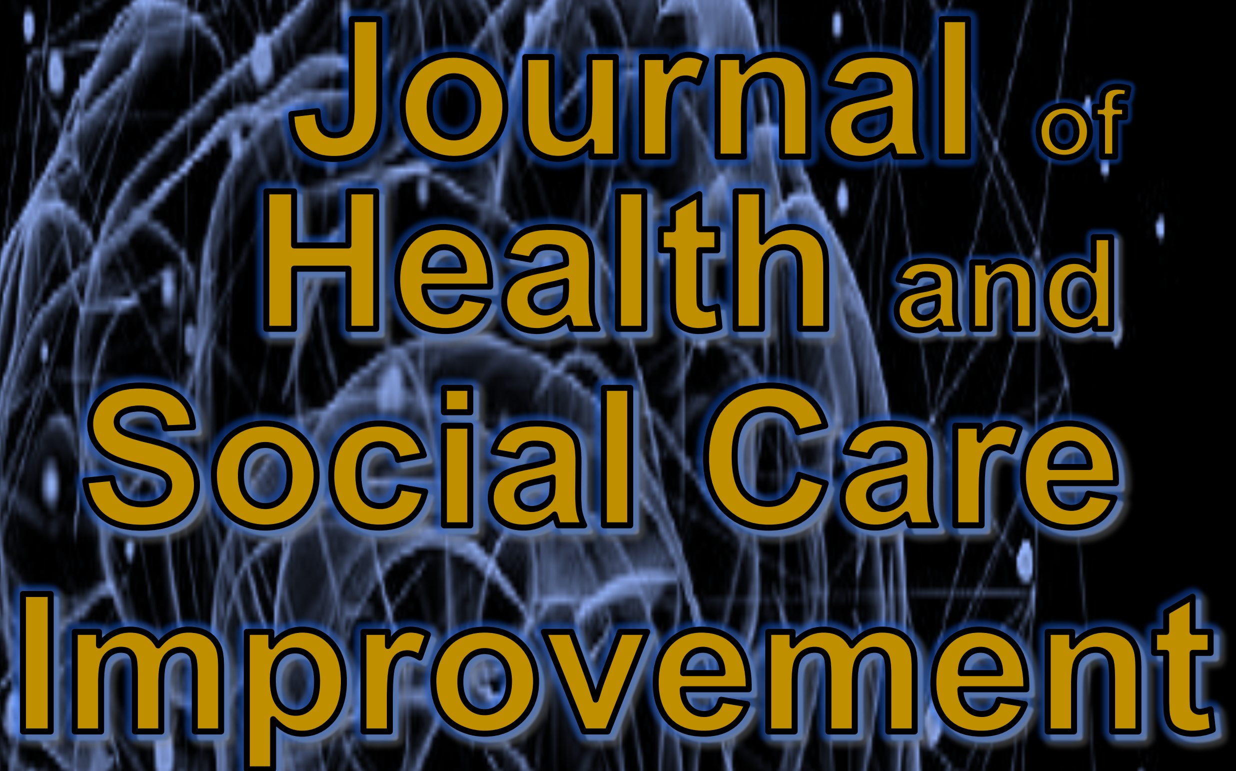

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Advice to Contributors

A new year, a new decade and so many new year resolutions to break. Yep, here we are again promising ourselves super-human attempts at self-improvement. Perhaps like me you've re-joined a gym, thrown out the crisps and biscuits, promised yourself to drink only 4 nights a week and learn Russian to impress the woman in the opposite flat. Maybe you've even decided to take your academia seriously and write for 15 minutes every day instead of nostalgically lamenting how the years easily fade. How it is now 2020 and you've still not completed that article for JoSCHI. Aha, I hear you cry, I see his secret agenda. I can see how, like some Soviet propaganda he's trying to make me feel bad and frightening me with threats of the gulag and Cossack dancing unless I contribute to the writing revolution. Well, this may be the case but what do you say we agree on a new covenant? How about today, right now you write for 15 minutes, join a writing group and see what happens. For our part here at JoSCHI, we'll attempt to rewrite our 'opportunity' constitution and commitment to help you get the most out of your pen. Unlike a Russian doll you don't have to be full of yourself just commit to make yours an inside job.

Click here for ABBA SOS (1975) (from previous editorial)
https://www.youtube.com/watch?v=89w-L3aICj4

Dean-David Holyoake
Developmental Editor

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An exploration of mental health professionals' attitudes towards people with mental illness

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Introduction

Over recent decades, there has been increasing attention paid to negative attitudes and stigma and discrimination experienced by people with mental health problems (Angermeyer & Dietrich, 2006; Evans-Lacko, Corker, Williams, Henderson, & Thornicroft, 2014; Gabbidon et al., 2013).

Negative attitudes towards individuals with mental illness have also been found in health professionals (Bjorkman, Angelman, & Jonsson, 2008; Gras et al., 2015; Rao et al., 2009) including psychiatrists (Chaplin, 2000) and other mental healthcare workers (Hugo, 2001; Nordt, Rossler, & Lauber, 2006). The use of negative language (Sartorius, 2007) or inappropriate diagnostic labelling (Schulze, 2007) by health professionals, is likely to both increase the stigma experienced by service users and to reinforce the negative attitudes held by many members of the general public (Caldwell & Jorm, 2001).

Research into negative attitudes held by health professionals towards people with mental illness has often focussed on looking at particular characteristics of the individual sufferer, for example gender or ethnicity (McKenzie & Bhui, 2007; SHSA, 1993). However it has been suggested that attitudes towards people with mental illness can also be affected by factors relating to the health professional, such as ethnicity (Silton, Flannelly, Milstein, & Vaaler, 2011, (Schafer, Wood, & Williams, 2011)), gender (Angermeyer & Dietrich, 2006), and personal or family history of mental health problems (Corrigan, Markowitz, & Watson, 2003). However, most of these studies have either focussed on a single health professional discipline or have failed to examine possible differences between different disciplines.

Several scales have been developed to assess attitudes to people with mental health problems; however these have largely been validated in non-professional populations, or have been specifically developed to explore attitudes in one particular professional group (Gabbidon et al., 2013; Svensson et al., 2011; Van Brakel, 2006). The MICA v4 Scale was developed by Gabbidon et al. (2013) to look at attitudes towards mental illness held by healthcare professionals and students in any discipline.

The aim of this study was to compare the attitudes of medical and nursing mental health professionals towards individuals with mental health problems and to identify factors associated with positive or negative attitudes. It was hypothesised that healthcare workers with a personal or family history of mental health problems would be less likely to hold negative attitudes due to social contact or experience.

Method

All psychiatrists working in five different Mental Health NHS Trusts in England and all nursing staff (including healthcare assistants) working in a large South London Mental Health Trust were invited to participate in a brief online survey by email. Potential participants were identified by a medical staff member in each of the trusts and contacted using internal email mailing lists

Measures
Participants were asked to complete the Mental Illness: Clinicians' Attitudes (MICA) Scale v4 (Gabbidon et al., 2013). The MICA v4 is a 16 item scale which can be used to assess healthcare professionals' and students' attitudes towards people with mental illness. Each item is scored on a six point scale from 'strongly agree' to 'strongly

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disagree'. Items 1, 2, 4-8 and 13-15 are reverse scored, as per the MICAv4 scoring guidelines. A total score is then calculated by adding the results for items 1 to 16. Questionnaire items are also grouped into 5 factors (as identified by Gras et al, 2015 and described in Box 1) and an average score for each factor is calculated. Higher scores indicate more stigmatising views.

In line with previous research, a score of ≤3 (indicating somewhat (dis)agree), was used to indicate a moderately positive attitude, whilst a score of ≤2 indicated a positive attitude (Gras et al., 2015).

The MICA v4 has been validated with nursing students and other healthcare workers. It has been found to have good internal consistency and inter-item correlations, good face validity and acceptable convergent validity.

The authors of the MICA v4 gave permission for an electronic version of the questionnaire to be created.

Participants were also asked to provide some demographic details including: age, gender, marital status and ethnicity, as well as current job title and degree of experience working in mental health. Ethnicity was initially categorised into five groups, reflecting the broad ethnic groups used by the Office of National Statistics (2012), however due to the small sample size, for the purposes of meaningful analyses, this was further reduced to the three most common categories in our sample (White, Black, Other). Finally, participants were asked to state whether they themselves, or a family member, had ever experienced mental health problems.

Factor 1	Views of health/social care field and mental illness
Factor 2	Knowledge of mental illness
Factor 3	Disclosure of mental health problems
Factor 4	Distinguishing mental and physical health
Factor 5	Patient care of people with mental illness

Box 1. Five factors of MICAv4

Sample size

A sample size of at least 30 participants in each professional group was required to provide sufficient information regarding the distribution of attitudes in this sample.

Statistical analysis

Data was analysed and scored using SPSS v23 for Windows. Categorical socio-demographic variables were compared between professional groups using Pearson χ^2 hypothesis tests. The association between the socio-demographic variables and the five factors of the MICA v4 and the total score was explored using one-way analysis of variance (ANOVA). In order to explore the presence of interaction effects between professional group and socio-demographic variables on attitudes to mental illness ANOVA models in Table 2 were refitted adding in the respective interaction effect and the two independent variables as main effects.

Results

190 responses were received. In total 19 participant's responses were excluded due to missing data, relating to at least one response, leaving 171 participants. Participants who omitted demographic information, were also excluded from relevant analyses.

Characteristics of participants

Table 1 shows the Characteristi*cs* of Participants. There were significant differences between professional groups. Compared to the nursing sample, the doctors had a more even gender distribution (p=0.002), were younger (p<0.001) and were less ethnically diverse (with a significant majority of Caucasian respondents) (p<0.001). Significantly more doctors than nurses reported a family history of mental health problems (p=0.001).

Thirty seven (37%) doctors were core trainees, 26 (26%) were higher trainees and 35 (35%) were consultants. Thirty one (43%) nurses were healthcare assistants, 7 (10%) were staff nurses, 4 (6%) were charge nurses, 10 (14%) were nurse practitioners, 14 (19%) were community mental health nurses and 6 (8%) were in managerial roles.

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		Doctors (n=99)	Nursing (n=72)	P value[a]
Gender	Male	45 (45%)	17 (24%)	0.002
	Female	50 (51%)	53 (74%)	
Age (years)	20-29	17 (17%)	12 (17%)	<0.001
	30-39	48 (48%)	9 (13%)	
	40-49	19 (19%)	19 (26%)	
	50-59	12 (12%)	25 (35%)	
	Over 60	0	7 (10%)	
Ethnicity	White	73 (74%)	35 (49%)	<0.001
	Mixed race	9 (9%)	4 (6%)	
	Asian	8 (8%)	3 (4%)	
	Black	3 (3%)	25 (35%)	
	Other	0	1 (1%)	
Previous history of mental health problem in self/family	Yes	75 (76%)	37 (51%)	<0.001
	No	16 (16%)	28 (39%)	
Previous mental health problem	Yes	38 (38%)	19 (26%)	0.088
	No	52 (53%)	44 (61%)	
Family member with mental health problem	Yes	70 (71%)	33 (46%)	0.001
	No	23 (23%)	32 (44%)	

[a] Pearson's χ^2 tests

Table 1. Characteristics of participants

Attitudes of doctors and nursing staff towards people with mental illness

Across the whole sample, significant differences were found between ethnic groups (Black, White and Other) on the overall score on the MICA (p=0.046) and on Factor 1 (p=0.010). Borderline significance was found on Factor 2 (p=0.060), with Black and 'Other' group participants scoring higher on these factors, indicating more negative attitudes towards people with mental illness.

Participants with a family history of mental health problems tended to report less negative attitudes on the MICA (p=0.058), Factor 1 (p=0.089) and Factor 3 (p=0.086), although results failed to reach significance level of 0.05.

Interactions between professional group and socio-demographic variables

.

Due to significant demographic differences between medical and nursing groups as demonstrated in Table 1, further analyses tested for interaction effects between professional group and socio-demographic variables for each factor of the MICA4.

There was a significant interaction between ethnicity and professional group with respect to factor 1 (p-0.005). Whilst Black doctors had the lowest scores on factor 1 (mean 1.5: 95% CI 0.6, 2.4), Black and 'Other' nursing staff scored much higher (mean=2.7: 95% CI 2.4, 3.0 and mean=2.6: 95% CI 2.2, 3.1 respectively). There was a further significant interaction between ethnicity and professional groups on Factor 2 (p=0.032). Black doctors had the lowest scores (mean 1.667: 95% CI 1.0, 2.4), whilst Black and 'Other' nurses scored higher (mean 2.2: 95% CI 2.0, 2.5 and mean 2.5: 95% CI 2.2, 2.9)

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		Scores					
		Total MICA4 score	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
Professional background	Medical, mean (SD)	2.000 (0.516),	2.102 (0.718)	1.854 (0.560)	3.066 (1.199)	1.770 (0.710)	1.490 (0.811)
	Nursing, mean (SD)	2.086 (0.578)	2.247 (0.909)	2.065 (0.751)	2.785 (1.135)	1.844 (0.839)	1.597 (1.109)
	F, p value	0.161 (0.689)	0.781 (0.378)	1.102 (0.296)	3.027 **(0.084)**	0.093 (0.761)	0.047 (0.829)
Gender	Male, mean (SD)	2.070 (0.579)	2.250 (0.880)	1.900 (0.639)	3.008 (1.377)	1.827 (0.734)	1.5889 (0.817)
	Female, mean (SD)	2.022 (0.526)	2.100 (0.758)	1.985 (0.671)	2.927 (1.065)	1.789 (0.783)	1.515 (1.040)
	F, p value	0.077 (0.782)	0.989 (0.322)	0.402 (0.527)	0.037 (0.848)	0.194 (0.661)	0.026 (0.871)
Age group	20-29, mean (SD)	2.148 (0.437)	2.000 (0.616)	2.112 (0.456)	3.448 (1.160)	2.017 (0.738)	1.466 (0.693)
	30-39, mean (SD)	1.935 (0.461)	1.978 (0.662)	1.909 (0.581)	2.930 (1.163)	1.697 (0.576)	1.412 (0.824)
	40-49, mean (SD)	2.044 (0.613)	2.213 (0.857)	1.875 (0.583)	2.842 (1.140)	1.836 (0.973)	1.658 (1.085)
	50-59, mean (SD)	2.125 (0.597)	2.487 (0.790)	1.960 (0.834)	2.811 (1.169)	1.865 (0.814)	1.568 (1.088)
	Over 60, mean (SD)	2.047 (0.834)	2.393 (1.638)	1.952 (1.206)	2.643 (1.464)	1.464 (0.668)	2.143 (1.282)
	F (p value)	0.721 (0.579)	1.781 (0.136)	0.601 (0.662)	1.129 (0.346)	1.085 (0.367)	0.844 (0.499)
Ethnicity	White	1.932 (0.497)	1.982 (0.687)	1.817 (0.580)	2.880 (1.146)	1.738 (0.667)	1.519 (0.891)
	Black	2.250 (0.621)	2.545 (1.089)	2.179 (0.751)	2.821 (0.964)	2.036 (1.128)	1.661 (1.202)
	Other	2.198 (0.549)	2.419 (0.733)	2.154 (0.707)	3.294 (1.393)	1.809 (0.688)	1.500 (0.913)
	F (p value)	3.147 **(0.046)**	4.774 **(0.010)**	2.871 **(0.060)**	1.023 (0.362)	1.070 (0.346)	0.095 (0.910)
History of MH Problem	Yes	1.963 (0.523)	2.054 (0.908)	1.820 (0.532)	2.930 (1.163)	1.759 (0.686)	1.500 (0.779)
	No	2.077 (0.573)	2.229 (0.777)	2.004 (0.719)	2.870 (1.164)	1.849 (0.820)	1.599 (1.085)
	F (p value)	0.085 (0.770)	0.115 (0.735)	0.353 (0.554)	0.438 (0.509)	0.078 (0.780)	0.002 (0.962)
Family History of MH Problem	Yes	1.941 (0.539)	2.035 (0.750)	1.846 (0.621)	2.825 (1.141)	1.745 (0.708)	1.471 (0.866)
	No	2.217 (0.532)	2.405 (0.894)	2.086 (0.693)	3.146 (1.212)	1.932 (0.865)	1.736 (1.142)
	F (p value)	3.661 **(0.058)**	2.941 **(0.089)**	0.761 (0.384)	2.981 **(0.086)**	0.341 (0.560)	2.179 (0.142)

Table 2. Analysis of each factor on the MICAv4 according to demographic characteristics of participants using one way ANOVA

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There was a significant interaction between 'Previous History of a Mental Health Problem and professional group with respect to Factor 2 (p=0.023). Mean scores on Factor 2 were similar for doctors who had had a mental health problem and those who had not (previous history mean 1.9: 95% CI 1.7, 2.1; no previous history mean 1.8: 95% CI 1.7, 2.0). However, nursing staff, who had personally experienced mental health problems scored much lower than those who not personally experienced mental health problems (mean=1.7: 95% CI 1.4, 2.0 versus mean 2.2: 95% CI 2.0, 2.4). Very similar results were also found in respect to Factor 1, although the interaction failed to reach significance (p=0.054).

There was a significant interaction between Family History of a Mental Health Problem and professional group with respect to Factor 1 (p=0.006). Similar mean scores on Factor 1 were obtained for doctors regardless of any reported family history of mental health problems (family history present mean 2.1: 95% CI 1.9, 2.3; no family history mean 2.1: 95% CI 1.8, 2.4). However, nursing staff with a family history scored much lower than those with no family history (mean=1.9: 95% CI 1.6, 2.2 versus mean 2.6: 95% CI 2.4, 2.9).

Discussion

This study set out to explore the attitudes of mental health professionals working in psychiatry towards people with mental health problems and factors affecting them.

Average scores on the MICAv4 were low, indicating moderately positive or positive attitudes towards people with mental health problems in this sample. However, the study identified certain key differences between doctors and nurses working in mental health settings.

Nursing staff from Black and Other ethnic groups held more negative views about mental illness and were also less likely to endorse the need to acquire knowledge about mental health problems, when compared with White nursing staff. Attitudes of medical staff in the field were not, however, affected by ethnicity. Our findings are with regard to nursing staff are consistent with Schafer (Schafer et al 2011) who also found less positive attitudes towards people with mental illness amongst Black and ethnic minority nursing students, compared with White nursing students. No research has specifically examined whether this ethnicity effect is also found in doctors.

Whilst a personal or family history of mental health problems did not result in significantly lower scores on the MICAv4 overall, when considered according to professional group, we found that nursing staff with a family or personal history of mental health problems tended to hold less negative attitudes towards people with mental illness and less negative attitudes with regard to gaining knowledge about mental health problems, compared to those with no family or personal history. Medical staff attitudes were not influenced by personal or family history of mental health problems. Other studies have found an association between having a personal or family history of mental illness and less negative attitudes towards others with mental health problems in a lay sample (Corrigan et al., 2003) and nursing sample (Martensson, Jacobsson, & Engstrom, 2014). But again this effect has not specifically been examined in doctors.

The differential impact of ethnicity and family and personal history of mental health problems on attitudes of doctors and nurses towards individuals with mental illness, warrants further exploration. Significant numbers of mental health nursing staff in London originate from low and middle income countries (Yar, 2001) where there is very limited research into attitudes towards patients with mental health problems (Thornicroft et al., 2016) and training in equality and diversity issues is not necessarily as integrated within training as in the UK. However it is not clear why the variation according to attitudes is not apparent amongst Black and Minority Ethnic doctors.

It is possible that having a family or personal history of mental health problems may reduce stigmatising attitudes through the knowledge or experience that is associated with this. This may be relevant in the nursing group where exposure to mental health problems in self or family led to less negative attitudes. Doctors' attitudes could be influenced by length and breadth of medical training resulting in less negative attitudes in this group regardless of their personal experience of

mental health problems. Location of nursing and medical training may also be an important factor when considering attitudes. Training in the UK now routinely incorporates equality and diversity training and education around mental health, which may not be the norm for training delivered in other countries.

Previous research has suggested that female nursing staff tend to hold significantly less stigmatising views of patients with mental health problems than male nurses (Chambers et al., 2010). However, we found no difference in attitudes according to gender, amongst the doctors, or the nurses.

Mental health professionals are important advocates for their patients. Whilst negative attitudes do not automatically translate into discriminatory behaviour and adverse treatment, they may affect the professional's ability to promote recovery and social inclusion. Alongside stigma and discrimination, negative attitudes have been described as a barrier to recovery amongst those with mental health problems (Chambers et al., 2010) and may result in worse outcomes (Alvarez-Galvez & Salvador-Carulla, 2013; Schomerus et al., 2015). Negative views of mental illness have also been associated with self-stigma in mental health patients (Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012). It is possible that exposure to people with mental health problems and education and training around mental health could reduce negative attitudes in healthcare staff, improving health outcomes for those using mental health services (Schomerus et al., 2015). The precise nature of interventions that are effective in challenging negative attitudes warrants further exploration.

This study has several limitations. Numbers were relatively small and so when carrying out analyses, there was the possibility of Type II errors. A selection bias is possible due to the method of data collection. We are unable to report a response rate because we did not have access to the individual email addresses of potential participants and do not know how many staff received the invitation. The small number of participants meant that broad categories were used for demographic variables for the purpose of analysis, particularly with regards to ethnicity, where each group (Black/White/Other) could represent diverse populations with significant heterogeneity. Nurse participants were all from one Mental Health Trust, which may limit generalisability of results.

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'MYSELF AND I': *Ethical reflections on autoethnographical research*

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Ethical deliberation is a central imperative throughout all research inquiry, interweaved with deep connections to our humanity (Turner, 2013). The intention here is to offer a reflective account of salient ethical issues unique to autoethnographical research. Autoethnnography is a narrative qualitative approach that draws on the lived experience of the author, in order to examine often difficult socio-cultural issues and give space for exploration, representation and interpretation of such. Thus the central character situated at the heart of the knowledge quest is 'myself and I', a point to which I will return.

Firstly, I aim to focus on an important thread of axiological debate that would appear unique to autoethnography; that of, 'relational ethics'. Indeed, it is difficult if not impossible when talking about myself to disentangle the 'I' from 'others', who may be intertwined in my lived experience and reality (Ellis, 2007; Chang, 2008; Roth, 2009; Turner, 2013). Relational ethics centres on the importance of being 'true' to self, without compromising others. Arguably, there is variance to this idea in a socially "*constructed ontology*", where my thoughts may differ to another's (Turner, 2013 p.220). When thinking along these lines the inquiry was a construction and interpretation of events that were layered and informed by the voices of relational others, to provide texture to my story.

As with all research the fundamental principal of confidentiality has to be maintained to provide anonymity of individuals or specific contexts within the data. However, this contention does become problematic when referring to siblings (Ellis, 2004; 2007; Tullis, 2013; Turner, 2013; Adams, Holman-Jones and Ellis, 2015). For this purpose, I strived to be ethically mindful of personal responsibility towards others, relative to '*alterity*' or the capacity to do good (Levinas, 1987). Mechanisms that enabled such capabilities hinged around accountability, a recognition of my "*narrative privilege*" (Adams, 2008) and my "*narrative conscience*" (Poulos, 2008 p.46). In line with Porter- Abbot (2008), I remained cognizant that my narrative could be mechanism for power and authority. Ultimately, I held accountability for what was disclosed about self and others but with the power rubric in mind; the practice of both 'process consent' and 'member checking' were implemented. The former to ensure voluntary participation throughout (Denshire, 2013; Adams, Holman-Jones and Ellis, 2015) whilst the latter enabled discussion of inaccuracies and reflection on any differences that emerged (Biscomb, 2012).

Furthermore, it was important to be mindful of not publishing anything I would find uncomfortable showing to those referred to within the text. However, this has potential to become difficult when sharing stories relating to the memory of someone who is now deceased. Arguably, the making of decisions on what to tell of those deceased carries ethical issues. The processes discussed above helped in the decisions of what and how to tell. Indeed, the upmost care was taken to share only what my siblings were happy with, and working to promote the fundamental principles of beneficence and non-maleficence at all times.

Notably, as indicated above, not all the data involved siblings and as the research evolved, 'Myself and I', became the prominent site for the inquiry. Moreover, what became apparent on the journey were the many layered complexities that have potential to surface whilst doing autoethnography. With this in mind, it was important to pay attention to these unanticipated ethical issues arising in the course of the research which may serve to ensure "*that emotional labour*

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is performed" (Jarzabkowski, 2012 p.10) through cultivating a heightened sense of emotional awareness towards self and others. This required my ongoing attention at all stages of the process in order to question, reflect, search and challenge intentions (Ellis, 2007).

Similarly, as alluded to above seminal proponents contend that ethical issues are highly important in relation to 'myself and I'. For this purpose, consideration has to be given at all stages of the research process to the possibility of revealing a vulnerable self. As indicated by Adams, Holman-Jones and Ellis (2015 p.65) "*you become the stories you write*" and in line with Tolich (2010), should be viewed as an 'inked tattoo' or permanent marking which cannot then be removed. For this reason, at the outset of my research I considered the medium of a composite character (Ellis, 2004) as a layer to protect and provide less visibility to my vulnerable self. However, as I was exploring the personal lived experience of mental health stigma; a topic in need of more openness and much talk, I decided against this; instead taking the cautious decision to display my 'inking' loud and proud. The explorative process included attention to my own self-care. For example, supervisory meetings, debriefs, along with ongoing attention to reflexivity through journaling were useful mechanisms of support (Muncey, 2010; Adams, Holman-Jones and Ellis, 2015; Tullis, 2013).

Finally, autoethnography is a highly subjective methodology, that through the doing of then became the product of an inquiry where 'myself and I' were pivotal, yet also deeply entwined with relational others in a co-constructed reality. From this personal reflection on my research practice, I hope to have conveyed an overview of some of the ethical complexities inherent within the genre, along with highlighting their equal importance to all other research approaches.

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Supporting and Fostering Work-based learning for Trainee Nursing Associates (TNA)

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Executive Summary:

The aim of this case study is to explore factors that affect work-based learning (WBL) for trainee nurse associates. It will focus on a pilot work-based Nurse Associate, foundation degree that I teach on. The objective of the TNA programme is to support students' to develop skills, understanding and personal attributes; which would improve their employability. The programme is underpinned with a constructivist-collaborative-andragogy and experiential approach as well as blended learning.

This case study identifies a range of factors, which affect student learning in a work-based context. An initial diverse group of one hundred students were enrolled to a pilot programme. The students are employees of the partner organisations. It is important to note that the students have extensive experience as health care assistance. Furthermore, the majority are mature students, who came into higher education through widening participation who generally had a historical negative experience of education. In order to address these issues inclusivity was central to the curriculum design in anticipation of the learners needs. Furthermore I gave due recognition, to the work place as a legitimate site for experiential learning (Kolb, 1984). Having said that, the harsh reality is that, there are numerous organisational and cultural barriers to work-based learning that need to be carefully managed (Evans, Hodkinson and Unwin 2005).

Pedagogic-andragogy theories relevant to work-based teaching and learning will be explored and the challenges and opportunities this presents. Four main findings from the case study, namely; Inclusivity: the holy grail for work-based learning, Students; a key partner in work-based learning, Clarity of expectations and finally Quality assurance challenges in work-based learning will be discussed in more detail.

The context of this case study is specific to health care however; the findings, themes and messages are not context specific and could be applicable to any work-based learning environment.

Key words: Inclusivity, Experiential learning, Andragogy, Work-based learning, Employability

Introduction

This case study is based on level 5 trainee nursing associate work-based foundation degree, which is being piloted at a large university in the west midlands. Higher Education England (HEE) following the Shaping Care Review, which recommended a work-based programme for a nurse associate role to address shortfalls in nursing workforce (HEE, 2015), commissioned the course. A local University in the West Midlands in collaborated with nine NHS partners set up a trailblazing work-based learning programme, which I have the privilege to teach.

Work-based learning presents both opportunities and challenges for students, universities and employers. This case study will focus on supporting and fostering work-based learning for students from non-traditional routes into higher education. It will explore opportunities and challenges of creating an environment conducive to an adult learning approach. I will evaluate the programme's effectiveness in supporting WBL using a reflective approach; I hope this will enable personal growth through experiential learning which would improve my teaching practice for the

benefit of learners as well as contribute to the body of knowledge on work-based learning.

Work-based learning is a contested term; for the purpose of this case study it will be used to refer to a collaboration between students, university and employers to create university level learning opportunities across university and the work place using an andragogic approach (Boud and Solomon, 2003), (Knowles, 1984). According to Evans, Hodkinson and Unwin, (2005) the work place has enormous potential as a site for learning. Its main advantage is that it meets the needs of learners, improves employability and contributes to in-house workforce development. In this case study I designed sessions that would not just extend the knowledge of the individual, but to meet the work force needs of the employer (Boud and Solomon, 2003).

This intrinsic case study research (Baxter and Jack, 2008) and reflective narrative (Gibbs, 1999) explores opportunities and challenges of work-based learning in a health and social care context. However, the lessons learnt, could be applied to work-based learning in other context; considering apprenticeships are high on the government agenda (DoE, 2018). In this case study, as a lecturer I take an insider's view, using a constructivist methodology; where truth is relative, and is built on the premise that knowledge is socially constructed. Constructivist paradigm rejects the notion of epistemic objectivity and applauds the subjective perspectives of individuals (Baxter and Jack, 2008). Baxter and Jack (2008) further opine that, participants are able to tell their stories through close collaboration between researcher and participants.

In this case study, I have used data from a variety of sources that is already available to me in my teaching role, including student feedback. Confidentiality will be maintained at all times, throughout this case study (NMC, 2015).

Across all participating organisations, there was consensus to actively champion the new role. Generally, students were excited and motivated about embarking on this personal and professional transformational learning journey; however, there were challenges to achieving this at times. Students on the TNA course attend university once a week and are at work for four days, with a discretionary study day. The programme's strategy is to widen participation into higher education for students who would otherwise not qualify through traditional routes. Therefore, I adopted an inclusive and collaborative approach to teaching and learning. This was underpinned by experiential learning which valued student prior experience (Kolb, 1984).

Findings

Inclusivity: the holy grail for work-based learning

A key finding from this case study is that TNAs students are not a homogenous group, they are diverse in many dimensions. The majority of students came into university through widening participation in higher education (non-traditional route); most left school with limited qualifications and some had special learning needs such as dyslexia. This affected student learning, Al Hassan (2012) opines that it is important to understand what influences student learning. Al Hassan likens it to piecing together a puzzle whose many parts must come together before the true picture emerges; the learner's individual characteristics, the context in which learning takes place and teaching strategies used affects students' learning. Inclusivity pedagogy formed the bedrock of my teaching practice; various strategies are used in teaching and assessing students. According to Florian and Spratt (2012) pedagogy is the knowledge and skills required by teachers to inform the decisions they make about their practice. Inclusive pedagogy is an approach to teaching that aims to raise the achievement of all learners, while safeguarding the inclusion of those who are vulnerable or marginalised (Florian and Spratt, 2012).

In terms of inclusivity, I used a range of teaching and assessment strategies. I also provided significant scaffolding support for learners, through individual and group tutorials to enable

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students to progress on the pedagogy – andragogy continuum. This individualised support was important in meeting student needs; however, inclusivity needs to be implemented sensitively, in a way that protects students from stigmatization (Waterfield and West, 2005). Furthermore, anecdotal evidence suggests students found it difficult to maintain work-life balance, which affected how they engaged with the course demands. In order to address these challenges I used blended learning strategies, learning resources are made available on-line through Canvas to enable all learners to engage with course content at their convenience.

Despite the challenges outlined above the students had a wealth of experience and seemed to excel when I used an experiential learning approach, which according to Dewey (1938) incorporating students' experience into teaching and learning is a powerful way to motivate and engage learners, this was achieved by reflecting on scenarios from clinical practice and debates.

Students: a key partner in work-based learning

The planning, developing and running of the TNA trailblazing programme is time consuming and requires a high degree of coordination. The collaboration between the university and employers required clear communication to clarify objectives. According to Ball and Manwaring (2010) universities and health care providers have a different language and culture; so for work-based learning to be successful, mutual understanding and effective communication is an essential step in building partnerships that work. Having said that I quickly realised that, actually; the most important partner is the students, without which there will be no work-based programme to talk about.

It is important to recognise students as an equal and important partner in work-based learning. Students' views and feedback is actively sought, and as a teacher, I adopted the use reflective practice to co-produce learning with students. Vygotsky (2005) highlights the benefits of teacher-student collaboration in enhancing active learning. Student feedback indicates that this is an effective strategy for active and deep learning. Collaborative working with students is beneficial as it uses familiar work context to support learning and also uses familiar work tasks to assess learning (Ball and Manwaring 2010), (Mezirow, 1991).

I treated students as adult learners and equal partners. Initially most students struggled to get theirs heads round the concept of (andragogy) self-directed-adult learning (Knowles, 1984). Student-centred-adult-learning approaches within an inclusive ethos underpinned the teaching approaches on the TNA programme. Andragogy approach recognises that students as adult learners would commit to learning when goals and objectives are seen as realistic and important to the learner. Furthermore, it was identified that students' motivation increased when learning objectives are related and relevant to clinical practice (Ball and Manwaring, 2010). According to Knowles (1984), adult learning is a humanistic approach based on self-directed and autonomous leaners, with the teacher as a facilitator. My experience on this course is that pedagogy – andragogy is not a case of either or, but is context dependant and rather dynamic and on a continuum (Merriam, et al 2007).

Furthermore, mentors in work placements are an important partner in facilitating student learning by selecting appropriate learning strategies to integrate learning from clinical practice and academic experience (NMC, 2015), (Briggs and Tang 2011)

Clarity of expectations

Although all the three partners (students, employers and the university) had varying expectations of the TNA course, I will only focus on student expectations and how this affected their learning. At the beginning of the university taught sessions the majority of students seemed to be caught-up in a 'disorientation dilemma', and expected to be 'spoon fed' by lecturers through chalk and talk sessions (Mezirow, 1991). However, there were a small number of students who seemed to have the Dunning-Kruger effect (illusionary superiority) based on the wealth of

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clinical experience they have. This later group of students had a sense of 'I know it all'. It felt like they had come to university for validation of their knowledge (Kruger and Dunning 1999). These two types of learners engaged differently with learning. On the other hand, while in the work environment the TNA's role could easily be blared. Some students are put under pressure to continue functioning as health care assistant in times of staff shortages and not full transition into a work-based TNA learner. The impact of this lake of role clarity and demarcation resulted in students missing out on learning opportunities in clinical practice. According to Bond and Solomon (2003), WBL requires effective partnership between learners, employers and HEI to foster student learning.

Some learners found that they were not getting the desired level of support from both the university and employers; students were not sure who to contact for help when they had issues with work-based modules. Furthermore, some employers were reluctant to release students for prolonged periods of study.

I believe as a teacher my role is to design and deliver courses that are constructively aligned and in the case of WBL, it has to apply to both employer setting and HEI. This promotes deeper learning in students; as it allows learners to see the link between learning outcomes, course content and assessment task in both contexts (Briggs and Tang 2011). Furthermore, academics and employers should work in partnership to provide on-going pastoral care for learners as this can enhance student engagement with the course and reduce drop rates. The TNA course was based on the belief that education is transformational; it provides opportunities for individual personal, professional growth and improves employability.

Quality assurance challenges in work based education

Experiential Learning Approach is central to teaching and student learning in this case study (Kolb 1984). Students for the TNA programme are drawn from diverse clinical settings ranging from primary care (GP practices) to community teams (District nurses) and acute in patients (hospitals). One of the challenges is ensuring quality and consistent learning and assessment across different work placements. Quality assurance of work-based teaching and assessment needs to be developed and managed across different placements. One of the findings in this particular case study is that, even though practice mentors had been trained to support nursing students; because the programme was rolled out at pace some mentors were unfamiliar with the new role of trainee nursing associates, which created some confusion. Students also found it frustrating having to explain the practice assessment document (PAD) to their mentors. Winter (1994) goes further by arguing that that there can be quality assurance problems in work-based learning, as identifying and assessing intellectual qualities of work place practice can be difficult.

Tulbure (2012) supports the notion of experiential learning by arguing that learning is more than just the presenting and acquisition of content, but is the interaction between content and experience where each influences the other. According to Kolb (1984), the Experiential Cycle is an ideal approach to educating adults as it touches learners with different learning styles. I used blended learning by making module content available on Canvas, making use of interactive face-to-face lectures and seminar groups, using regular formative assessment and feedback.

Discussion

This case study identified four key findings; inclusivity: the holy grail to work-based learning, Students a key partner in work-based learning, Clarity of expectations and finally Quality assurance challenges in work-based learning.

Inclusivity is a requirement in widening participation to higher education (the entire students came through non-traditional routes) and making a business case for inclusivity by design is more cost effective rather than addressing issues on a case by case because that would be benefit all students. Complying with the disability legislation is the bare minimum, not all students declare their

disabilities for fear of stigmatisation. Making lessons inclusive and student-learning-focused, gives every student the opportunity to fulfil their potential. However, the challenge of delivering sessions that are inclusive and accessible to all students is that it is resource intensive.

Students are an important partner in WBL. As a teacher my role is to facilitate student learning and acknowledging that student bring a huge amount of experiential knowledge from clinical practice, which they can draw from. Therefore, I have an expectation that students co-produce knowledge as equal partners; students have a valuable contribution to make in their learning. Peer learning through problem based learning and group work is a useful strategy in encouraging students to contribute and collaborate in knowledge production. Action learning sets and coaching are useful strategies that can be used to enhance social and collaborative dimension to learning with the teacher as facilitator. These sessions can be delivered jointly between the university and the practice partners.

This trail blazing programme was launched at pace, this required communication and close collaboration between partners. This was a challenge as managing the expectations of all the key partners can be time consuming; it required time commitment for regular meetings. In order for the student voice to be heard, student representative formed an integral part of the course review team. If work-based learning is to be effective in meeting its objectives the student voice needs to audible and taken into consideration. Students' representation is important in capturing the students' lived experience through the course. The challenge is that this can be time consuming for the student representatives. This can be overcome by finding novel ways such as having representatives from all the partner organisations who can alternate attending meetings.

There were challenges in quality assurance for work-based learning across the university and work placements. The TNA is a generic course, which covers all branches of nursing, the diversity of learning opportunities required a strategy to ensure student learning and assessment was consistent across the board. Several strategies were used; each student was allocated a personal tutor and a mentor for the duration of the course. The university also employed practice educators who worked closely with mentors in clinical practice. This ensured students had consistent support. Practice educators are a useful resource for students, mentors and lecturers.

Conclusion

In conclusion, this case study has shown that despites its challenges, WBL present a great opportunity for using the work place as a learning resource; which would improve student employability. The university has a shared responsibility with employers for teaching, which is excellent for linking theory to practice. WBL is beneficial to employers in addressing skill shortages by growing their own workforce. In order to support and foster WBL for students, appropriate learning provision and a diversity of well-supported placements with skilled mentorship is essential. Furthermore; Inclusivity, an adult-learner approach underpinned with experiential learning strategies with clear expectations is key in supporting and fostering effective learning in a work-based context. The words of the great philosopher Confucius seems to sum up WBL well, 'I hear and I forget. I see and I remember. I do and I understand'.

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