us' approach which coincides with findings that a "subtle and, yet, ubiquitous manifestation of power is in the very words and language used. The use of language is a strategic act that often preserves relational asymmetry" (Cutcliffe & Happell, 2009, p.121). The power of language was identified by participants as contributing to exclusion with one participating identifying:

...it's because people have been them and us, again, I think it's because of a lack of contact and a lack of inclusion...when you have a group that is excluded it's much easier to be derogatory about them... (Participant Orange, p.14).

Another participant identified institutionalised nursing practices as contributing to inequalities. She states:

...we have a habit of creating monsters. Largely through inexperience, but also through poor judgement, old fashioned style nursing... (Participant Violet, p.5).

The language of mental health, in particular, specific pseudo-psychiatric terminology was highlighted as contributing to power differentials through:

...I hear young people talking about people being schizo and...spaz and things like that, and I think oh god I thought we got over that but I don't think we are... (Participant Orange, p.8).

Negative terminology impedes active involvement by service users through categorisation and labelling with diagnostic criteria which maintains psychiatry's power over them and limits their ability to participate in planning their care (Roberts, 2010). This form of 'labelling theory' evokes a human response to certain diagnosis where "behaviour is affected by the label itself rather than the

person to whom the label is attached”, this cultivates and strengthens prejudice (Mason et al., 2010, p.336).

MHNs work within a political arena with power struggles and historical approaches to enforced treatment and abuse (Berry et al., 2010; Stickley, 2006). MHNs are expected to undertake a myriad of complicated roles within the workplace including “custodian, carer, cigarette source, counsellor, educator, behaviour modifier and gaoler” (Lawn & Condon, 2006, p.117). Furthermore, the ambiguous structure of MHN services contribute to power inequalities occurring (Rydon, 2005). Participants identified power imbalances existing due to service users viewing nurses as authoritarian figures which led to role confusion within the relationship. One participant stated:

...how do I work with them to get them involved with us so that they're not looking at us as though we are punishing them all the time, so we are not looking like we are looking down on them... (Participant Blue, p.1)

Further identified was a multitude of state social service involvement that impacts on service user engagement. She stated:

...trying to get them engaged can be really hard...because they see us on a par with the Police, CYFS and Probation...because we are another government organisation (Participant Blue, p.1).

Fisher (2007) identifies the dilemma facing mental health nursing due to conflict in role such as guidelines advocating for accountability in care in the least restrictive setting (MHA, 1999) versus a duty to provide safety to service users, staff and the wider community (NCNZ, 2005). Social control and surveillance is in direct opposition to the presumption of nurses providing ‘care’ and can lead to exclusion through isolating and disempowering service user rather than inclusion (Bertram & Stickley, 2005). Cody (2003) suggests paternalistic practices are embedded in nursing practice and they need to be addressed for empowerment to occur. He advocates for increased awareness of historic and current influences to enable the nursing profession to move forward (Cody, 2003).

The dominance of bio-medical model and psychiatry over nursing is well researched and defined within historic and current mental health literature. Scholars continue to challenge the bio-medical concept of mental illness as Szasz (1974) cited in Leung (2002, p.54) states “mental illness is a metaphor and a myth; it is not the name of a medical disease or disorder, but a quasi-medical label”. In contrast, Brimblecombe (2005) argues that the bio-medical model has been beneficial for nursing through their exploitation of the power within it. Further suggested is that nurses are not dominated by psychiatry, rather it is nurses continuing to view and verbalise their inferiority that is maintaining the status quo, therefore reinforcing the continuation of power differentials. Feeling dominated results in nurses feeling isolated and incapable of affecting change (Beecher, 2009; Berry et al., 2010; Spring & Stern, 2002). Participants also identified power imbalances and powerlessness existing within the nursing profession and identified it as impinging on implementing service user involvement. One participant identified:

...people get entrenched in their positions and in their ideas and unless there is continual movement, and, like a fluidity, brought into the mental health nursing profession, then we become stagnant. And when we become stagnant we don't advance...MHNs have powerful voices and I think we have been conditioned not to use them... (Participant Orange, p.9).

Pessimism and disbelief towards effective change in MHS occurring was identified by participants. With one stating:

...I think that there are some people that are pessimistic like me and just think it's a load of bullshit the things we get told... (Participant Gold, p.6).

Another suggested collegial scepticism impacts on the reality of user involvement. She stated:

...I think there is a good smattering of cynicism in a lot of DHB's and with the nurses and the professionals that work there. Because I don't think they can see how it can be implemented... (Participant Orange, p.19).

Literature highlights that powerlessness in nursing is a direct result of a multitude of disempowering practices within current health care environments. Factors such as role distortion, increased workplace pressure, limited autonomy and poor career advancement potentially leave nurses feeling dissatisfied and lacking motivation to embrace new initiatives (Cleary et al., 2011b; Loukidou et al., 2010; Wand, 2011). Of concern is that this sense of 'powerlessness' can extend beyond nurses and can also dwell within service users who adopt a powerless and compliant 'good patient' position in an effort to maintain a consistent relationship with the expert practitioner" (McCloughen et al., 2011, p.53).

Nursing practice embodies interlinking factors of political action, clinical practice, research and education with the focus being public interest and positive health outcomes for service users. Therefore it is vital that future nurses become actively involved in policy reform and health initiatives if the profession is to move forward in the future (Kagan, 2006; Te Pou, 2009). Moreover, nurses as a professional group, must begin to question how much we contribute to maintaining and promoting paternalistic practices in healthcare settings through examining our attitudes towards service users involvement.

4.3 ATTITUDES

The challenge that MHN faces is to facilitate involvement through practising in a manner that elicits service users' personal resourcefulness, potential and ability to challenge, therefore challenging the status quo (Roberts, 2005). Evidence clearly shows that service users value having choices in their relationships with nurses. This includes fundamental aspects of being involved, informed and contributing to treatment options (Cody 2006; Beresford, 2010). Therefore nurses need to be aware of how their own personal biases (in the form of beliefs, attitudes, and behaviour) can adversely affect relationship with users if actual equality and collaboration with service users can exist (TARRIER & BARROWCLOUGH, 2003; Wolf, 2012).

In order to understand driving forces of service user involvement individual attitudes of nurses were explored. A number of participants identified personal attitudes, experience and education being fundamental in guiding their understanding and implementation of user involvement. One participant spoke of his belief in service users:

...I have always had a huge belief in people being active about how they utilise the services and I have this really strong belief that people often don't choose to have mental illness and I think we can make their journey, um, easier or more difficult... (Participant Gold, p.2).

Whilst another spoke of her work experience and moral values as being fundamental. She stated:

...I think it's just experience...it's knowing what's right, it's knowing how to help client and not, yeah not, putting our own expectations onto them... (Participant White, p.1).

Another spoke of strength of character as vital. She states:

...I think the attribute is that you must be ardent, you must be an advocate, you must have the courage of your conviction and you must have good knowledge and be passionate... (Participant Green, p.4).

Another spoke of having family members having mental illness as impacting on her attitude towards involvement. She said:

...I've had family with mental illness who was in the old system...I mean we never knew what was going on. I always try and keep in my mind, how did I feel when that was me... (Participant Orange, p.6).

Roberts (2005) research expands on this to identify that nurses need to critically reflect and question their communication, labelling and assumptions about mental illness if service user involvement is to occur legitimately and participation in treatment planning is to be conducive to individual needs. They need to listen to service users assumptions, beliefs and goals about their

experience of mental illness is vital, nurses also need to be aware of how their own assumptions and viewpoints can influence decision making and potentially foster restrictive and paternalistic practices (Kagan, 2006; Wolf, 2012).

MHNs attitudes are influenced by a number of issues such as the “considerable debate within psychiatry regarding accurate diagnosis, causative factors, appropriate treatment modalities, optimal service provision and realistic expected outcomes for mental illness in general” (Ross & Goldner, 2009, p.563). The NZCMHN (2004) standards define MHNs attitudes as being professional, optimistic, respectful, and able to work in partnership with service users, with individual nurses being skilled in both personal and practical skill knowledge and having an ability to view the service user in context (Happell et al., 2011). Given that MHNs are seen as role models and leaders in respect of mental health care their attitudes and behaviours towards service users are important to gauge (Wahl & Aroesty-Cohen, 2009). Key drivers of their attitudes and beliefs were concepts of recovery, care, respect and humanity, reflective practice and education. The consistent theme of caring surfaced from discussions with participants. One participant stated:

...all you need to have is heart for those people...I don't think anyone would be here that didn't care because the frustration would just drive you crazy... (Participant Blue p.3).

Another participant highlighted enthusiasm for MHN as an essential attribute. She said:

... passion, because I don't think you could do this, work in mental health without a passion. Can't come to work and eat your lunch in this job... (Participant Lime p.6).

Further identified was the importance of having humanity as an attribute. One participant stated:

...for me, that is so important that you acknowledge them as human beings and that if you can't...you shouldn't be in the job"... (Participant Green, p.5).

Others acknowledged acknowledgement of individuality and seeing beyond the label of mental illness. With one participant stating:

...I always work from the theory that I try very much to treat people the way that I'd like to be treated...just because they have mental illness doesn't give them any less respect or common decency... (Participant Violet, p.8).

Whilst another stated:

...I try and always remember that they are people first and foremost and mental illness is merely a portion of their journey, it's not the totality of who they are... (Participant Orange p.6).

MHN's attitudes and actions impact on treatment outcomes and the quality of life of service users (Wahl & Aroesty-Cohen, 2010). New Zealand service user research clearly reports that MHNs "should be professional, convey hope, know and respect the client, work alongside the client, privilege human quality and be able to connect with clients" (Happell et al., 2011, p.903). However overexposure to caring for and about service users, can lead to feelings of burn out, stress and being overwhelmed which consequently damages their ability to formulate a collaborative relationship with service users (Van Dusseldorp et al., 2010). It is therefore vital MHNs reflect on whether they are promoting a 'care for' or 'do for' environment (Roberts, 2010). A risk of paternalism may continue to exist within MHS unless equality and collaboration between clients and health professionals can occur (TARRIER & BARROWCLOUGH, 2003).

4.4 PATERNALISM

Paternalism occurs when individuals who are perceived as having power or authority place restrictions or limitations on the autonomy or liberty of others (Roberts, 2004). It is suggested that paternalistic acts are often justifiable in mental health through the enforcement of legal treatment of service users under the masquerade of maintaining community rights and safety (Cleary et al., 2011b; Loukidou et al., 2010; Talley & Coleman, 1992). As MHN's attempt to deliver care in a more humanistic manner, it is argued that they and other health professionals continue to face criticism due to their assumption of controlling roles in regards to restraint, force and containment (Hall, 2004). Participants within this study identified difficulties they experienced when relinquishing power and control back to service users. One participant stated:

...it is really comforting if you can be in control and you are directing everything that is happening. That puts you in a place of comfort because are person driving lots of things... (Participant White, p.7).

In contrast another participant identified that service users didn't want to make decisions about their mental health care as they viewed nurses as experts. He stated:

...They are used to people being directive, well you're the nurse, you know better, you know about these things, what do I know... (Participant Gold, p.7).

A lack of collaboration between nurses and service users was identified as a major contributor to ongoing power differentials. One participant identified:

...I don't think we work in collaboration in our practice. You know in our day to day practice. You watch people and they'll just give people their medications at a certain time of the day. They don't ask the people when do you take your meds at home, what's the usual time for you to do that... (Participant Orange, p.2).

Whilst another identified coercive practices as raising dilemmas within nurses. She states:

...you see that with some nurses they get quite uncomfortable with service users, you know, because they'd like to be able to lock the door really. Because they use to, they use to be able to, now they can't... (Participant Orange, p.11).

Despite mental health reforms attempting to release clients from paternalistic and authoritarian control, mental health policy has failed to promote clients self determination and autonomy (Cleary et al., 2011b; Wand, 2011). The reality is that more clients are treated involuntarily under the guise of inpatient and outpatient treatment orders (Szasz, 2005). His conclusion is that progress cannot be made until clarification occurs on the what 'progress' is and de-stigmatisation about mental illness being a 'disease' occurs. Only then could the number of people in the world subject to treatment be reduced.

Mental Health nursing academics highlight that the nursing profession has been cast into subservience and sub-ordinance roles by medical professionals, the public and nursing management (Cleary, Horsfall, Deacon, & Jackson, 2011; Duffy, 1995; McCall, 1996). Historically, unequal power relationships exist due to nursing being classed as women's work, and societal views of nurses as 'handmaidens' and 'angels of mercy' reinforce this (Farrell, 2000; Morris-Thompson, Shepherd, Plata & Marks-Maran, 2011). Duffy (1995, p.5) states this is "reinforced through primary socialisation, nursing education and professional socialisation" and will continue whilst stereotypical female images of nurses remain embedded in society. Participants also identified power differentials existing between medical and mental health disciplines. One participant stated:

...I also think that for so long mental health has been portrayed as a second sister to the general nurse. We have always had bad publicity... (Participant Green, p.1).

The risk of powerlessness within MHN was identified by one participant as potentially limiting service user empowerment. He said:

...I think in psychiatric nursing, if we are not careful, is going to get pulled into the vortex and we're going to be less empowered ourselves and therefore we'll be less able to empower our clients... (Participant Pink, p.7).

In contrast, Hamlin (2000) argues that powerlessness within mental health nursing is due to nurses isolating themselves from other professional groups and displaying a lack of pride in nursing and a desire not to participate in furthering the nursing profession. In agreement Wand (2011) identifies MHNs being viewed as distinct and separate from medical nurses reinforces inequalities of power and creates division between professional groups. Roberts (2000, p.5) in part, agrees by identifying that MHNs “lack a public “voice” that describes the contribution of nursing actions to the care of patients” and rarely publicly discuss the aspects of their work, therefore maintaining a culture of silence and not promoting the profession.

Historically the MHC (2002) viewed advancement of MHS through the active participation of service users to improve the service delivery and facilitate experiences from exclusion to inclusion. They view service user involvement as being paramount in formulating inclusive approaches by enabling understanding about mental health discrimination and countering stigma (MHC, 2004). With promoting, encouraging and supporting user involvement, opportunities for change emerge through service users knowledge, expertise and experience of distress and social exclusion being heard (MHC, 2012). Through individualised recovery orientated care occurring, service users are enabled and empowered to achieve their personal understanding of recovery (Diamond et al., 2003; MHC 2012; Te Pou, 2009). As such recovery from mental illness is a reality for many service users if care is planned and delivered in a service user and family driven manner that incorporates treatment, provider options and choices (Schauer et al., 2007).

4.5 SUMMARY

This chapter has presented the environmental and relational factors that participants identified as impacting on service user involvement. Through exploration of the environmental dynamics of practice participants have identified historic influences that impact on their personal and professional understanding of service user involvement. Furthermore, they identified particular issues of power dynamics; a hierarchical structure of human resources; and a debate regarding care versus control. All of which have limited implementation of service user involvement and support from nurses toward such.

The following chapter addresses the second aim of the research: To explore with MHNs how they recognise, describe and incorporate service user involvement in practice through utilisation of strength based approaches.

Chapter Five: Strength Based Approaches

"Our real problem, then, is not our strength today; it is rather the vital necessity of action today to ensure our strength tomorrow." (Dwight D. Eisenhower, cited in <http://www.presidency.ucsb.edu>)

5.0 INTRODUCTION

This chapter addresses the second aim of the research project. Through using the framework of the second aim I examined how MHNs recognise and describe how service user involvement is incorporated into practice. The discussion within this chapter is demonstrated through narratives gained from participants during the interview process and is supported by relevant literature. In the process of thematic analysis the first sub theme describes participants' beliefs about services user and nurse relationships. This led on to development of the second sub theme of recovery orientated practice. This sub theme identifies a brief historic overview of recovery concepts and illustrates how they incorporate such into practice. The third sub theme follows on from recovery towards the participant's understanding of socially inclusive practice and the actions they view as essential when working alongside service users. The final sub theme discusses the concept of stigma and discrimination within practice from the participants' perspectives. The discussion assists in answering the research question of: What are the environmental and relational factors which affect service user involvement in community mental health settings from the perspectives of MHNs?

5.1 BELIEFS IN SERVICE USER INVOLVEMENT

Literature defines a service user as a person who is, or has been, an active participant of mental health and/or social services (Diamond et al., 2008 Lloyd, 2008; MHC, 2002). From the onset of the study it became clear that similar viewpoints about the definition of a service user was held by each participant with key points being users of MHS and having lived experience of mental illness.

Participants' definitions of service user involvement included:

...A person who has a lived experience of mental illness and uses MHS. That's what it means to me... (Participant Orange, p.1).

...A service user is a person who I see on a regular basis, they use my service, they use the service of the psychiatrist, they may see the GP, they may go into the healthy lifestyle programme, they are involved... (Participant Green, p.14).

These definitions are in keeping with Dougherty and Tse's (2005, p.11) definition of a service user as "individuals with mental illness who have been users of MHS and who identify themselves as such". Participants' responses indicated commonality and shared understanding in regards to their interpretation of what defined a service user.

Service user involvement is defined as "the extent to which the patient is involved in defining problems and setting the targets that constitute the plan of care" (Stringer, Van Meijel, De Vree & Ven Der Bijl, 2008, p.679). Diamond et al. (2003) and Hui and Stickley's (2007) research identify oppositional viewpoints which impact on service user involvement, these being from the top down (the socio-political arenas of governmental and organisational policies, procedures and legislation) and the bottom up (service users and consumer run organisations and advocacy agencies). Whilst mental health literature frequently uses terminology of user involvement, participation and empowerment interchangeably, difficulties arise due to individualised definitions and understanding that are formulated by service users, clinicians and professional groups (Ion et al., 2010; Peck, Gulliver & Towel, 2002). To overcome this Borg et al. (2009) propose that service user involvement be viewed not as a singular concept but rather as a concept that includes a multitude of levels.

Individually participants described a variety of concepts relating to service user involvement, these included: involvement, participation, collaboration, listening, meaningful discussion, willingness to engage and user friendly. Participants cited years of nursing experience, literature read, workplace setting and personal values and beliefs as rationale in guiding their understanding. This is in keeping with Peck et al. (2002) research outcomes. One participant identified service user involvement being driven through goal setting. She stated:

...for me it's having the service user/client, involved in their care right up to full capacity really. Their recovery goals and actions are theirs, so we don't actually put on to them our perception of what we want them to do and how we want them to do it. They can actually facilitate what they want... (Participant Gold, p.1).

Whereas another identified participation from service users as the key to goal setting. She stated:

...Service user involvement is about participation in their care, they need to be involved, some family and whanau as well because it is their illness, not ours, to take ownership of their recovery... (Participant Lime, p.1).

One participant identified respect of service user viewpoints as encompassing involvement. He stated:

...I think it's when clients or service users views and ideas are kind of heard by the organisation or by the service and really worked on, worked with, so that things change for the better in an ongoing way. It's when you really listen to people rather than paying lip service to the idea... (Participant Pink, p.12).

Other participant's identified the services willingness to engage in care as impacting on the viability of service user involvement. She said:

...I think that it encompasses a few things, such as how approachable we are, whether they are willing to engage, whether we are user friendly. As all those kind of dynamics that go around it, kind of impact on them being involved with our service... (Participant Blue, p.1).

Borg's et al. (2009) research highlights the differing concepts which impact on individuals understanding of service user involvement. They suggest these variances exist due to individuals having differing perceptions about involvement which is determined by their experience.. Which is congruent with this research as a common factor expressed by all participants was that their understanding came from years of experience in working alongside service users. One participant identified her confusion following deinstitutionalisation around the concept of service user involvement. She stated:

...we didn't quite know how to cope when service users were moved from institutional care to community settings, I think we tried to put people into, you know, square holes into round pegs all the time"... (Participant Gold, p.1)

Wilson (2007) highlights how historically implementation of service user involvement was limited within mental health given that traditional medical and nursing models failed to incorporate the individual aspects of peoples' needs. Browne and Hemsley (2008, p.447) further criticise MHNs as being "slow to adjust their attitudes and modus operandi to wholeheartedly implement these policies".

In agreeance one participant identified her nursing experience as being a possible barrier to service user involvement. She stated:

...the bin mentality becomes entrenched... (Participant Orange p.15).

This statement highlights Bennetts, Cross and Bloomer's (2011) research which identified that some mental health clinicians are more institutionalised than the service user they are working with. They argue that continued institutionalised practice has prevented control being relinquished to service users.

Close relationships with the service users was identified by one participant as influencing her attitude towards involvement. She stated:

...because we are all individual and what suits one person can be totally and utterly inappropriate for someone else. So yeah I guess it's a time thing, it's an experience thing, getting to know your clients, building a rapport and getting an understanding of their culture, their ethnicity and their upbringing... (Participant Violet, p.2).

Whilst another stated:

...It's also having worked closely with clients/service users for a long time and always finding that in my practice, the best way of working with people is to listen to what they have to say and try to work with them... (Participant Pink, p.6).

One participant identified that her education and her experience of mental illness within her family as guided her understanding. She stated:

...I guess through my research, through my studies. I've seen family with mental illness so I know what a service user is, and I get what it is to be family with mental illness... (Participant Orange, p.1).

In contrast, another participant cited his observation of poor nursing practice as shifting his attitude towards service user involvement. He stated:

...I have always had a huge belief in people being active about how they utilise the services and I have this really strong belief that people don't choose to have mental illness. I think that we can make their journey easier or more difficult. I've worked with many colleagues who make it bloody difficult and that has been a huge driver for me I decided I was never going to be that sort of clinician... (Participant White, p.1).

In agreeance, Summers (2003) research highlights how the attitudes of health professionals can either severely limit or promote service users being involved in care within society. Berry et al. (2010) further identifies how MHNs can actively social exclude service users if they hold stigmatising viewpoints and discredit their potential. In order to improve mental health practice and enhance service user outcomes, nurses are encouraged to embrace recovery orientated practice principles.

5.2 INSIGHT ON RECOVERY

The 'recovery' concept has emerged and strengthened throughout the 20th century and has been a driving force behind policy formulation within MHS (MHC, 2011). The MHC (2007. p.21) originally defined recovery as "an individual, empowering process for people with mental illness and/or addiction and is a journey as much as it is a destination", and through recovery, consumer unification and strengthening of values and beliefs occurs. Recent MHC (2011) literature identifies recovery as consisting of four essential components, these being: clinical recovery (outcome orientated); personal recovery (sense of self); recovery based services and systems (services facilitating recovery); and recovery friendly societies (social inclusion). This highlights that recovery involves more than symptom alleviation. Its broad focus includes service users finding individualised tenacity, ownership and embracing their experiences of mental illness through self acceptance (Barnes, 2011; Meddings & Perkins, 2002).

However the concept of recovery is at times mystified not only due to an association with 'cure' but also due to the diverse interpretations that exist in literature (Cleary & Dowling, 2009; Davidson, 2005). The reality for many service users is that no cure exists for their experience of mental illness, rather their tools and strategies for obtaining wellness expand. One participant challenged governmental and ministerial recommendations citing a lack of consultation in policy development. He stated:

...the government and Ministry of Health do provide this information and they do promote it, but they can promote lots of things and they do it from up there.

It's the people down here that have to embrace that and then really enact the stuff for the person who is the end user, which is the service user. I think there are some people that are pessimistic like me and just think oh it's a lot of bullshit... (Participant White, p.8).

Additionally a lack of transparency in how recovery principles can be applied within nursing practice was reported. One participant said:

...I hear the word recovery talked about a lot but I don't see it being enacted. I see a version of recovery that's actually designed to make the nurse or the clinician feel okay, so that they feel okay about it. But actually it is a lot of bullshit because practice actually isn't focused on the client. Practice is focused more on my need as a clinician and not the clients need... (Participant White, p.6).

Furthermore, so called political correctness impacting on service user involvement was identified by one participant. He stated:

...I think that the government has embraced recovery because it is the new way of being, and they have to be seen as an organisation to be supportive of these things. So they embrace that because they think it is politically correct... (Participant White, p.8).

However, promotion, encouragement and support of user involvement in service provision provides an opportunity for much needed change to occur within MHS. According to Diamond et al. (2003) utilising recovery concepts with service users enables and empowers all to achieve their personal understanding of recovery and potential. Schauer et al. (2007) affirm that recovery from mental illness is a reality for many service users if care is planned and delivered in a participatory and inclusive manner.

Participants identified understanding recovery principles as fundamental within MHNs practice. She said:

...To be independent within the community really and know that through life they are always going to have challenges but they have the knowledge and ability to live well... (Participant Lime, p.6).

Another participant identified his personal values fitting with a recovery focused approach. He stated:

...when I found information about recovery, to me that was like coming home. I'd actually been using recovery in my practice for many, many years. I just didn't call it recovery and when I found that structure I just went hallelujah...so I fully embrace it... (Participant White, p.1).

Mezzina et al. (2006) identify a myriad of concepts and relationships that guide and inform recovery principles such as personal, interpersonal and social spheres. However Masterson and Owen's (2006) viewpoint of recovery holds a more singular view, in that self determination occurs within service users when they take ownership of their recovery, rather than relying on health professionals to drive their recovery. Participants in this study also identified recovery being dependent upon individual services users' willingness to engage with nurses. Participants stated:

...It's only as good as the involvement you get from them... (Participant Blue, p.11).

...A lot of it will depend whether or not they want to be involved because sometimes you will get people who are in total denial and they don't want anything to do with us... (Participant Green, p.11).

Research shows that service users acknowledge the benefits of recovery focused practices in that it increases their self determination, enhances their understanding of mental illness and facilitates their return to functioning

through the building of inner strength and self belief (Caldwell, Sclafani, Swarbrick & Piren, 2010; Russinova, Rogers, Ellison & Lyass, 2011).

Nurses facilitate recovery for service users through assisting them to identify and overcome barriers through formulating “supportive environments that facilitate integration and acceptance” (Russell & Lloyd, 2004, p.272). Service users are more likely to come from a position of strength and actively engage with services when they have developed a sense of personal perspective about their mental health (Camann, 2010; MHC, 2010). In agreement, one participant identified self awareness as vital, she stated:

...I just think it's about looking at recovery as achievable goals, like it's always about achievable goals for the clients. You know people can help themselves move forward if they know their relapse indicators and what to do... (Participant Gold, p.6).

The MHC (2007, p.22) views MHS of the future being based on the recovery values of “self determination, social inclusion, hope and choice” therefore enabling service users to actively participate and formulate recovery in a self-sustaining way. Clayton and Tse (2003) suggest that recovery concepts can be further expanded to include the principles of the Treaty of Waitangi. When protection, partnership and participation are addressed, a culturally sensitive recovery approach can be achieved and a move towards social inclusive practice can occur.

5.3 WORKING WITH INCLUSION IN MIND

Social inclusive practice is a fundamental aspect of recovery which aims to ensure that service users not only live within communities but are part of communities (MHC, 2007). Social inclusive practice is neither a treatment nor an intervention, but a set of ideals and beliefs that enlighten cultures, policies and practices. Furthermore, the promotion of social inclusive practice should be of prime concern to MHNs and it is demonstrated through information and knowledge sharing, viewing all options, service user freedom and self

determination over health care decisions (Stickley, 2005). One participant stated:

...I've been talking for quite a few years now, since I worked as a CPN, about the whole kind of social inclusion thing and I've always said that's the way we are headed. We have to be inclusive, our group and probably the clients we deal with, and probably people with intellectual disability, are always going to be, in some respects, the last cabs on the rank because they are probably the hardest in terms of social inclusion... (Participant Pink, p.5).

Whilst social inclusive practice is viewed as essential, this study highlighted participants' scepticism in regards to inclusion being achievable in current mental health environments. One participant viewed discriminatory attitudes towards service users as being a barrier, he said:

...It's easier to socially include somebody who is in a wheelchair because you can put a ramp to get to the building or whatever. It's quite hard to do that when you've got somebody that is covered in tats and they are all over their face and they look scary or they may talk strangely about things and they might react differently to situations then you expect. You know to socially include people is always going to be harder to do. But, I don't think it is impossible... (Participant Pink, p.5).

In agreeance, Masterson and Owen (2006) assert that recovery based services that promote social inclusive practice can only exist when fair and equitable division of power occurs between service users and nurses. The consumer movement, along with publications of private accounts of serious mental illness by service users, have informed public awareness, increased understanding, decreased stigma and educated about mental illness (Lapsley et al., 2002; Wand, 2011).

Assertive mental health campaigns have raised community awareness and shown positive effects in lessening discrimination and exclusion (Knight & Moloney, 2005; Phoenix Research, 2011b). However, whilst research has shown

that educational approaches regarding discrimination can alter attitudes, it does not necessarily alter individual behaviour towards service users experiencing serious mental illness (Barnett & Barnes, 2010; Bradshaw et al., 2007).

One participant identified a change in nurses' viewpoints towards service users as paramount in the delivery of social inclusive practice. She stated:

...I think the whole social inclusion movement really is a fundamental issue...It is critical that mental health nursing changes. I think we should be flexible enough to understand that (a) it needs changing, and (b) actually be in a position where we advocate and support people who have the ideas and can speak from a direct and personal perspective about what they would find better for them in terms of their treatment... (Participant Pink, p.3).

In contrast another identified service user advisor roles as implausible and having a limited impact within organisations, he states:

...service advisors have always had, I think, a pretty bad, raw deal because most people think that they are just nutters. You know, oh well, your well now but you're a nutter really, you know you've got all these outlandish thoughts. I wonder when you are going to get unwell again. How are you supposed to deal with that? I've seen and I've heard it, how is the consumer advisor supposed to deal with their job when that's how they are perceived... (Participant White, p.8).

Socially inclusive practice is viewed as a unique multi-dimensional process whereby nurses can assist service users to transform their abilities to a point whereby life satisfaction, hope for the future and feelings of value and contribution to the community become a reality (Berry et al., 2010; Lapsley et al., 2002). It is noted however, that acceptance of socially inclusive practice cannot be achieved by the direct relationship with service users alone. Its success also relies upon educating society and altering individuals preconceptions about mental illness (Berry et al., 2010; Masterson, & Owen, 2006).

Participants reported a number of characteristics regarding socially inclusive practice. The concept of caring about people in distress was identified, with one participant stating:

...all you need to have is heart for those people...I don't think anyone would be here that didn't care because the frustration would just drive you crazy... (Participant Blue, p.3).

Another participant identified enthusiasm for MHN as being essential. She stated:

...really a passion, because I don't think you could do this, work in mental health without a passion. Can't come to work and just eat your lunch in this job... (Participant Lime, p.6).

Other participants identified humanity and connectivity as fundamental to inclusive practice. They stated:

...for me, that is so important that you acknowledge the human being and that if you can't...you shouldn't be in the job... (Participant Green, p.5).

And further:

...I try and always remember that they are people first and foremost and mental illness is merely a portion of their journey, it's not the totality of who they are. (Participant Orange, p.6)

Research identifies the vital role nurses play in facilitating socially inclusive practice such as identifying and overcoming barriers and formulating “supportive environments that facilitate integration and acceptance” (Russell, & Lloyd, 2004, p.272). Inclusive practice can become a reality when service users find and define their “own definitions of living well, and then make the decision to respond and work towards what is important to them: psychological, spiritual, intellectual, emotional, physical, and cultural well-being.” Read (2003, p.1). Socially inclusive practice is fundamental to recovery and aims to ensure that

service users not only live within communities but are part of communities (Berry et al., 2010; MHC, 2007b).

5.4 COUNTERING STIGMA

Research shows that the degree of stigma and discrimination that service users experience is dependent upon the amount of knowledge that the public possess about mental illness (Barnett & Barnes, 2010; Gaebel, Zäske, & Bauman, 2006). Discrimination and stigma is identified as the most significant feature impacting on the ability to recover from mental illness (MHC, 2005). The MHC (2004, p.9) define discrimination as “unfavourable treatment based on prejudice” and Byrne (2001, p.281) defines stigma as “a mark or sign of disgrace or discredit”. Publications of private accounts of serious mental illness by service users has endeavoured to raise public education through increasing understanding, decreasing stigma and normalising mental illness (Lapsley et al., 2002; Peterson et al., 2008). Assertive mental health campaigns have raised community awareness and shown positive effects in lessening discrimination, stigma and exclusion for consumers (Knight & Moloney, 2005; MHC, 2012).

From a New Zealand perspective Peterson et al. (2008) acknowledge that despite legislation and public awareness campaigns to reduce discrimination it remains problematic within our society. Service users report the majority of discrimination occurs from friends and family. One participant identified family influences impacting on recovery for a service user she worked alongside. She stated:

...even for this day and age there is still so much stigma around mental health. I have clients whose parents don't want them to be on medication because they believe there is nothing wrong with them, that they shouldn't be under mental health and that's because the parents are so embarrassed by the fact that they have a family member who's involved... (Participant Violet, p.10).

Another participant reported fear of prejudice and stigma impacting on service users accessing services. She stated:

...the clients themselves, they are often reluctant to tell other people that they are in MHS because they may lose their jobs, their friends, their marriage, or any kind of work relationship and so it still comes back to the stigma... (Participant Green, p.2).

Stigmatising attitudes within families is concerning given research highlighting how family involvement can improve client outcomes and promote recovery through rapport building, identifying concerns/problems and facilitating communication (Barnett & Barnes, 2010; Rose, Mallinson, & Walton-Moss, 2004).

Serious mental illness has a negative effect on quality of life due to experiences of social rejection impacting on self confidence, self worth, sense of identity and belonging (Peterson et al., 2008; Verhaeghe et al., 2007). The impact of stigma is “often deleterious, and may be disabling concerning an individual’s self esteem and chance of recovery” (Knight & Moloney, 2005, p.499). Additionally, stigma has psychological processes whereby service users report internalising shame or feeling flawed for having been diagnosed (Hinshaw, 2005; McAllister, 2008). One participant acknowledged the fear the service users can experience when diagnosed with mental illness. She states:

...it the perception of what it would mean coming here and fear that we are going to lock them up. Some think that when they come through the doors they will be locked up... (Participant Gold, p.5).

Stigma is dependent upon the amount of knowledge that the public possess about mental illness which in turn impacts on their attitudes towards people experiencing mental illness. Participants in this study cite media sources as detrimental to the community’s understanding of mental illness. One participant identified:

...I think now, looking over my past 30-40 years of being involved with groups that haven’t been accepted in society, I think that the media has a lot to do

with it. I think that we haven't come as far as we think we have and there is a sense of complacency about people ... (Participant Orange, p.8).

Another participant identified an ingrained fear of service users as a major contributor to stigma. She stated:

...I also see that the community and the media puts up barriers and sometimes we put them up because we may be nervous, a bit scared of the person... (Participant Green, p.8).

In current day and age, media sources have the ability to raise awareness of mental health issues and assist in lessening stigma and discrimination. However, The MHC's (2005) survey on New Zealand Print Media reported that media coverage about mental health issues seldom reported anything positive. The association of violence with mental health clients was mentioned once in every five articles therefore reinforcing the viewpoint of the dangerousness of clients who had mental health issues. This survey suggested that "the media draws on, as well as influences, everyday beliefs about mental illness" (MHC, 2005) therefore reinforcing negative public perceptions of mental illness.

Of the same opinion are Lauber and Sartorius (2007, p.103) that "Violent crimes shown on television are more often ascribed to people with mental illness than to others". Regardless of research that shows that mental health clients are often the recipients of violence rather than perpetrators and there is evidence proving that mental health clients do not engage in crime activities any more than the general public (Lauber & Sartorius, 2007).

In contrast another participant identified health professionals as playing a major role in cultivating stigma. She stated:

...My theory is the most stigma is from health professionals. I think sometimes a consumer advisor would be good to work on the big white hospital [general hospital] because that's where I think the stigma comes from... there is no inclusion for mental health over there because they are scared of it. They

might say they know about it but they don't want to know about it. It's just ignorance... (Participant Lime, p.3).

Another participant also identified stigmatising attitudes from medical health professionals, however she expanded on this to inform as why this may occur. She stated:

...You know you have a scenario when somebody overdoses for the third time in a month and ends up in the Emergency Department via ambulance, the staff are going to become agitated in having to deal with that person for a third time. It's time consuming, it's resource consuming, financially it costs quite a bit of money. But they have got no idea why that person is taking so many overdoses and what kind of frame of mind they are in, what factors – life factors/home factors/environmental factors have contributed to that situation... (Participant Violet, p.7).

MHNs are in a unique position to assist service users in an inclusive manner through enabling “consumers to become independent, effectively manage their illness, and participate in community life” (Lemaire & Mallik, 2005, p.125). In a broader sense, nurses need to argue for service user rights, including “self determination, autonomy, informed consent and right to refuse treatment” if a decrease in discrimination is to occur (Read, 2003, p.3).

To counter stigma participants identified viewpoints towards challenging discriminatory practices. One participant acknowledged encouraging hope, he stated:

...I think stigma is alive, well and truly, but I truly believe that just because you have been a service user it does not mean that you are condemned to a life of being in the institution or having contact with MHS... (Participant White, p.9).

Whilst another reported being an advocate and promoting connectivity, she states:

...If someone becomes a part of your world and is a part of the community and is included as a full functioning member then it becomes day to day normality to have that person or that group of people involved...I'm a passionate advocate for all to be actually involved not just MHS...I've always felt that it was very unjust that the majority rules... (Participant Orange, p.8).

Furthermore another participant identified education with young people as being vital to assist in decreasing stigma and discrimination about mental health.

She stated:

...I think we need to put the resources where it is needed right from the beginning. You know if you have a sore toe you put a band aid on it and if you don't put that on it, it will fester. We need to be putting the money into our children all the way through so their mental distress has less impact on them as adults and they can have a life...I think we can achieve that but we just have to change what we do... (Participant Gold, p.7).

Research shows that New Zealand schools are failing to keep young people safe with evidence showing that bullying within schools as contributing to “anxiety, depression and poor overall mental health” (Cushman et al., 2011, p.249). Students attending mental health programmes within schools have demonstrated “significantly fewer mental health difficulties, less functional impaired and improved behaviour, and reported improved mental health knowledge, attitudes, beliefs, and behavioural intentions” (Walter et al., 2011, p.191). Therefore education targeted at mental health awareness and becoming ‘mentally healthy’, can promote a greater sense of self worth, social competence and increased resilience to counter discrimination (Cushman et al., 2011; MHC, 2012).

The effects of discrimination are far reaching in that “every time a person with experience of mental illness is limited from playing the best part she or he can in society, our society is poorer for it” (Peterson et al., 2008, p.25). If discrimination continues to occur, society will continue to have higher numbers of people receiving government benefits, being poorly educated and experiencing unsupportive family environments (Mental Health Advocacy Coalition, 2008; Peterson et al., 2008). Participants identified stigma and discrimination existing within current MHS however many verbalised optimism and hope for future service delivery through incorporation of socially inclusive models of care and improved education to decrease barriers that currently exist.

5.5 SUMMARY

This completes the discussion of the environmental and relationship factors that affect service user involvement from the perspective of nurses working within community mental health settings. Participants beliefs towards service user involvement has enabled helpful and hindering attitudes and perceptions of nurses to be identified. The factors which can impact on service user involvement, such as stigma and discrimination within MHS, has been discussed with participants identifying the need for further education within nursing and society to enable the formulation of inclusive environments.

In the next chapter, discussion on the outcomes of this research project will be presented. I describe the strengths and limitations, recommendations and make suggestions for future research for nursing in regards to service user involvement.

Chapter Six: Discussion and Recommendations

"Change is the law of life and those who look only to the past or present are certain to miss the future." (John F. Kennedy cited in <http://www.nhdp.org>)

6.0 INTRODUCTION

The final chapter of this thesis provides discussion on the findings of the research question and aims. The particular environmental and relational factors which participants identified as affecting service user involvement within their mental health team settings are included. The relevant issues arising from the data analysis is discussed in conjunction with considerations for service user involvement within mental health nursing. The strengths and limitations of this study are outlined and the chapter concludes with recommendations for future nursing practice.

6.1 A HISTORY OF CHANGE

Historically mental health care has involved case management of service users sometimes through the use of disempowering practices, coercion, control and institutional behaviours by mental health professionals (Connor & Wilson, 2006; Hopton, 2006). International protest and inquiry into psychiatric care delivery in the 1960's led the charge for promoting service user involvement worldwide. Change within New Zealand occurred as a result of the Mason Inquiry Report (1996) which led to the establishment of The MHC (The Commission). The Commission was charged with developing policy with an aim to improve the health of New Zealanders experiencing mental illness. Such policy development sought to develop inclusive societies and the promotion of recovery focused initiatives such as Te Tāhuhu (2005), Te Kōkiri (2006) and latterly Te Hononga 2015 (2007). In 2005 the Ministry of Health identified a need for improvements in service delivery and Te Pou o Te Whakaaro Nui (Te Pou) was contracted to develop frameworks to improve MHS delivery within New Zealand. This led to Te Pou (2009) developing a framework of essential skills, knowledge and attitudes required at individual

and organisational levels to ensure optimal mental health care. Te Pou (2009) promote a standard of practice framework to be followed within mental health settings, yet many nurses are unaware of this document and the recommendations it contains.

It is apparent that a vast array of literature exists which advocates for implementing service user involvement to improve current mental health practice. However, nurses interviewed reported little interest in educating themselves as literature is viewed as being verbose, the goals unachievable and non transferable to their current practice. Their attitudes may change given the current economic environment of revenue cutbacks which has forced the Commission (MHC, 2011) to reprioritise projects for the 2011/2012 year to focus on two main priorities. The Commission funding has decreased by 25% less which has caused projects to be postponed and staff numbers to be cut. These cutbacks have filtered down to organisational levels as participants identified difficulty in up-skilling, undertaking further training and promoting service user involvement due to workplace constraints and demands. This is in keeping with research of how nursing practice is subject to funding cuts, under staffing and limited choice, all of which severely impact on their ability and desire to undertake education. Wolf's (2012) research also acknowledges that whilst nurses verbalise ongoing commitment to service user improvements, time restraints and conflicting role demands diminish their capacity to do so. This compounds what The Commission suggest is a "mismatch between growth in demand and supply of MHA services in New Zealand, given resource and workforce constraints" (MHC, 2012, p.1). With diminished funding and fragmented support occurring in all areas of MHS planning and delivery, it remains uncertain as to how service users will achieve inclusion. Participants identify that difficulty arises through their attempting to juggle the environmental factors of workplace demands versus best practice guidelines in order to facilitate and promote inclusive and recovery focused care. These factors are identified as contributing to power dynamics and conflict within the therapeutic relationship.

6.2 CONFLICT IN THE CARING RELATIONSHIP

Mental health policy champions for change within MHS through advocating for service users to attain control over their health needs (Berry et al., 2010; MHC, 2011b). These changes have not occurred without ethical discomfort as nurses are required to relinquish historic case management roles and embrace person centred care. Conflicting roles of 'caring' versus 'curing' within mental health nursing contributes to institutionalised practices and limits service user involvement. In part, legislation such as The Mental Health Amendment Act (1999) negates service user choice and maintains professional power. Berry et al. (2010) acknowledge that mental health legislation sets precedence for paternalistic nursing practice with the requirement of nurses to use containment and control, under the guise of the law, to enforce care. Participants themselves identify feeling ethically divided regarding advocating for service user rights versus society's expectations that they police and monitor service user behaviours. This leaves them feeling uncertain on how to provide effective care that is in keeping of the needs of service users, organisations, professional guidelines and society's beliefs. Ambivalence to implement inclusive service user driven care continues as they express feelings of powerlessness and an inability to articulate their unique identity within a changing and challenging health care environment.

Participants suggest that role confusion is derived and maintained at an organisational level, with service user involvement initiatives viewed as tokenistic acts which enable the organisation to meet Ministry obligations and funding requirements. Ion et al. (2010) acknowledge the reality is service users championing for self determination have little impact on formulation and implementation of mental health practice. Service user disempowerment is further maintained through nurses retaining power over their treatment options. This is in part due to nurses being fearful of relinquishing professional control and their uncertainty regarding their role. This role confusion plays a part in maintaining a belief of superiority over service users in an effort to retain professional control. Professional control is directly oppositional to the goals of

recovery orientated practice and is a causative factor to power differentials being maintained within MHS. Nurses interviewed acknowledged that their personal attitudes, bias and beliefs guide their interactions with service users. Therefore it is vital that they utilise personal reflection and professional supervision to determine their contribution towards inclusive and exclusive practices. It is clear that organisational requirements and role confusion adversely affect recovery orientated practice. Clarity can be obtained through exposing ambiguities and examining how their influential attitudes can lead to transformation within nursing practice.

6.3 INFLUENTIAL ATTITUDES

Nursing practice is sanctioned through legislative, professional and ethical expectations and requirements (Kagan, 2006; NCNZ, 2005; NZCMHN, 2004; Te Pou, 2009). Alongside this, the individual aspects of the nurse such as values and beliefs play a major role in shaping and guiding delivery of inclusive nursing care. Education and past experiences with service users all contribute to an individual sense of identity and determine understandings of nursing care. Due to a multitude of factors influencing practitioners it becomes difficult to pinpoint factors that impede the uptake of 'Real Skills for Real People' in mental health nursing (Te Pou, 2009). However, it is likely that paternalistic practices and organisational demands contribute to reports from participants that they feel oppressed and ineffective to change. Furthermore, hierarchal pyramid structures within healthcare settings are a key context in promoting authoritarian practices. This occurs through subjugating and silencing agitators for change through a 'chain of command' mentality which promotes maintenance of the status quo (Hui & Stickley, 2007). Nurses interviewed identify this evokes moral distress and a feeling of being unable to challenge organisational directives due to fear of reprisal or belittlement. This limits their ability to advocate for service user involvement whilst they retain such perceptions.

In order for MHNs to confront constraints within organisations, exploration of an alternative model of care for mental health care needs to occur. The current emphasis of the bio medical model reinforces and retains the perception that there is a need to control service users through the diagnostic labelling of mental illness and medicalisation of mental distress. Nurses identify that power is maintained through the use of diagnostic labelling which creates a division within the therapeutic relationship and a focus of care on managing the illness symptoms rather than care in accordance with service user choice and needs. A medical model of care delivery maintains and fortifies stigmatising attitudes within nurses (Roberts, 2010). Therefore for service user involvement to become a reality within current services it is essential that nurses reflect on the reliance they place on diagnostic criteria and their alliance with the medical model. Examination of the power that is contained within the language and terminology within MHS is required if service user inclusion and autonomy is to become a reality. If nurses examine and challenge the part they play in cultivating service user disempowerment through labelling of mental illness then socially exclusive practices can be addressed.

6.4 POWERLESSNESS IS 'RISKY'

Feelings of powerlessness within the nursing profession partly stems from historical stereotypes of nursing as women's work and societies perspectives of nurses as 'handmaidens' and 'angels of mercy' (Summers & Summers, 2010). Disempowerment is perceived to exist between medical and mental health disciplines, in that MHNS are viewed as inferior and 'second class' to medical nurses. This may be a result of misconceived expectations and perceptions of the two roles within society. In addition, funding discrepancies between medical and mental health budgets contribute to system discrimination as allocations favour medical equipment and treatments over psychosocial treatment options. These financial restraints lead to a lack of implementation of service user involvement initiatives and disadvantage MHS (Lauber & Sartorius, 2007; Tomes, 2006). Participants' identified government 'slash and burn' approaches leaving them feeling stressed, stretched and unable to spend quality time with service

users. Feeling frustrated and overwhelmed by their organisation's 'do more with less' and 'work smarter' messages, contributed to them feeling dismissive of service user involvement initiatives.

Additional funding for mental health was 'ring fenced' in the early 2000's in response to 'Blueprint' recommendations to develop initiatives to improve MHS within New Zealand (MHC, 1998; MHC, 2012b; Phoenix Research, 2011). Despite this additional funding it is shown that initiatives were idealistic, not auctioned effectively, and surpluses were absorbed by DHB's with only 70% of 'Blueprint' recommendations being achieved (MHC, 2007b). A lack of momentum in implementing and advancing service user involvement has left it fragmented within current MHS. Ongoing reshuffling of funding and services fortifies regression of service user involvement initiatives due to money being redirected into in-patient units and medical services (Mental Health Advocacy Coalition, 2008; Schulze & Angermeyer, 2003).

Mental health funding is dependent on population based funding formulas¹⁰ and monitored through fixed input models¹¹ which further reinforces organisations placing priority on meeting targets, statistics and legislative requirements, rather than focusing on service users wellbeing (MHC, 2012c). This creates dysfunctional environments where service user involvement initiatives become stagnated and deemed less important. Participants identified an inability to be 'present' for service users due to their feeling obligated to place organisational auditing and documentation requirements first, and they felt leadership viewed service user involvement as being less important and deferrable. It is evident that the standards of practice which prioritise service user inclusion in care delivery and individual recovery will continue to be ignored if not promoted, supported and prioritised by mental health organisations and the nurses who work within them.

¹⁰ Population-Based Funding Formula (PBFF) determines the share of funding to be allocated to each District Health Boards (DHB), based on the population living in each district.

¹¹ Fixed Input Model – funding for inpatient beds and full time equivalents dependent on population size.

Participants identified power imbalances within their roles limiting their ability to embrace service user involvement initiatives. It is apparent that powerlessness within mental health nursing will continue to exist whilst nurses remain silent and subdued by oppressive forces. In agreement Roberts (2005) acknowledges that through nursing lacking transparency and openness about their roles and functions, a culture of silence is maintained and the nursing profession remains demoted. Critics have censured MHNs for being more institutionalised than the service users they work with and sluggish in adjusting their attitudes and practice to adopt service user involvement initiatives (Bennetts et al., 2011; Browne & Hemsley, 2008). Recognition of the vital and significant role nurses play in promoting service user involvement within healthcare and society settings can improve service user outcomes (MHC, 2012). Therefore it's essential that nurses reflect on the part they play in fostering the continuation of oppression.

Opportunities for change are positive aims of *Te Hononga 2015* (MHC, 2007), *Let's get real* (Te Pou, 2009) and *Blueprint II* (Mental Health Commission³, 2012). Such recommendations mandate MHNs to stake their claim on the future of their professional identity as advocates and supporters of the service user involvement. Nurses can and do rise beyond oppressive forces through working collaboratively with service users, examining and challenging oppressive attitudes and educating society about the value of service user involvement.

6.5 INSIGHT ON RECOVERY

Recovery principles aim to empower service users with personal tenacity and autonomy over their mental health needs and guide nurses to practice in an inclusive manner. The concept of recovery has proved difficult to define due to it being interpretative in nature and adapted to individual understanding and beliefs (Davidson, 2005). Whilst participants' acknowledge recovery principles are essential within current practice they reported the reality is that little occurs. Rather they felt the 'top down' approach driven by ministerial directives does not truly reflect and meet the needs of nurses and service users. This is in keeping with Masterson and Owen's (2006) findings that recovery criteria may

leave service users feeling a sense of segregation, coinciding with nurses' viewpoints that recovery principles are geared more towards meeting health professionals' needs rather than truly incorporating the needs of the service user. It is clear that recovery principles aim for better outcomes and ownership for service users yet the reality is that 'one size does not fit all'. Recovery criteria and principles need to be transferable and adaptable to suit individual service user needs. Through nurses being educated on the multifaceted approaches to understanding recovery, then flexibility and adaptability of care to meet service user needs is more likely.

Nurse participants reported recovery as being service user participation in treatment decisions to assist them to gain independence over their experience of mental illness. They acknowledged the important contribution MHNs makes in facilitating education about living well with mental illness when working alongside service users, families and the wider public. However they identified that service user independence cannot become a reality if service users themselves don't embrace it or want it. It is clear that literature is plentiful about barriers to implementing service user involvement, such as services users being viewed as too unwell to participate and service provider's hesitant to relinquish control. However, whilst literature explores health professionals institutionalised attitudes and pessimism towards service user involvement, scarce literature exists that captures service user and society viewpoints (Berry et al., 2010; Caldwell et al., 2010; Happell, 2009).

Participants identify they view the therapeutic relationship with service users as valuable and identify unique care occurs through direct connectivity and appreciation of humanity. Yet acknowledge that scepticism regarding certain service users ability to fully participate in their care remains entrenched. This viewpoint reinforces the retaining of power and promotes co-dependent relationships where decisions about care are nurse directed. Cutcliffe and Happell (2009) acknowledge that nurses embark with good intentions however insidious power dynamics can lead them to practice in a disempowering manner including

undervaluing service user participation. Development of critical self awareness and emotional competence is a key relational dynamic to developing inclusion within practice (Wilson & Carryer, 2008).

6.6 WORKING WITH INCLUSION IN MIND

Practice that is socially inclusive is a fundamental aspect of recovery. Essential to this is the role MHNs play in promoting social inclusion. Participants' embrace the concept of practising in a socially inclusive manner however they identified that championing for change for service users experiencing mental illness is not easy due to misconceptions existing at both individual and societal levels. Masterson and Owen (2006) agree that socially inclusive practice can exist if discrimination is addressed in society. Challenging disempowering attitudes and incorporating flexibility and adaptability in nursing practice ensures the delivery of care is determined by service users. Education about mental health, having an awareness of options and feeling empowered to voice preferences is vital to foster inclusion within therapeutic relationships.

Nurse participants' acknowledged that service users employed within organisations can be viewed negatively and distrustfully by health professionals. They identify this perception plays a major role in maintaining inequality and exclusion and creates an environment that inhibits inclusion. It is apparent that participants felt nurses contribute to undermining service user involvement through discrediting the valuable contribution service users make in service delivery. Despite participants identifying caring as the essential attribute, they reported this can be negated through discriminatory attitudes and maintaining control over service user's contribution. Government policy advocating for socially inclusive practice within MHS is well documented, however the reality is that its current implementation is being blocked. Through the exploration of nurses contribution to stigma, steps to overcome discrimination and rectifying exclusive practices can be examined.

6.7 COUNTERING STIGMA

Stigma and discrimination toward service users is a direct result of the knowledge and attitudes and is identified as the most significant aspect impacting on service user recovery and involvement within communities (Peterson, Barnes, & Duncan, 2008; Barnett & Barnes, 2010). Despite policy and public awareness campaigns, stigma and fear of prejudice can obstruct service users and their families from approaching MHS for assistance, therefore affecting recovery and potentially exacerbating mental health symptoms.

Nurse participants' reported some service users are reluctant to engage due to fear they will lose their employment, their friends, their relationships and/or their family. It is shown that fear of social rejection can adversely affect self worth, a sense of identity and self confidence and contributes to internalisation of shame (Barnett & Barnes, 2010; Hinshaw, 2005; Peterson et al., 2008; Verhaeghe et al., 2007;). Historic stereotypes play a significant role in maintaining stigma with nurses reporting some service users describe a fear of incarceration and being forcibly administered treatment (Barnett & Barnes, 2010; Mental Health Advocacy Coalition, 2008). It is important that the sources of these negative depictions of mental illness be identified and rectified for discrimination in practice to be addressed.

Media sources contribute to discriminatory attitudes towards mental illness through depictions of individuals as being dangerous, erratic and unpredictable (MHC, 2005). Of concern is that 7 years after this publication, negative stereotypes about people experiencing mental illness continues to exist within New Zealand society (Barnett & Barnes, 2010; Phoenix Research, 2011b). This negative publicity influences public perceptions and beliefs about mental illness and contributes to service user feelings of shame. Stigmatising attitudes will remain the status quo if society continues to exclude people deemed to be behaving outside perceived social norms.

Participants' identified that nurses are in a prime position to challenge stereotyped beliefs and educate colleagues and communities about mental illness and identified that an inclusive society begins with a purposeful therapeutic relationship between nurse and service user. However acknowledge that discriminatory attitudes within the discipline can hinder this occurring. Research shows that nurses are in a prime position to facilitate inclusion if they unifying their voices to challenge discrimination and stigma (Peterson et al., 2006).

It is consistently stated throughout this chapter that nurses have opportunities to champion for change through breaking down barriers that contribute to service user exclusion. One avenue to do so is becoming focused on changing their attitude toward a future generation of service users. Enhancing education within young people could potentially reduce stigmatising attitudes within New Zealand society. Nurses' active involvement in education within school environments potentially fosters inclusion and eliminates discriminatory attitudes towards mental health. Walter et al. (2011) clearly identify that mental health programmes within schools lessen stigmatising attitudes and equip individuals with skills to cope with mental distress. Therefore promoting mental wellness initiatives is an investment into the emotional wellbeing of young people. Mental health promotion is a vital first step for MHNs to embark on if beliefs about the value of service user involvement are to be respected.

6.8 STRENGTHS AND LIMITATIONS OF THE STUDY

A small sample size of eight participants may have been a constraining factor, however qualitative data collection aims for rich description rather than the ability to be generalised. In addition all eight participants were employed within one DHB, therefore contextualising the research. However, it is expected that this research in regards to funding restrictions and experiences of stigma may be applicable regionally. It is acknowledged that this study offers a snapshot of current dynamics within mental health practice that may help and/or hinder

service user involvement initiatives. Moreover, service user involvement is an evolving concept within MHS and this research is a part of that journey.

6.9 RECOMMENDATIONS

The following recommendations are proposed enhance the capacity, capability, quality and strengthening of service user involvement within mental health nursing.

6.9.1 Capacity

1. Given funding limitations placed on health delivery services, it is vital that current service delivery changes to incorporate new ways to working. Caring for service users in a timely and person centred way is essential.
2. In order to reduce the demand on secondary health care services more emphasis on care delivery within primary health care settings is required. Through MHNs being aligned with community organisations, GP's and wellness clinics better access to mental health advice and treatment can occur potentially reducing the long term experience of symptoms.
3. MHNs becoming more visible and accessible to provide mental health education for all ages of service users and their whanau and friends and can assist in building resiliency and skills to cope with mental distress.
4. MHNs engagement in educative programmes within schools can lessen stigma and discrimination towards mental health illness.

6.9.2 Capability

1. Upskilling to recognise the need for user preferences and inclusion is paramount. Developing awareness about barriers to service user involvement and its implementation can be identified. Acknowledging discrimination in practice within current health

delivery enables avenues for skill and competency enhancement to be identified and addressed.

2. Policy's impact on mental health nursing practice. For service user involvement to improve MHNs require in depth understanding and knowledge of policy guiding mental health practice and service delivery. Blueprint II (MHC, 2012; MHC, 2012b) aims to promote service user involvement initiatives and ensures best value within public health. It also advocates for change from traditional service delivery within secondary health settings to one that improves access to primary health care settings.
3. MHS future consists of optimising clinical pathways which streamline service delivery. It is essential that secondary care settings provide training and education and fund nurses to upskill and attend training.

6.9.3 Quality

1. Quality can be achieved through MHNs committing to actively supporting service user involvement within the organisations they work. Service users need to be empowered and supported to be actively involved in treatment decisions, options and resources available to support their decision making process. MHNs need knowledge of ways to improve service user involvement through socially inclusive practice to meet service user needs.
2. Nursing leadership needs to take an active role in promoting and encouraging dynamic practice geared at service user involvement. Nurses in leadership positions embracing and advocating of involvement initiatives is paramount. Through leadership, education, upskilling and improving understanding transformative practice within MHS can be achieved.

6.9.4 Strengthening the Profession

1. Blueprint II and Let's Get Real guidelines offer valuable insights into the future direction of mental health nursing practice and offer an opportunity for nurses to become advocates for service user involvement and champions for change within MHS settings.

6.10 RECOMMENDATIONS FOR FUTURE RESEARCH

Exploration of relational and environmental factors affecting service user involvement within MHS settings is recommended. It would be valuable to ascertain perceptions of novice MHNs regarding service user involvement. Furthermore, undertaking research with service users to examine their perceptions and attitudes towards involvement would be the next step to examining the current environment in a journey towards inclusive care.

6.11 CONCLUSION

This study has examined environmental and relational factors which affect service user involvement from the perspective of eight experienced community MHNs. Participants identified years of experience and nursing education as impacting on their understanding and knowledge regarding nursing's role in service user involvement initiatives. Furthermore, organisational funding constraints, policy and legislative requirements impact on collaborative time with service users and limits their ability to advocate for inclusive practice. It is clear that organisational demands and workplace environments play an important role in ensuring nursing practice embraces service user involvement. For nurses to embrace service user involvement, they need to commit to undertake education and enhance their knowledge and practice.

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**MENTAL HEALTH NURSES WORKING IN ADULT
COMMUNITY MENTAL HEALTH AND/OR
ADDICTION SETTINGS.**

**MUST HAVE EXPERIENCE OF WORKING
ALONGSIDE SERVICE USERS WITHIN THE
COMMUNITY MENTAL HEALTH AND/OR
ADDICTION SETTING.**

**DO YOU WANT TO BE PART OF A NURSING
STUDY EXPLORING THE PERCEPTIONS AND
ATTITUDES
TOWARDS SERVICE USER INVOLVEMENT?**

**IF THIS SOUNDS LIKE YOU, OR YOU WOULD LIKE
MORE INFORMATION, PLEASE CONTACT:**

VICKY BROWN
VICKYBR@XTRA.CO.NZ
06 350 8184 (EXTN 7947)/0274 252 778

**THIS STUDY HAS BEEN APPROVED BY THE
CENTRAL REGIONAL ETHICS COMMITTEE.**

What are the perceptions of and attitudes toward service user involvement from the perspective of mental health nurses working in a community and addiction settings?

INFORMATION SHEET

My name is Vicky Brown and I am a current Master of Philosophy student at Massey University. I am employed as a Community Psychiatric Nurse at Palmerston North Community Mental Health at Midcentral Health DHB. My contact details are (06) 3508184 (work) and (06) 3293095 (home). My research supervisor is Stacey Wilson, her contact telephone number is (06) 3569099, extension 7513.

I am conducting a qualitative study to examine the perceptions of and attitudes towards service user involvement from the perspectives of community mental health and addiction nurses working within community mental health settings.

Participant Recruitment:

I am seeking to interview 8-10 nurses for this study. If you are interested in applying please make contact with me, if you are:

- A registered nurse working in community mental health and/or addiction services.
- Willing to be interviewed by me and with your permission audio taped.

When you have indicated your interest in participate in the project (either by telephoning or emailing me directly), I will explain further the projects procedure. The interviews will take place at an agreed venue convenient to your workplace. The interviews will take approximately 1-2 hours.

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any particular question
- Withdraw from the project at any stage
- Ask any questions about the project at any time during participation
- Provide information on the understanding that your name will not be used at any time
- Be given access to a summary of the project findings when it is concluded
- Request a copy of the audio tape
- Ask for the audio tape to be turned off at any time during the interview.

Confidentiality will be maintained, however if unsafe practice is disclosed I would be required to act ethically and professionally which would include discussing issues with my supervisor.

If you have any questions or concerns about your rights as a participant in this study, you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone (NZ Wide) 0800 555 050

Free Fax (NZ Wide) 0800 2787 7678 (0800 2 SUPPORT)

Email (NZ Wide): advocate@hdc.org.nz

If you are interested in participating in this project or have any questions regarding the information sheet or about the project, please contact me directly on (06) 3293095 or vickybr@xtra.co.nz or contact my supervisor Stacey Wilson, telephone (06) 3569099, extension 7513 or S.Wilson@massey.ac.nz. I look forward to speaking with you.

A qualitative exploration of the perceptions of and attitudes toward service user involvement from the perspectives of mental health nurses working in a community setting.

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years.

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to the interview being audio taped.

I understand that I can ask for the audio tape to be turned off at any time.

I understand that I can request a copy of the audio tape to be given to me.

I understand I can decline to answer any particular question.

I understand I can withdraw from the study at any point up until the data has been analysed.

I understand that my privacy and anonymity will be protected and that all information will remain confidential.

I understand that if any unsafe or illegal practice is disclosed I will advise my team leader or manager, as advised by the researcher.

I understand that should unsafe practice be disclosed, the researcher would act ethically and professional which could include discussing issues with her supervisor.

I understand I can be given access to a summary of the findings when the study has concluded.

If you have any questions or concerns about your rights as a participant in this study, you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone: (NZ Wide) 0800 555 050

Free Fax: (NZ Wide) 0800 2787 7678 (0800 2 SUPPORT)

Email: (NZ Wide) advocate@hdc.org.nz

Signature _____

Full name (printed) _____

Ethics Ref: **CEN/10/09/35**

A qualitative exploration of the perceptions of and attitudes toward service user involvement from the perspectives of mental health nurses working in a community setting.

PROOF OF CONSULTATION

This form will be held for a period of five (5) years.

TO WHOM IT MAY CONCERN

CONSULTATION ON 'A QUALITATIVE EXPLORATION OF THE PERCEPTIONS OF AND ATTITUDES TOWARD SERVICE USER INVOLVEMENT FROM THE PERSPECTIVES OF MENTAL HEALTH NURSES WORKING IN A COMMUNITY SETTING.

This letter confirms that consultation occurred on the above mentioned proposed research to assist in the development of aims and questions. Furthermore cultural and social responsibility issues were discussed and examined to decrease the risk of inequalities occurring and to ensure the studies appropriateness to service user, whanau, cultural and social needs is maintained.

Signature: _____

Full name (printed) _____

Designation: _____

Date: _____

A qualitative exploration of the perceptions of and attitudes toward service user involvement from the perspectives of mental health nurses working in a community setting.

SEMI STRUCTURED INTERVIEW GUIDE

What is your understanding of Service User Involvement?

What are your attitudes/perceptions towards service user involvement?

Have you heard or read anything about service user involvement and participation in the provision of mental health services?

From a nursing perspective are there any environmental and/or relational factors which affect service user involvement?

Within the organisation you work is there any environmental and/or relationship factors which affect service user involvement?