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Suicide, Ethics and Service-user Participation in Mental Health: A Portfolio of Related Papers

Submitted by

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DipNsg, BN, BA Hons, PGDip (Psychotherapy)

December 2009

in partial fulfilment of the award of

Doctor of Nursing Science

in the School of Nursing, Midwifery and Nutrition

Faculty of Medicine, Health and Molecular Sciences

James Cook University

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Statement of Sources

I declare that this thesis is my own work and has not been submitted in any form for another degree or diploma at any university or other institution of tertiary education. Information derived from the published or unpublished work of others has been acknowledged in the text and a list of references given. The contributions of others to collaborative work presented in this portfolio have also been acknowledged in text.

14^h April 2010

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Dedication: I'd like to dedicate this portfolio to the memory of Neil Fergusson. Neil died in 2009 before submission of this portfolio. Neil was one of the most sincere, warm and generous people I have been lucky enough to have known. He taught me a great deal about case management and mental health care, and was always generous in permitting me to share his stories for the benefit of others. All those that met Neil, particularly nurses and students were enriched for having known him.

1. Acknowledgements

Many people have supported and encouraged me in the development of my academic work, not least my supervisors at James Cook University and colleagues at Dublin City University. Of particular note is Professor Phil Barker who has provided consistent encouragement and inspiration over many years and whom I am proud to count as a personal mentor and friend. I need also to acknowledge the forbearance of my partner, Claire Lakeman who tolerated my sometimes wild swings in mood, was a one person trial audience for my conference presentations and tirelessly proof read my draft manuscripts.

This portfolio is comprised of a range of publications arising from several independent projects, traversing a range of topic areas and involving the participation of many people in varying roles. Where possible the contributions of different people have been acknowledged either in the publication or via naming them as a co-author. In all circumstances in which I am listed as the first author I was responsible for the write up of the project and the publication is primarily my intellectual property and original work. 'Real world' research, as with mental health nursing practice is generally a collaborative endeavour and this is certainly true of the projects reported here.

1.1. Supervisors

This doctorate was supervised by Professor Mary Fitzgerald from commencement until 2008. From 2008 until completion Professor Colin Holmes was Supervisor and Dr Lea Budden Associate Supervisor.

1.2. Contributors to projects and publications

Ethics and Commentary

Most of the publications in this section are entirely my own work with three exceptions. Jim Walsh and Paddy McGowan are colleagues at Dublin City University, are former mental health service users and have been prominent activists for mental health service reform in Ireland. Together we have critically reflected on the politics and power, paradoxes and contradictions of service user participation. This has led us to develop and present ideas in different ways and at different forums such as conferences (See: Walsh, Lakeman, & McGowan, 2009; Walsh, McGowan, & Lakeman, 2007). I initiated the writing of a formal paper and was responsible for drafting and revising the document for publication.

Two papers relating to 'pharmaco-centrism' and depression were written in partnership with Professor John Cutcliffe. This collaboration was initiated when I shared a first draft of a paper citing examples of a 'pharmaco-centric' bias in nursing publications. This was developed into the first published piece (Lakeman & Cutcliffe, 2009). We agreed to take turns leading the writing of a series of articles and John took the lead writing the second article (Cutcliffe & Lakeman, 2010). Our intent is to write a further paper explicitly addressing alternatives to biomedical conceptualization and treatment of depression.

Suicide and suicide research

Professor Mary Fitzgerald (of James Cook University) was my doctoral supervisor during the period I undertook the literature review and survey of researchers and ethics committee members. Mary played a crucial role in analyzing the data and reviewing the manuscripts before submission for publication and is acknowledged as second author of these publications

Sudden Death in the Homeless Sector

This research project was part funded by a €10,000 grant from the Electric Supply Board (ESB) Electric Aid Ireland fund and a €4,000 grant from The Homeless Agency (Ireland). It represents phase one of a project to explore the needs of homeless sector workers in relation to responding to sudden death. Subsequent phases will be undertaken in collaboration with Evelyn Gordon, Raphaela Kane (both of Dublin City University) and representatives from the Homeless Agency to develop and evaluate an intervention to better prepare homeless sector workers deal with the sudden death of service users.

Family and carer participation

When Professor Phil Barker was seeking to revise and publish the 2nd Edition of the textbook, 'A Craft of Caring', Tom Keen, the original author of the chapter on collaborating with patients and families (and retired from academia) recommended that I undertake the review and re-write. This chapter retains the form and much of the content of Tom's original draft and thus I recommended that Tom retain first authorship.

Dr John Allan, then clinical director of mental health services in Townsville seconded me to be a part time project officer for one year to promote and evaluate the impact of family and carer participation standards for the adult mental health services in Townsville. Dr Allan secured sponsorship from Queensland Health for the project and provided supervision of this aspect of my work. The standards of practice were developed by a steering group (outlined in the publication). I was responsible for day to day project management, designing the evaluation protocol, data collection, analysis and finalizing the report. The published reports were written entirely by myself. Marilyn Voss (a local carer) was appointed to assist with data collection (particularly interviewing carers) and her warmth, empathy and positive regard demonstrated the potential for service users and family members humanizing both the research process and mental health services. Sadly, Marilyn has since passed away and will be missed by all those who knew her.

Migrant Mental Health

The migrant mental health project was undertaken using a 'science shop model'. A science shop project provides the scientific resources of a University or Institute to address on a problem or issue of concern to a community. This project was funded by a European Union grant (FP6-2005-Science-and-Society-20 Proposal Number 44702 NewCom) led by Professor Ronaldo Munke (of DCU) and mentored by experts in running science shops from Queen's University (Belfast), Dr Eileen Martin and Dr Emma McKenna. My initial role was as a member of the steering group but I later led the analysis of data and writing up of the project (Lakeman et al., 2008). My colleague at DCU, Dr Ann Matthews reviewed the manuscript presently accepted for publication and included in this portfolio.

The project was developed and undertaken in partnership with an organization called Cairde and the intent was to develop the capacity of the organization and its members to undertake their own research. Thus members of new communities allied with Cairde identified the main problem (the mental health of migrants), developed a plan for the research, recruited participants, and convened and facilitated focus groups. The following people were also involved in analyzing the data: Muriel Redmond, Tonya Sanders and Jim Walsh.

Peer Group Supervision

The published piece on peer supervision is a write-up of a project undertaken by Christine Glasgow. Christine undertook an action research project which I supervised in partial fulfilment of requirements of a Masters Degree (which she was subsequently awarded). Apart from supervision of Christine my contribution to the project was the adaptation of this model of supervision and training of nurses in peer group supervision. The write up which I undertook was largely to articulate the model of supervision which I have also adapted for homeless sector workers, nursing interns and students.

Recovery

The Delphi study examining recovery competencies for mental health workers was commissioned by the Irish Institute for Mental Health Recovery (IIMHR). Members of the IIMHR recommended an initial panel of experts by experience (which was augmented by a snowballing recruitment method). The IIMHR donated gifts to give to participants. Other costs associated with the project were met by an award of €2000 from the Dublin City University School of Nursing research fund.

1.3. Copyright of published work

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Professor Phil Barker (editor) granted permission to include the chapters from the textbook 'Psychiatric and Mental Health Nursing: The Craft of Caring'.

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2. Introduction

This portfolio is comprised of the products of an academic journey including publications arising from research projects as well as academic commentary. It commences with a chronology of the professional and academic influences that have shaped my ideas about the proper focus of mental health nursing from my training to the present time. It considers and presents arguments for the importance of ethics, a consideration of power and subordination, improving the participation in mental health care and argues that the proper focus of nursing is essentially concerned with fostering the right conditions for people to grow and develop. These may be considered threads that weave their way through the published work.

Publications are clustered broadly into content areas. The first area addressed is ethics which is comprised of six published articles and a book chapter. Ethics is a common thread throughout the portfolio. The second section comprising the most substantial body of empirical work is on suicide and sudden death. It includes a review of qualitative studies on how people live with or overcome suicidality, two published reports on a project examining the opinions of ethics committee members and experienced researchers address ethical problems associated with suicide research and a report (submitted for publication) on a grounded theory study examining how homeless sector workers deal with the sudden death of service users. The third cluster address family participation and provides an overview of principles of family participation (a published chapter) and two articles reporting on a research project relating to improving family and carer participation in an adult mental health service. Three further research projects are presented including a Delphi study of mental health recovery competencies, a descriptive study examining perceptions and experiences of migrants in Ireland regarding their mental health and well-being and an action research project to introduce a model of clinical supervision to a

clinical area. The portfolio concludes with a brief consideration of the ontological position of contingent realism that underpins the various projects.

Reflecting on the body of work that makes up this doctoral portfolio, I am challenged to identify a beginning and an end point. Certainly enrolment in the doctoral programme, whilst a career milestone was by no means the beginning of this academic journey. Collating these published works engenders some sense of achievement or closure, but as new and continuing projects stretch out before me, it is readily apparent that there is no clear end.

This professional doctoral path was recommended and chosen on the grounds that it might best suit a practicing professional who might elect to undertake a series of projects directly related to their work, the merits of which would at least in part be judged by successfully negotiating the peer review and editorial demands associated with publication. Since enrolment I have not only changed jobs (shifting from mental health practice to education) I have also moved continents (from Australia to Ireland). To borrow a metaphor (Schön, 1987), moving from one swampy lowland where messy, confusing problems defy technical solutions to another even less familiar but more literally swampy place. The content of this portfolio has out of necessity taken some twists and turns as my journey as an academic and practitioner has. Despite the seemingly disparate content areas of this portfolio there are some common threads that bind this body of work together. By way of explanation the following section briefly outlines some of my journey as a nurse and how some of my thoughts and beliefs about the nature of nursing and mental health have evolved.

3. The nature of mental health nursing and mental health care

Modern psychiatric nursing arose from the organization of asylum attendants or keepers and followed the organization of asylum doctors into modern psychiatry from the middle of the 19th century (Nolan, 1993). Whilst the ascendancy of psychiatry as a fully fledged autonomous profession of considerable influence is well chronicled (Porter, 2004) and its practices and influential world view critiqued (Foucault, 2006; Goffman, 1991; Szasz, 1973), nursing rarely earns even a footnote in the history of madness or its management. Morrall (1998) argues convincingly that psychiatric or mental health nursing has attempted to project professionalism but is in fact a subordinate occupation most closely aligned with the social control function of psychiatry and with its historical foundations firmly rooted in the asylum. Clarke (2008) concurs that nursing is a practice based occupation, lacking a unifying theory and undertaking most of its functions under medical direction. Clarke (1999) has also pointed out that we lack a universally agreed definition of what psychiatric nursing is (let alone mental health nursing) although many point out what it 'ought' to be. The body of published work in this portfolio addresses in part what nursing ought to be and by way of introduction the following is a chronology of some of my ideas about the proper focus of nursing and the experiences that have influenced me.

3.1. Becoming a mental health nurse and discovering the importance of ethics

Peplau (1989b), one of the most influential figures in psychiatric nursing described a range of roles which nurses in psychiatric settings (hospitals largely) could perform and distinguished these from the roles of properly trained 'psychiatric nurses' which included the provision of counselling, group

psychotherapy, 'specializing' patients experiencing panic, planning programmes and so forth. I commenced my career in the mental health field as a nurse working in the traditional psychiatric setting of the large rural psychiatric hospital in New Zealand (rather than as a psychiatric nurse). New Zealand had adopted a Comprehensive Nursing pre-registration curriculum in the mid 1970s and 'specialty' undergraduate training was entirely phased out within 10 years. This shift in terms of preparation of nurses from hospital to technical institute and from specialty registration (psychiatric, paediatric, psychopaedic, general) to generalist or comprehensive training was better received in New Zealand than across the Tasman although it is widely recognized that the psychiatric and mental health component of curriculum is often marginalized (Prebble, 2001).

In Australia, undergraduate preparation of nurses has been stridently criticized for poorly preparing people to work in mental health (Happell, 2001, 2007; Wynaden et al., 2000) and for contributing to a shortage of nurses as only a minority of graduates express a preference to work in the mental health field (Happell & Gough, 2007). Implicit in much of this discussion are preferences to return to specialty pre-registration training, although some have argued for the dissolution of traditional disciplinary boundaries and the development of a generic mental health worker (Holmes, 2006; Proctor & Welbourn, 2004).

Interestingly debate about generic preparation in the Republic of Ireland is muted (See: Grant, 2006). Whilst pre-registration nursing education only moved into the University sector within the last 6 years Ireland continues to train nurses in different professional streams (general, children's, intellectual disability and psychiatric nursing) over a relatively long time (typically 4 years). Despite policy documents outlining the development of community mental health services (Department of Health and Children., 2006) and promoting a recovery based ethos (Mental Health Commission., 2005) the provision of mental health services continues to be largely institutional, undertaken from hospitals and there is little tangible evidence of this lengthy and intensive training contributing to better services than in other jurisdictions. My own

conclusion is that formal educational preparation is but one necessary although insufficient ingredient in promoting good practice. I have made this case in relation to advanced practice (Lakeman, 2000a) and this is implicit in the promotion of clinical supervision as a method to improve practice (Lakeman, 2002). The quantity and quality of the psychiatric and mental health pre-registration education I received was considerably less than current students might receive in Ireland but I certainly count the experiences as highly confronting and influential to my thinking.

My initial exposure to mental health nursing was largely positive with my first placements in the acute psychiatric unit (a relatively new building) attached to Wellington hospital in New Zealand in the mid 1980s. My tutors appeared passionate about the field, as did the nurses, psychologists and others who worked in the day service facilitating interesting groups. I identified with the people who were admitted to hospital, many were the same age and some were former classmates and colleagues. I warmed to the field and spent a summer volunteering at a drop in centre for people diagnosed with mental health problems, teaching carving and generally just being part of the programme.

Mental Health legislation at the time required that anyone who was deemed to require compulsory assessment or treatment be sent to what were known as gazetted hospitals. The main gazetted hospital where I undertook student placements was a large psychiatric hospital some miles from Wellington on the outskirts of Porirua. This was once a rural asylum built in the Victorian era but urban sprawl had caught up with it and decay had started to set in (see figure one). This was a pleasant, largely peaceful environment with a large swimming pool, recreation hall, arts and crafts centre, canteens, a dental service and even a museum. However, my first morning on a male 'continuing care' ward in this hospital was something of a shock. On entering the ward I and a colleague were met with an image of naked men of indeterminate age queuing on the stairs to take a bath. Following being dipped and towelled off by two nurses

they were handed their clothes from a communal pile on the floor. Most men it seemed eked out their days in the aptly named 'dayroom', smoking in silence, rocking in their seats, racked with tardive dyskinesia and perfectly attuned to rituals of coffee breaks, meals, bathing and bed times. This was my first encounter with institutionalization of such a profound nature and I was deeply disturbed by it.



Figure One: Views of Porirua Hospital

After graduating in 1989 I worked in a regional hospital mostly on medical and surgical wards and after a holiday and some twists of fate I found myself working at Lake Alice Hospital as a staff nurse. Lake Alice hospital was founded in 1965 to house the 54 most violent psychiatric patients nationally and until 1988 the National Secure Unit at Lake Alice was the central focus of forensic psychiatric practice in New Zealand (Brinded, 2000). I felt nervous but not

under-prepared for the roles that I was required to assume. Of the New Zealand psychiatric hospitals (all of which have now been closed and replaced by mental health units attached to general hospitals) Lake Alice Hospital had perhaps the most ignoble of histories. Its closure was followed by a successful class action by former children hospitalized there in the 1970s and routinely administered paraldehyde and unmodified electro convulsant therapy (ECT) ostensibly to modify aberrant behaviour (see the 'Peter Ellis Website', 2007). Whilst I did not witness such overt cruelty, patients were subject to many indignities and Lake Alice continued to have many of the hallmarks of the total institution famously described by Goffman (1991).

It was made clear from the outset that nurses did as they were told by senior staff and doctors (although there weren't many of these), administered medications, maintained calm, order and routine in the wards and intervened (with the use of restraints, medication and seclusion) in violent situations. Whilst compassion and kindness were sometimes evident and some staff did their best to punctuate the drudgery of daily life with regular outings and fun activities, the kind of work that I observed being undertaken did not seem to me to require any special qualifications and certainly did not seem to be informed by a distinctive body of theory or research.

The intensive experience of living and working at Lake Alice had a formative influence on my subsequent thinking about the nature of mental health and mental health work. Above all it appeared to me that what we did with, or to people had profoundly ethical dimensions, both at the societal level (through law and policy) and at the individual level (that is how we related to and interacted with each other). Mental health professionals are predominantly concerned with what Hume (2003) described as 'ought questions'. That is, how we ought to be, what we ought to do and how we ought to respond to people in distress. Hume pointed out that we often attempt to predicate statements about 'what ought to be' on statements about 'what is'. These however, are quite different classes of statements that are at best tenuously linked. This is perhaps

even more so in relation to responding to madness or distress, as the validity of many of the fundamental constructs of psychiatry such as mental illness and disorder are contested (Parker et al., 1995; Szasz, 2003) or found to be limited in their utility to make sense of peoples problems (Read, Moshier, & Bentall, 2004).

Being a forensic hospital many people (although by no means all) were incarcerated because they were deemed to be dangerous. Arguably New Zealand's most famous whistleblower, Neil Pugmire (charge nurse of the National Secure Unit) gained notoriety for a letter that was made public in parliament by the shadow minister of health warning of the pending release of a man perceived as a dangerous sex offender because of a change to Mental Health legislation (Essex, 1994). The man was freed and went on to rape a two year old girl soon after release. There are certainly examples of people who are dangerous, that are likely to cause themselves or others harm. Such predictions or statements are always conditional (i.e. dependent on the presence of certain factors such as intoxication), are rarely solely due to mental disorder (although this may be one of the conditions) and are generally unreliable. How society ought to respond to those perceived as dangerous is a 'big picture' ethical problem, the solutions to which has led to various totalitarian regimes in the 21st century locking up, exterminating or 'psychiatrically treating' people perceived as dangerous (see: Szasz, 1994, 2007). At the more mundane, everyday level of nursing practice the identification of someone as dangerous or potentially threatening can lead to defensive behaviours (e.g. distancing) on the part of nurses and others that can provoke a violent and confirming response ('what ought' confirms 'what is'). I and a colleague have argued that dangerousness, rather than being some kind of objective reality located in the other person is a social construction which becomes a self-fulfilling prophesy (Lakeman & Curzon, 1997).

The social constructionist view, particularly the critical stance it demands towards taken for granted ways of understanding the world, and the premise

that knowledge and social action go together (Burr, 2003) have been influential ideas on my thinking. These underpinning assumptions are evident in the commentaries in this portfolio (Lakeman, 2010a; Cutcliffe & Lakeman 2010; Lakeman, Walsh & McGowan, 2007) and in previous work (Lakeman, 1997a, 2001d, 2004, 2006; Lakeman & Curzon, 1997). Whilst I am broadly aligned to a constructionist view of the social world, I am also a pragmatist and acknowledge that research like rhetoric can serve many purposes: To convince as much as to reveal, to shape and construct subjectivities and to deconstruct. A range of research methods are useful in furthering our understanding of and shaping the world. When studying for my first degree I recall being particularly impressed by the programme of work by Morrison (1990, 1992, 1993, 1994) on inpatient violence. Morrison utilized a range of empirical methods to understand violence in hospitals and amongst many useful insights her programme of research confirmed how staff patterns of behaviour could provoke violence (Morrison, 1990) and of course could reinforce non-coercive ways of relating.

Barker (1999, p. 201) declared that psychiatric nursing "...is fundamentally, a moral or ethical pursuit". My invited response to this paper (Lakeman, 1999) was to argue that a prerequisite to ethical practice is ethical sensitivity, that we ought to be troubled by ethical problems. A conclusion that one could draw from Hume's problematising of the relationship between 'what is' and 'what ought' statements is to discard attempting to use logic and reasoning in ethical reasoning and revert to emotivism (essentially we know something is right or wrong because it feels that way and any statements about what is right and wrong merely express my sentiments or preferences). There were many things I observed at Lake Alice (and later) that led me to feel uneasy and prompted me to consider them as ethical problems, for example, the problem of forcing someone to bath (Lakeman, 1996a). However, a problem with the thesis that ethics is something that is properly felt is that many people I observed did not appear to experience any dis-ease from practices that I found disturbing or rationalized as ethically problematic. I observed people acting confidently, with

seemingly absolute conviction that their proclamations relating to the mental state of others, the treatments required and the social order within the asylum were truths beyond dispute.

The asylum is a field with its own habitus. Bourdieu (1979) popularized this idea which he described as a system of dispositions that individuals develop in response to conditions and which thereby reinforce and regulate those conditions. Recently Stacey, Joynson, and Diamond (2008) in a narrative enquiry found that recent graduates often enter the field (inpatient work) imbued with person-centered values. They described how the nurses experienced dissonance in various ways when they were called to perform practices that conflicted with their values and how this subsequently influenced the expression of those values in practice (Stacey, Joynson, and Diamond (2008, p.28). Institutions are powerful enculturation influences which in time shape people's values and perceptions of proper conduct. Lake Alice, (like many other institutions) was particularly problematic because of its isolation and being a closed system with little surveillance from outside. As Goffman (1991, p.84) noted asylum staff evolve a theory of human nature that "rationalizes activity, provides a subtle means of maintaining social distance from inmates and a stereotypical view of them, and justifies the treatment accorded them" . These observations of total institutions published over 40 years ago accord with my experience of not only the asylum but also of health care institutions generally which have the potential to degenerate to a base state far removed from their stated purpose.

Reflection on practice through the lenses of ethical theory can play a part in correcting the tendency of institutions to degenerate and professional behaviour to become institutionalised. To overcome the moral blindness that can come from a closed professional habitus I exhorted nurses to consider and declare their values and to reconcile their practice with those values (Lakeman, 1999). This might lead to some anxiety which needs to be tolerated, and contained whilst the problem is explored and solved. Thus the study of ethics (and the

inclusion of a chapter from an introductory nursing text book in this portfolio (Lakeman, 2008a) is essential to the development of a competent nurse. The risk of not containing such anxiety is that the individual and the organization can begin to respond defensively and destructively. These dynamics were exquisitely described by Main (1957) in relation to staff groups and Menzies-Lyth (1988) in relation to organisations. These insights are explored further in Lakeman (2006, 2008c).

Defensiveness might also explain the dogmatic insistence on treating theories about the biological causation of mental illness as uncontested facts and persisting with treatments that have been found to be ineffective (See: Lakeman & Cutcliffe, 2009). What the relatively short history of psychiatry ought to teach us is that theories and treatments are fallible, certainty is illusionary, and all psychiatric knowledge is open to revision. Questioning received wisdom, resisting dogma, and maintaining a critical stance towards knowledge claims are ethical imperatives for health professionals.

3.2. Power and subordination in psychiatry

No consideration of the ethics of psychiatric care, the social position of nursing in the psychiatric industry or indeed the day to day interactions between nurses and patients would be complete without an acknowledgement of power. Yarling and McElmurry (1986) argued that nursing is not free to be moral because of its subordinate relationship to medicine. Whilst in many ways nurses are the eyes and ears of medicine and in the psychiatric field they are frequently the enforcers of compulsory treatment, it is ethically wrong for nurses to be simply tools to be manipulated (Lakeman, 2000d).

No nurses were held to account for the aforementioned human rights abuses at Lake Alice Hospital despite the perceived punishments being meted out mostly by nurses. Today, 'following doctors orders' may be a flimsy defence if a nurse dispenses a wrong treatment but refusing to administer a prescribed treatment

on ethical grounds continues to be exceptionally problematic for nurses. This was poignantly brought home to me some years ago when I was asked to help a group of nurses at an acute psychiatric unit to articulate a case to refuse to administer a depot injection. As it happened they articulated the case elegantly but impeccable reasoning doesn't necessary guarantee a good outcome.

A man was admitted to hospital for assessment under the New Zealand Mental Health Act (1992). It was suspected that he had been hypo-manic for some weeks before admission. This was difficult to confirm as he was a musician who worked at nights. He acknowledged that he had been 'burning the candle at both ends' and had very little sleep over several days. He had been depressed and suicidal in the previous year and the assessing doctor suspected he had Bipolar Affective Disorder. There were no overt signs of hypomania on admission or subsequently. He slept soundly (with a mild sedative on the first night) and his speech was not pressured (as one might expect to observe in hypomania). The man refused to take the Lithium that was prescribed for him. He comprehended fully the purpose of Lithium as a mood stabilizer and read the available literature. He clearly stated that he did believe he had this particular disorder and he perceived the risks associated with taking the drug to outweigh the potential benefits. He rationalized his previous episode of depression as a consequence of a relationship break down. The nursing staff who had spent considerable time with him believed he was making an informed and reasonable decision and the man even agreed to reconsider taking Lithium if he was noted to have an elevated or depressed mood within several months of admission. The psychiatrist instead prescribed a depot form of an antipsychotic and gave the man an ultimatum to take the lithium orally or receive the depot forcibly by injection. The man refused to take the lithium and the doctor ordered that the man receive the depot which the nursing staff refused to administer.

The nurses made their case about the man appearing informed, reasonable and rational, and that the depot form of this particular antipsychotic was not

even listed as indicated for acute mania, let alone for the prophylactic treatment of bipolar affective disorder. The doctor ended the discussion curtly (and loudly) with the ultimatum that if the injection wasn't administered by the nurses (he would not administer it himself) within 24 hours he would report each nurse to the Nursing Council alleging professional negligence and write strongly worded letters to the Nursing Director seeking their dismissal. As it happened, the patient in this instance who couldn't help but overhear this ultimatum and being rather sympathetic to the plight of the nurses later agreed to try the lithium (and I have little doubt stopped it immediately upon discharge). Whether or not these kind of bullying tactics would have led to sanctions of the nurses is questionable but nevertheless this incident caused the nurses considerable anxiety.

As Szasz (2007) noted the coercive character of psychiatry was more apparent in the past and particularly in the asylum in which the inmate was incarcerated, "diagnosed" and "treated" against his or her will¹. Despite sustained critiques of coercive practices in society and psychiatric nursing they remain a reality and even bodies such as European Court of Human Rights has attached little weight to the idea of a capable refusal in the face of medical opinion that treatment is needed (Richardson, 2008). If the voice of nursing was subordinate to medicine in the example provided the voice of the service user was illegitimate relative to medicine.

Thankfully my experience of working in multidisciplinary teams has generally been much more collegial and characterized by respect for the contributions of differing viewpoints and contributions. There are however, always dynamics associated with professional power at play in psychiatry. Sometimes I suspect

¹ Szasz has also consistently argued that there is no such thing as illness in the sense that the kind of problems of living that people seek help for have no proven biological cause (hence the use of speech marks around diagnose and treat). Indeed where biological causes for an illness are established then the care and treatment then comes under the purview of other branches of medicine such as neurology. My reading of Szasz's work and personal communication with him suggests that the central argument is against any kind of compulsion in psychiatric care. The lack of empirical proof for mental illness merely adds further weight to that argument.

harmony in teams is maintained because the nurses simply administer the prescribed treatments and submit to the authority of the medical doctor. The idea of collaborative or 'multidisciplinary team' working has become firmly established as good practice in mental health care based on the assumption that different disciplines bring markedly different perspectives to bear on the multidimensional and multi-aetiological nature of illness, distress and suffering. Prosky (2003) argues that whilst multidisciplinary team working has become *de rigueur* the aetiological base of biological psychiatry relating to brain chemistry has become universally embraced so as to have eclipse the aetiologies underlying other professional approaches. Thus we have teams that appear multidisciplinary but are in fact governed by a biological aetiology and interventions stripped of their aetiological basis (e.g. interpersonal, relational, or eco-systemic) appear shallow indeed.

The formalisation of 'multidisciplinary team' working is newer in Ireland than in Australasia. When I arrived in Ireland I was surprised to discover that nursing and medical notes were kept entirely separate and that nurses were solely accountable to others higher up a nursing hierarchy. The Health Service Executive has mandated the restructuring of health services and O'Shea (2009) states multidisciplinary team working marks the end of professional segregation and that clinical professionals will contribute to teams from the perspective of their own discipline and will be accountable to the clinical director (medical consultant). O'Shea stresses that nurses in Ireland will need to develop a new culture of collegiality and accept the fact that medical consultants will remain ultimately accountable for services provided. In a very tangible way medicine has power over nursing and both have disciplines have considerable power over service users.

Foucault (1970, 1975) proposed that power is sustained through discourse which uphold differences in power as natural and normal and knowledge as self evident. This is explored in Lakeman and Cutcliffe (2009) where we examine whose interests are served by what we coin a 'pharmaco-centric' discourse in

relation to mental illness. The dominant biomedical discourse is exposed as problematic in various ways in much of my published work either explicitly as in Lakeman and Cutcliffe (2009) or subtly (Lakeman, 2008b, 2008d) where I argue that some problems the bring people into contact with mental health services ought to be construed as 'between people' rather than 'solely' within them.

Fricker (2007) proposes a form of power called 'identity power' which is directly dependent upon shared conceptions of the social identities of those implicated in the particular operation of power. Fricker (2007) outlines a distinctively epistemic form of injustice which arises from identity power dynamics and causes harm by diminishing people's capacity as knowers. Fricker's ideas can in part explain my dis-ease for the social position of the asylum inmate at Lake Alice and a hardening of my position against dogmatism and projections of certainty in mental health care. Fricker (2007) described two kinds of injustice. The first 'testimonial injustice' occurs when prejudice causes a hearer to give a deflated level of credibility to a speaker's word, diminishing them as an informant or giver of knowledge.

As a consequence of being diagnosed or identified as mentally ill the credibility of a person's testimony is immediately suspect and in some cases completely discounted. In the many occasions I have personally attended tribunal hearings to confirm or extend compulsory treatment orders, I have never witnessed a person successfully challenging the testimony of a psychiatrist. There is a hierarchy of credibility which I and colleagues outline (Lakeman, Walsh, & McGowan, 2007) in which the consultant psychiatrist is presumed to have the greatest insight into the mental world of the patient, followed by non-specialists doctors, allied health professionals, and lastly the patient him or herself. Some ways of construing the work of the nurse such as the Tidal Model (Barker, 2001, 2003) explicitly attempt to illicit the voice of the service user (which is more often than not entirely absent from accounts of care) and imbue it with some credibility. However, in some wards I visit in which a first person narrative account of difficulties is recorded these are rarely made reference to and the

medical diagnosis is the essential account of the problem that is given greatest credibility and suppression of symptoms the greatest priority.

Fricker (2007) coined the term 'hermeneutical injustice' to describe a social situation in which a collective hermeneutical gap prevents a person from making sense of an experience which it is strongly in their interests to render intelligible. The person is unable to make sense of their experience in the most useful way because of a collective prejudicial lens to make sense of a situation or experience. Fricker (2007) uses the example of a woman experiencing sexual harassment in a culture that lacks a critical understanding of that concept. An overconfident assertion of a psychiatric diagnosis or overzealous belief in biomedical explanations may lead to hermeneutical injustice. For example a person may accept the often uncritically espoused biochemical imbalance explanation for their low mood and forgo the opportunity to explore what historic, social or environmental factors may actually have contributed to their 'depression'. This premature foreclosure of aetiological exploration was obvious in the audit of clinical files for evidence of family participation outlined in this portfolio (Lakeman, 2008b, 2008d). It was apparent that arguments with a spouse were antecedent to some repeat admissions to hospital. Nevertheless the patient was viewed as the depressed person in need of treatment, a view seemingly shared by the spouse, health professional and the patient (whose ambivalence with the relationship was rationalized as a symptom). The opportunity to explore the problem as a relationship/interpersonal problem rather than a biochemical one was missed and this was a form of hermeneutical injustice.

Keith (2003), a psychiatrist who practices family therapy argues that placing the problem inside the patient makes it correctable by medication and thereby reduces anxiety associated with ambiguity and uncertainty. It has long been appreciated that individuals and organizations behave defensively to contain anxiety sometimes to the detriment of the wellbeing of the individuals themselves and service users (Main, 1957; Menzies-Lyth, 1988). I have argued

that many common practices in mental health may serve a purpose of palliating anxiety (Lakeman, 2006). Indeed the very tools that are commonly used in research such as scales and measures and which have been selectively imported into mental health practice provide a reassuring sense of certainty (Lakeman, 2008c) but which ultimately sustain the dominant discourse and shape the way health professionals see the world, their work and the people with whom they work. This may well be a natural phenomena but it needs to be reflected on to counter the potentially dangerous (and repeatedly demonstrated) tendency of psychiatry and allied professionals to dehumanize the 'patient' and to uncritically accept whatever theory which is in vogue as fact.

3.3. Participation and recovery in mental health care

I left Lake Alice Hospital in 1993 and spent two years working in a nearby town in an acute unit and day hospital (whilst balancing other roles). This was a time of tremendous social change in New Zealand including a swing to right wing 'market' driven ideology and managerialism in the public sector. Radical and rapid change was afoot. New Zealand introduced a new Mental Health Act in 1992, that did away with the idea of gazetted hospitals and emphasized that compulsory assessment and treatment occurred in the 'least restrictive environment' (Ministry of Health, 1997). More radical still was the response to a series of inquiries into mental health services (see: Chaplow, 2004) which led to the enactment of the Mental Health Commission Act in 1998 and the release of a blueprint for mental health services that placed the evolving idea of 'mental health recovery' at the centre of mental health service reform (NZ Mental Health Commission., 1998).

At the beginning of the 1990s I recall feeling somewhat isolated in relation to my views about mental health nursing and mental health care but this changed in the mid 1990s with the development and popularization of the internet. I was one of an original cohort of nurses with an interest in psychiatric or mental health nursing to join and contribute to the international e-mail list group set up

by Len Bowers. This was about when I began to identify as a mental health nurse and began to identify with an international community of nurses. These were heady days in which the freedom to communicate and exchange ideas so freely was a novelty. At that time even the mobile phone was a rarity and I recall visiting people in their homes from time to time who did not have access to a telephone. It was relatively easy to be isolated professionally but communication technologies and the internet in particular changed that. Whittington et al. (2009) and myself (Lakeman, 1996b, 1997b, 2000b, 2001b, 2002; Lakeman & Murray, 2000) explored how communications technologies could help shape professional identity, and be used for research, education and for clinical supervision.

The ubiquitous reach of these communications technologies and the extent they have become integrated into people's lives are now taken for granted. However, these technologies have enabled the international popularization of concepts such as 'mental health recovery' and the exponential growth in mental health interest groups (e.g. the Hearing Voices Network, Mind Survivors, The Critical Psychiatry Network etc) since the mid 1990s. Furthermore the internet has made accessible all manner of knowledge, previously jealously guarded by professionals. In essence they have promoted a shift to a more egalitarian organisation of mental health systems and a demystification of professional knowledge.

As both Roper and Happell (2007) and Warne and McAndrew (2007) note it is now a clear policy expectation in the United Kingdom and Australia to involve those that use mental health services in every aspect of health care design, provision and evaluation. It is no longer unusual to have former or current users of services employed in some manner (albeit usually in very small numbers) in mental health services. In New Zealand and Australia it had become common place by the turn of this century for consumer or service user consultants to be on interview panels for staff in mental health services. Involving people who are service users or non-professional caregivers as teachers in the preparation of

health professionals is now widely promoted (Happell & Roper, 2003; McAndrew & Samociuk, 2003; Repper et al., 2001; Simpson, 2006) and employing academics with first hand experience of mental health problems (or 'experts by experience') is becoming more common place (Happell, Pinikahana, & Roper, 2003). A modest research base characterised largely by surveys of small numbers of people before and after an educational intervention suggest that these initiatives improve the attitudes of health professionals (Happell, Pinikahana, & Roper, 2003; McAndrew & Samociuk, 2003; Roper & Happell, 2007; Wood & Wilson-Barnett, 1999). Increasingly service users are not only collaborating with health professionals in designing and undertaking research (Ochocka, Janzen, & Nelson, 2002) but they are leading research (Hounsell & Owens, 2005; Walsh & Boyle, 2009) and running 'user led' organizations (Brown, 2009).

The increased involvement of service users in all manner of roles within mental health services and in the preparation of health services ought to be welcome if for no other reason than it serves to open up otherwise closed systems. Service user involvement attenuates the propensity for systems to degenerate into oppressive structures. It is also (at least theoretically) therapeutic for participants i.e. active participation is helpful in enhancing and maintaining the well-being of participants. Reviews of self-help groups such as alcoholics anonymous reveal that they are at least as helpful as any professionally led approach and achieve this through enhancing self-efficacy, coping skills and motivation and facilitating adaptive social network changes (Kelly, Magill, & Stout, 2009). Active participation in mental health care may not be the only, or even the critical ingredient in mental health recovery from mental health difficulties but it does seem helpful to many (Farkas et al., 2005; Finfgeld, 2004; Fitzsimons & Fuller, 2002).

Whilst improving the quality of participation at every level of mental health service organization and delivery ought to be welcomed, the positive impacts of these developments may not be realized if they are embraced uncritically.

Myself and colleagues (Lakeman, Walsh, & McGowan, 2007) argue that there is a stratification of power in relation to service users or 'experts by experience' that parallels the stratification of power within mental health services. The power of the burgeoning service user movement as a critical voice and agent of mental health reform risks being attenuated by the assimilation of service users into institutional roles. Nurses have long been able to maintain a comfortable, secure and pensionable job by not questioning, challenging or arguing. This is also true of service users who assume paid roles within mainstream services. There is a need to agitate, argue, and present radical critique and alternatives to the status quo. Service users need to be particularly vigilant of being manipulated or their messages subtly subverted by the dominant discourse. My view is that we need to maintain a scientific attitude and a healthy scepticism towards knowledge claims and indeed the latest jargon, catchphrase or rhetoric.

As well as improving and increasing the participation of service users in mental health services there is an increasingly powerful lobby of family members or 'carers' who advocate for improvements in the everyday care provided by mental health services and in particular for the contributions of non professional carers to be recognized and respected. The research undertaken on enhancing family participation described in this portfolio (Lakeman, 2008b, 2008d) is an example of a pragmatic approach to improving the quality of family participation in mental health care. The project was commissioned by a group of 'stakeholders', 'consumers' and advocacy groups in collaboration with a health service who identified a problem area, sought and obtained funding for the project and commissioned project workers such as myself to develop a research protocol.

Early on it was agreed that if the project was to have any credibility then a 'carer' needed to participate in undertaking the research. Modest but tangible improvements occurred in the quality of family members participating through the project. This could have been as a consequence of the Hawthorne effect in

which an individual's behaviour is altered by being observed, although this research artefact is typically understood to be a short lived phenomena. (Leonard, 2008) and the observation was fairly prolonged in this case. This ought to be acknowledged as a potential problem with any research which purports to introduce an intervention to improve practice (in this case a policy change). However, the presence of advocates, consumer consultants, or researchers interested in routine practice might well be the underlying mechanism for many service improvements and encouraging participation in as many ways as possible is inherently good.

3.4. Towards the proper focus of mental health care

After a period of time teaching in New Zealand I moved to Townsville in regional North Queensland. My initial appointment was as 'Clinical Nurse Consultant' on what was coined a 'Mobile Intensive Treatment Team'. This small team consisting of a social worker, occupational therapist, psychologist, part time psychiatrist and a nurse were charged with providing a service based on the well described principles of assertive community treatment (Marshall & Lockwood, 2000; The Sainsbury Centre for Mental Health, 2001; Ziguras & Stuart, 2000) to those people who were deemed to have the most complex of needs or the demonstrated propensity to use the most mental health services. The team targeted the estimated 10 to 30 percent of patients who used 50 to 80 percent of resources (Kent, Fogarty, & Yellowlees, 1995) and a small cohort of people who had been hospitalized for lengthy periods of time and who had been deemed to be too difficult to discharge without extensive support. I have extensively described the nature of the work undertaken elsewhere (Lakeman, 2001a). What was particularly interesting about this work was that it illuminated many of the tensions and paradoxes between the rhetoric and reality of mental health care.

Many service users had been compulsorily detained and treated, imprisoned or hospitalized, resisted treatment efforts and were frequently deemed to be

beyond help. Referral to our team was sometimes recognized as a last ditch attempt to secure or maintain community tenure for people. The kind of interdisciplinary politics that sometimes accompanies attempts to obtain psychiatric hospitalization or around pressures to discharge people was refreshingly absent as colleagues recognized that if our team said that they could not manage someone, no one else was going to. Past attempts to coerce clientele to receive treatment had often been unsuccessful, and whilst some clients were technically required under the Mental Health Act or as a condition of parole to accept what ever care or treatment we specified, coercion could not be the basis for an ongoing intensive relationship.

Assertive Community Treatment (ACT) and its various incarnations around the world have been repeatedly demonstrated to be an effective way of organizing the delivery of a package of care to individuals with particularly complex needs (Lakeman, 2001a). However, at the time there was growing concern about the compatibility of ACT with personal recovery (Dziopa & Ahern, 2009) and that in some jurisdictions ACT teams had become highly paternalistic and little more than a vehicle to impose medication on people in the community (Spindel & Nugent, 2001). In a randomized control trial of ACT (reduced caseloads) versus standard community care in the United Kingdom (Burns et al., 1999) had found no difference in clinical outcomes, although later they conclude that case managers were not using the additional time available to them to provide 'evidence based' practice (Burns et al., 2000). Just as ACT appeared to have lost something of its gloss 'mental health recovery' was in its ascendancy and various attempts in Australia in particular were being made to explore and reconcile other movements such as evidence based practice, service user participation and outcome measurement with this new unifying concept (Andresen, Caputi, & Lindsay, 2006; Deane et al., 2006; O'Hagan, 2004; Oades et al., 2005; Rickwood, 2004).

I had rarely felt as effective and useful as a mental health practitioner as I did during the first couple of years in Townsville working in this small team. I was

quite conscious of balancing the various tensions that arose in everyday work, between protecting the public and protecting the service user from the public, a desire to intervene with enabling the person to be self-directing and so forth. Within two years all but a handful of those that were referred from long term hospitalization no longer needed our involvement with their needs being amply met by social support agencies, families and primary care practitioners. Most people adapted to community living exceptionally well, with dramatic reductions in hospital usage, stable tenure of accommodation and achievement of personal goals. Occasionally we witnessed a reduction in delusional ideas, disordered thinking or labile mood that we credited principally to the judicious use of medication. However, often the relationship between success (reduction in specific symptoms or problematic behaviour or achievement of the person's goals) and our interventions was considerably more complex.

Of critical importance to the well being and successful community tenure of many people we worked with was the environment, both physical and social. On occasion a mismatch between the nature of available housing options and the person's needs led to the break down of relationships between the service user and neighbours and ultimately deterioration in the individual's mental state. For example one socially intrusive, alcoholic man was placed in a high density housing complex for retired pensioners and within hours had offended all his immediate neighbours with his drunken boisterous behaviour; On another occasion a man who was very much a rural person and whose main goal in life was to tend his own garden was chronically suicidal in his second floor apartment building and made frequent suicide attempts and gestures. He, a colleague and I (Nielsen, Lakeman, & Quadrell, 2001) made an impassioned plea to colleagues to find accommodation where he could experience 'dirt under foot'. Ultimately he was re-housed in a rural community, was able to realize his goals and his suicidality diminished.

When I later moved teams to focus entirely on helping individuals who were homeless, the relationship between environment and mental health was even

more dramatically demonstrated. We attempted to assist a man who had previously been diagnosed with schizophrenia, who appeared to be profoundly psychotic at times and had an expansive elated mood characteristic of someone who had taken methamphetamine which is what we initially suspected. A urinalysis disconfirmed our theory. For two months we administered risperidone consta (a long acting antipsychotic) to him every two weeks but this didn't appear to make any difference to his presentation and we spent much of our time intervening when he experienced a crisis. He had his possessions stolen whilst he was sleeping rough, was evicted from an emergency shelter for fighting, and was pursued by police for causing a disturbance at a welfare office. In a tearful and dejected state, he requested that he go to hospital to clear his head but he discharged himself with an hour after being spoken to in what he considered a patronizing manner by a nurse. It was apparent that the man was not going to improve if sleeping in a park and we managed to secure a bed for him in a shelter for aboriginal men. The man warmed to the communal sleeping arrangements and the maternal caring demeanor of the manager. Breakfast and an evening meal were provided and residents had to leave during the day. This appeared to be the right mix of security and structure for the man whose mental status rapidly improved to the point at which he was providing helpful advice and support to other service users.

The irony was not lost on me that the cost of this man's medication and the expense of delivering it to him would have easily covered the ongoing cost of private rental accommodation. In one sense we were medicating the consequences of poverty. This is not to say that simply providing a house would have led to stability or the man conforming to middle class notions of good citizenship. The relationship between meeting basic needs and mental health or wellbeing is complex. What this case did illustrate was the inextricable relationship of environment to mental health and the importance of environment as a context which impeded or enables healing. This of course is an old idea

overshadowed by the biomedical turn in psychiatry with its emphasis on symptom identification and pharmaceutical treatment. Paradoxically the current fascination with genetics and the role of environment on genetic expression may reinvigorate an interest and focus on the impact of the environment on mental health.

Attention to the environment and its impact on the individual is a common thread to nursing in the asylum, contemporary psychiatric unit or community outreach. Nightingale stressed the importance of an environment conducive to recovery and exhorted nurses to use the environment to assist nature to heal (Marriner-Tomey & Alligood, 2005). Nightingale recognized that factors associated with the patient's surroundings affect both biological and psychological approaches. LeBel (2006) pointed out that the purposeful use of environment interventions such as the provision of good food, music, aroma, an aesthetically pleasing environment, and activities such as physical work and occupation as alternatives to coercive care has a long history in formal mental health care provision that predates the medicalisation of insanity.

In psychiatric and mental health nursing Peplau (1952) is widely held to have made the next big leap in nursing specific theory after Nightingale, borrowing from psychological theories of the time to stress how the relationship between nurse and patient could make a positive difference to a person's development, adjustment and recovery. Peplau suggested that interest in the idea of the 'milieu' during the 1950s was a reaction against the prevailing "dreadful environments" in asylums and psychiatric hospitals up to that time (Peplau, 1989a). The idea of the milieu as a therapeutic environment gained renewed popularity from the 1960s and crystallized attention on not only the physical environment but interpersonal, and interactive factors within the milieu and how ward governance arrangements could contribute to people's recovery. Peplau (1989a) did note that 'milieu therapy' was initially championed by psychiatrists and had lost popularity as psychiatrists turned their attention towards pharmaceuticals as the major treatment of mental illness.

The concept of the 'therapeutic community' based on the premise that the social environment or social system can play a direct role in treatment of some problems was developed in the 1950s (Jones, 1956) and gained increasing popularity as a way of organizing mental health inpatient environments up until the 1970s. So much so that Main (1983) some years later commented that the term therapeutic community had been used so frequently in such widely differing ways as to be almost meaningless. By the 1970s group interventions of various kinds were also exceptionally popular as was an interest in general systems theory, and social psychiatry was at its zenith (Blazer, 2005). Main, (1983, p.199) outlined a quite pragmatic way of using systems theory in everyday practice:

It will be clear that sometimes the disorder inside one system will secondarily disturb one or more of the systems with which it is dynamically related, perhaps of a lower order, or a similar order or a higher order. In diagnosis we therefore need to distinguish those disturbances which arise from inside a system from those which are merely reactive to the strains created by other related systems, and to be capable of locating our diagnosis accurately at the appropriate level of system. Put in more human terms the individual may be disordered because of matters inside himself, or his disturbance may be essentially reactive to another person's disturbance – let us say that of his wife. His own disorder, whether internal or reactive, may create strains for nobody but himself or it may affect other family members. He may again create strains for a higher-order system, let us say his employers, or be under strain from that. And so on.

Main (1983) asserted that one needed to utilize different kinds of interventions at different levels of the system. Main was as scathing of the psychiatrist that attempted to treat a higher level system disruption as an individual problem as he was of a psychiatrist failing to diagnose and appropriately address what ought best be construed as problems within the individual. Nevertheless this is precisely what happened in some therapeutic communities including a tragic

experiment in running Ward 10B at Townsville General Hospital along the lines of a therapeutic community.

The therapeutic community has cemented a niche particularly in relation to drug free, highly structured residential programmes for recovery from addictions (Broekaert, 2006; Bunt, Muehlbach, & Moed, 2008; Clarke, 1994). Such programmes have become established in at least 65 countries and have good outcomes in terms of abstinence if people complete the programmes. In modified form particular principles of the therapeutic community continue to be promoted in acute psychiatric units. Mistral et al. (2002, p.10) state that "... the effective functioning of a psychiatric ward is best supported by a 'culture of inquiry'... based upon a collaborative, democratic and deinstitutionalized approach to staff-patient interaction". One near ubiquitous legacy of the therapeutic community in psychiatric wards is the ward meeting in which various decisions about the ward environment are made and at least on occasion people are provided the opportunity to discuss how other people's behaviour on the ward affects themselves.

On arrival in Townsville I was soon made aware by former patients of ward 10B at Townsville General Hospital of a disturbing history in what otherwise appeared to me a reasonably innovative service. As outlined by Wilson (2003) ward 10B was set up in 1973 with a view to running it on therapeutic principles. According to Wilson (2003), Dr John Lindsay was appointed in part because of his training in and commitment to both family therapy and therapeutic communities. Like Lake Alice Hospital, it appeared that the ward became a closed system with minimal surveillance from outside. Rather than adhering to ethical and egalitarian principles, a rigid hierarchy developed in which the medical staff could not be questioned. Perversely, democratic principles were extended to treatment decisions. All patients regardless of their mental state were expected to attend ward meetings which were undertaken with complete openness (and no regard for privacy), and decisions about patient care were put to a group vote and carried out immediately (Wilson, 2003). Such decisions

extended to drugging individuals and the openness extended to staff sharing whatever they thought or felt about patients which sometimes was scathing or abusive. The commission of inquiry that was convened in 1991 identified thirty-five people who died by suicide or suspected suicide and thirty who died from a medical condition, most either in the ward or within a month after their final contact with it. Again, this confirms the danger of adhering to dogma or at least a failure to temper faith in treatment methods with a commitment to ethical principles. What it also reinforces is the incredible power of the environment or milieu to influence the wellbeing of people for better and for worse.

Nursing and indeed all health professionals ought to be concerned about influencing people's health for the better. Barker (1989) in attempting to reconcile therapy with nursing at a time when there was an accelerating movement to create a 'nurse therapist' role separate from other nursing coined the term 'trephotaxis' to describe a good enough orientation to nursing care which integrates rather than separates therapeutic functions. Barker (1989, p.138) stated that the original Greek meant the "provision of the necessary conditions for the promotion of growth and development" and the aim of nursing "...in any situation, is to institute conditions which will assist individuals to grow and develop in such a way as is meaningful and appropriate to themselves". This simple idea has been the way I have conceptualized the central function of my nursing practice ever since and whilst not all work in this portfolio explicitly addresses the aims of nursing it has been a persistent theme and underlying assumption of my published work.

Barker (1989) pointed out that 'trephotaxis' was not a model of nursing but the concept clearly presaged the development of the Tidal Model later. Rather, than water being the central metaphor (as it is in the Tidal Model), Barker used the competent gardener as a metaphor for the good enough nurse. He suggested that it was insufficient for a gardener to simply care about or like plants, a competent gardener demonstrates concern and protection and an understanding of the correct environmental conditions required for each plant to

thrive:

The definition of care in this context is functional. It is not enough to talk to the plants, to love plants, to care about plants. The meaning of the role is expressed by the function of the relationship. A good gardener will rear plants which, eventually, will need less care. (Barker, 1989, p.135)

At much the same time as Barker (1989) was developing the concept of 'trephotaxis' (a term which never caught on), Antonovsky (1987, 1992, 1993, 1996) was reinvigorating another term, 'salutogenesis' which has gained more of a hold on people's imaginations. The underlying assumptions, implications for mental health practice and particularly for mental health promotion are similar to the Tidal Model. Rather than starting with a consideration of 'pathogenesis' or the determinants of disease and ill-health in health promotion Antonovsky (1996) suggested that we ought to start with consideration of 'salutogenesis' or a consideration of how health is created and maintained. Antonovsky (1996, p.13) stated that curative medicine is devoted to those who are drowning; and preventive medicine, to those in danger of being pushed into the river upstream. Both share a pathogenic orientation and concerned with risk factors and their amelioration. A salutogenic orientation in contrast is concerned with salutary factors or to extend the metaphor, how people learn to swim well wherever they are in the river. In relation to mental health, a salutogenic perspective is concerned with the promotion of mental health not the treatment of illness which is almost the total preoccupation of psychiatric (euphemistically called 'mental health') services.

Antonovsky suggested that people develop or obtain 'general resistance resources' which enable people to adapt and positively respond to stress so that they develop and maintain a 'sense of coherence'. According to Antonovsky (1987) a sense of coherence has a number of dimensions including comprehensibility or the extent to which both internal and external environments are structured, predictable and explicable to the individual;

manageability or the extent to which resources are available to meet the demands of life; and meaningfulness or the extent that ones life makes sense emotionally and challenges or demands are considered worthy to invest in or engage with. General resistance resources may be physical and biochemical, material, cognitive and emotional, attitudinal, interpersonal/relational or socio-cultural. To promote or restore health one needs to be cognizant of salutary factors within the individual, between people and within the physical environment.

Antonovsky's theory has reinvigorated health promotion generally (Davies, 2008) and provides a theoretical framework to inform the promotion of mental health at a population (Lindstrøm & Eriksson, 2005) as well as at an individual level (Langeland et al., 2006; Langeland et al., 2007). A salutogenic approach to mental health work (Langeland et al., 2007) has much in common with the Tidal Model (Barker, 2001, 2003; Barker & Buchanan-Barker, 2005, 2008) in that principles of narrative therapy or brief solution focused therapy are drawn upon in everyday interactions, a metaphor of the fluid nature of life is employed, the medical diagnosis is de-emphasised, particular attention paid to the individual's story and goals, and emphasis is placed on identifying and mobilizing people's strengths and coping resources. Both approaches emphasis values and practices that appear congruent with personal mental health recovery although the Tidal Model, derived as it is from a consideration of what people need nursing for rightly accommodates the need for crisis care. The exploration of recovery competencies described in this portfolio (Lakeman, in print-b) suggests that crisis care may be necessary but in the interests of conceptual clarity ought to be distinguished from recovery focused care.

In 2006 I took up a position in Townsville as a team leader setting up a homeless outreach team based on principles of assertive community treatment. Since taking up an academic position at Dublin City a year later I have worked extensively with workers in the homeless sector in Dublin, both developing and delivering courses on case management and also undertaking research on

sudden death within the sector (reported in part within this portfolio). Working in the homeless sector is humbling as a mental health professional, as it quickly becomes apparent that only a minority of people can be helped with a pathogenic approach to treatment. Even when people appear to have a clearly defined mental illness (which is rare indeed) a focus solely on treating the illness is rarely helpful in terms of helping the person attain and sustain stability; and for many people who don't appear to have over mental health problems simply providing accommodation is rarely effective either. A consideration of the internal and external environment and the person's adaptive capacities is pivotal to effective helping.

A salutogenic orientation (although perhaps not consciously considered at the time) was in part a motivating factor in the formulation of research questions. For example, 'How people cope with hearing voices' (Lakeman, 2000c), how people live with or overcome suicidality (Lakeman & FitzGerald, 2008), and how people sustain their compassion working with the trauma of sudden death of service users. What follows now are reports from some of these projects. The themes of ethics, power, participation and salutogenesis are revisited again in the final section in order to consider the significance of this portfolio.



Figure Two: Some of the operational psychiatric hospital in Dublin. From top left (Clockwise) – St Patrick’s Hospital, St Brendan’s Hospital, St Vincent’s Hospital Fairview, and St Ita’s Hospital

4. Publications

4.1. Ethics and Commentary

Barker (1999, p.199) as I point out in the book chapter reproduced next, suggested that “we might view ethics as the basis for choosing the kind of professional life we believe we should lead so that we need not look back with regret in the future”. This is essentially the motivation for preparing this body of work, as much as one can know one’s own motivations. That our motivations are sometimes obscure, and our taken for granted assumptions are not irrefutable facts are key points that are revisited in different ways in the work presented in this section.

Nursing has a long history of conservatism and is known for its’ reliable caring presence rather than radical edge. Obedience towards one’s superiors has long been held up as a virtue of the nurse. Rodgers, (1985) suggested that the values of nurturance, endurance, forbearance and obedience derived from Victorian notions of the virtuous woman continue to permeate the professional ethos of nursing. Nursing has in many ways achieved emancipation from it’s servile past, has realised at least some of its aspirations towards professional status and nurses now enjoy a plethora of semi-autonomous roles. However, in many ways the functions of nursing continue to be defined by others. Nurses follow “doctors orders” and administer medically prescribed treatments and monitor their effectiveness. Nurses perform essential functions as extensions of the eyes and ears of medicine and in psychiatric nursing, nurses also tend to be the strong arm or enforcers of compulsory treatment. Given, the instrumental nature of nursing

work it is not surprising that the relatively young nursing academy has to date been relatively conservative in its critique of the status quo. Faith in the virtues and knowledge of prescribers and an acceptance of authority are necessary conditions for an easy professional life. This is not particularly problematic in most areas of medical care. However, in psychiatric care in which many of the assumptions are contestable, coercion is a mandated component of treatment, and the evidence base in support of treatments is often fairly shallow this passive professional stance is ethically problematic.

Chomsky (1967) asserted that intellectuals, because of their privileged positions have a responsibility to ask difficult questions, expose lies and analyse actions according to their causes and motives and often hidden intents. Clarke (2008, p.145) notes that there is an almost anti-intellectual tradition, at least in the UK, and that "...pushing for alternative solutions to problems – especially where this involves debunking conventional views – can be perceived as fomenting unrest". Thus the nursing academy with some exceptions tends to be mostly conservative in relation to its expressed views on psychiatric care, and even more radical commentary or argument e.g. O'Brien and Golding's (2003) call for a moratorium on coercive practices barely makes a ripple within mental health nursing circles, let alone on the wider mental health system. Coercion is part and parcel of the daily reality of psychiatric nursing practice, justifying coercion is a basic social process (Vuckovich & Artinian, 2005) and the more one engages in coercive practices the more one perceives they are acceptable (Whittington et al., 2009). This dynamic of rationalising, justifying or merely uncritically accepting prevailing practices is a survival strategy of practitioners that also pervades nursing leadership.

It appears that nurse academics and educators embrace the aspiration to be leaders (Ortelli, 2006) although how this is operationalised or realised is unclear. Some researchers / academics call for radical critique, the forging of a revolutionary academic habitus or as Ladson-Billings and Donnor (2005,

p.291) assert the role of the critical scholar is to,

... break new epistemological, methodological, social activist, and moral ground... We need scholars to take up their causes (along with causes they identify for themselves) and creatively engage them. We look to them because of their departure from the scholarly mainstream...

This is in accord with my view of a genuine nurse academic or leader.

However, nursing as practice based occupation has tended towards being concerned with extending or expanding the practice field which has been the hot topic of debate in recent years (see for example: Elsom, Happell, & Manias, 2006; Hales et al., 1998). Following, a chapter providing an overview of ethics as applied to mental health nursing several commentaries address a number of causes I have taken up in recent years. These all problematize in different ways assumptions that I believe are taken for granted in psychiatry. Problematization in this sense is similar to the Foucauldian idea which is the opposite of a polemic. That is, raising questions rather than providing answers (Warner, 2004). In particular I have attempted to deconstruct the certainty and dogmatism that I see as pervasive, and ultimately self-deceiving and potentially dangerous embedded in health systems and ultimately the everyday practices of nurses.

The theme of ethics is taken up again in the concluding section and the body of work in this portfolio is considered as a whole in relation to its contribution to ethics and furthering ethical care.

- 4.1.1. Lakeman, R. (2008). Ethics and nursing. In P. Barker (Ed.), Psychiatric and mental health nursing: The craft of caring (2nd ed., pp. 607-617). London: Arnold.**



CHAPTER 69

Ethics and Nursing

Richard Lakeman*

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The many ethical dimensions of psychiatric nursing	610		

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- 4.1.2. Lakeman, R. (2006). An anxious profession in an age of fear. Journal of Psychiatric and Mental Health Nursing, 13(4), 395-400.**



An anxious profession in an age of fear

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LAKEMAN R. (2006) *Journal of Psychiatric and Mental Health Nursing* 13, 395–400
An anxious profession in an age of fear

This paper proposes that some practices and trends in mental health care may be considered as defensive responses to collective anxiety and fear. On a larger scale similar dynamics occur around fear of terrorism. Collectively and individually we are pulled by the defensive forces and dynamics associated with anxiety. This can in part explain the polarization that occurs around issues of definition and response to mental illness. Fear and anxiety push services towards simplistic viewpoints and futile practices. The capacity to view things from the perspective of others, embracing explanatory and therapeutic pluralism and adopting a humble attitude, may be helpful in enabling anxiety to be channelled productively.

Keywords: anxiety, fear, psychiatry, terrorism.

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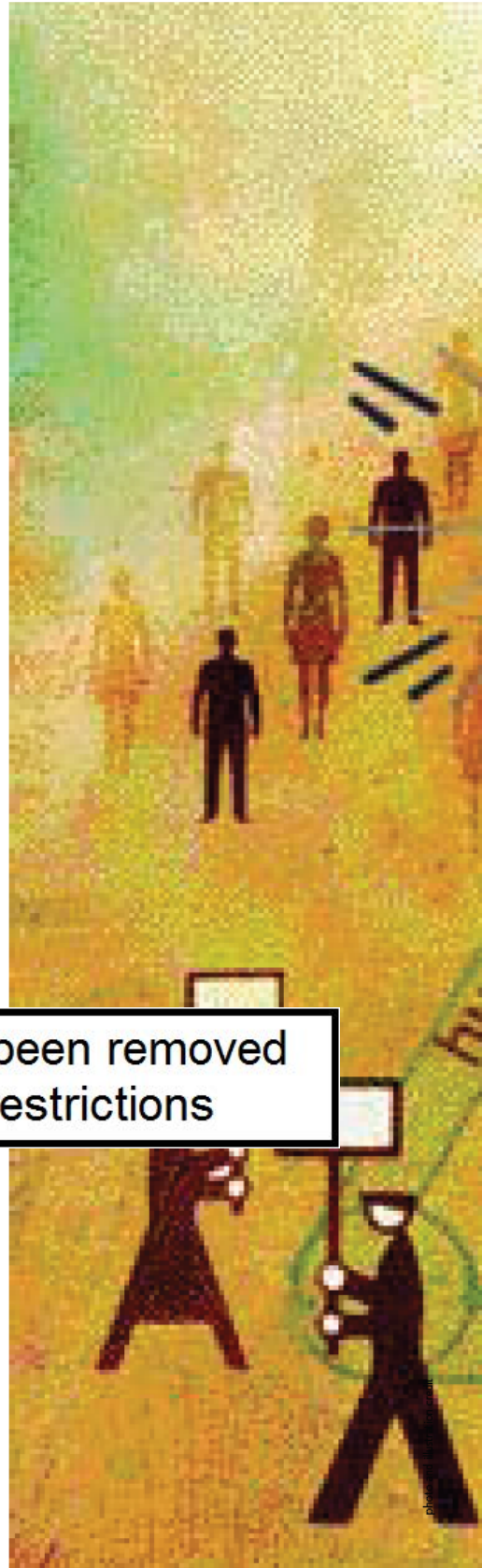
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- 4.1.3. Lakeman, R., Walsh, J., & McGowan, P. (2007). Service users, authority, power and protest: A call for renewed activism. *Mental Health Practice*, 11(4), 12-16.**

Service users, authority, power and protest: A call for renewed activism

Richard Lakeman and colleagues argue that there has been an explosion of roles for service users in mental health services in recent years. One consequence has been the emergence of a hierarchy among users, with some attaining 'celebrity status'. But the service user movement grew from protest and there continues to be a need for service users and others with an interest in promoting mental health to be activists, the authors conclude

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- 4.1.4. Lakeman, R. (2008). The medium, the message, and evidence based practice. Issues in Mental Health Nursing, 29(3), 319–327.**

COMMENTS, CRITIQUE, AND INSPIRATION
THE MEDIUM, THE MESSAGE, AND
EVIDENCE-BASED PRACTICE

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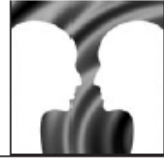
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- 4.1.5. Lakeman, R., & Cutcliffe, J. (2009). Misplaced epistemological certainty and pharmaco-centrism in mental health nursing. Journal of Psychiatric and Mental Health Nursing, 16(2), 199-205.**



Commentary

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**Misplaced epistemological certainty
and pharmaco-centrism in mental
health nursing**

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- 4.1.6. Cutcliffe, J. R., & Lakeman, R. (2010). Challenging Normative Orthodoxies in Depression: Huxley's Utopia or Dante's Inferno? *Archives of Psychiatric Nursing*, 24(2), 114-124.**

Challenging Normative Orthodoxies in Depression: Huxley's Utopia or Dante's *Inferno*?

John R. Cutcliffe and Richard Lakeman

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- 4.1.7. **Lakeman, R. (2010). Mental health nursing is not for sale: rethinking nursing's relationship with the pharmaceutical industry. *Journal of Psychiatric and Mental Health Nursing*, 17(2), 172-177.**

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4.2. Suicide and sudden death

Suicidality is an important clinical concern. Whilst, most often associated with depression, suicidality is pathognomonic of no particular disorder (Harwitz & Ravizza, 2000). Perception of imminent suicide risk is a common reason for psychiatric hospitalisation (Cochrane-Brink, Lofchy, & Sakinofsky, 2000) and risk of completed suicide has been found to be particularly high within a week of admission or discharge from hospital (Meehan et al., 2006; Qin & Nordentoft, 2005). A recent Australian study of the prevalence and predictors of suicide attempt in an incidence cohort of 661 young people with first-episode psychosis, found a high prevalence of suicidal behaviour (Robinson et al., 2009). However, the rate of repetition of suicide attempt was lower than expected, suggesting that specialist services play a role in reducing suicide risk (Robinson et al., 2009). Suicide risk assessment has been described as a critical nursing task (Cutcliffe & Barker, 2004) and the kind of care provided by nurses can be pivotal to successful resolution of the suicidal crisis (Samuelsson et al., 2000). Nevertheless, very little research has addressed how people resolve their suicidal crisis. The following review (Lakeman & Fitzgerald, 2008) addresses an important gap in the literature by considering how people overcome suicidality.

Since publication of the review (Lakeman and Fitzgerald, 2008) a further grounded theory study has been published which addresses the research question through focusing of young adults recovery from repeated suicide-related behaviour (Bergmans, Langley, Links, & Lavery, 2009). Bergman et al. (2009) claimed to have used a grounded theory methodology (based on Strauss & Corbin's guidelines published in 1992) and their results are remarkably similar to the findings in the review. Bergman et al. (2009) suggest

that recovery from suicidality / high risk behaviour involves three related processes which they called 'living to die', ambivalence and tipping/turning points and unique steps or 'pockets of recovery'. The initial (what seems to be an in-vivo code) 'living to die' is similar to the notion of 'struggle' in the review and 'tipping/turning' is also consistent with the 'turning points' described in the review. How research findings from studies using different qualitative methodologies can or ought to be brought together by way of synthesis is contentious. The compatibility of the review with subsequent research lends some credibility to the process of synthesis employed.

On embarking on the review and being aware of the huge public, academic and clinical interest in suicide I did expect to be overwhelmed with research. This was not the case, with only a tiny percentage of academic writing on suicide addressing recovery. Meanwhile, a colleague was finding it difficult to obtain approval from a University Ethics Committee to undertake qualitative research involving previously suicidal young men, despite having access to good back up services and support from health and welfare services. The practical and ethical problems of accessing and engaging with suicidal people as a researcher appear formidable and negotiating a resolution of problems with ethics committees appears daunting. These difficulties may contribute to the current paucity of research which involves engagement with currently suicidal individuals. In order to identify the major ethical and pragmatic problems associated with suicide research (the two issues are sometimes intertwined) and how these issues are resolved, a survey of both experienced suicide researchers (Lakeman & Fitzgerald, 2009a) and ethics committees (Lakeman & Fitzgerald, 2009b) was undertaken. It is hoped that this work will be helpful to others in anticipating and successfully resolving problems that might currently impede work on understanding suicide and resolving suicidal crisis.

My recent clinical work has been with homeless people and part of my teaching focus has been on preparing homeless sector workers. Suicide is a pressing concern for those that work in the sector. People whom are homeless are

widely understood to be at risk of suicide although there is a paucity of research addressing suicide within homeless populations (Christensen & Garces, 2006). In a study from the United Kingdom in which a cohort of over 10,000 people who presented with deliberate self harm were followed up over a 14 year period, those who were of no fixed abode were twice as likely to from probable suicide than domiciled patients (Haw, Hawton, & Casey, 2006). In an examination of the clinical records of those who had been in contact with mental health services within a year before their death in Wales and England (between 1996 and 2000) 3% were found to have been homeless at the time of their death (Bickley et al., 2006). In some samples homeless people have been found to have rates of suicidal ideation ten times greater than the general population (Fitzpatrick et al., 2007). In a United States survey of homeless people diagnosed with mental illness, 51.3% reported having made a suicide attempt (Desai et al., 2003).

Homeless people have much higher rates of morbidity and mortality than the general population and often engage in high risk behaviour (Votta & Manion, 2004). Determining whether death is a suicide or accidental is particularly difficult. For example, drug overdose is a common cause of death in the homeless sector and this can often appear accidental. However, those that have died by overdose often demonstrate a history of suicidal ideation (Jones et al., 2002) and in one sample of non-fatal overdoses a little under half of all people reported suicidal intent (Neale, 2000). Homelessness has also been found to be a strong predictor of death following medical detoxification for substance dependence (Saitz et al., 2007).

The report produced in this portfolio relating to how workers respond to sudden death in the homeless sector had its genesis when there was a call for applications from a beneficent trust for projects around suicide and suicide reduction. It had been my experience as a practitioner, manager and supervisor that the impact of sudden death of service users could be very destructive and few workers (of any discipline) are prepared for such events. It was soon

apparent from a cursory review of the literature and knowledge of the sector that separated suicide from other forms of sudden death when considering how workers respond would be impractical. Thus this project took a wider remit to examine the impact and response to sudden death with a longer term view to develop some form of intervention (informational, educative, or psychotherapeutic) to assist workers deal with this aspect of their work.

- 4.2.1. Lakeman, R., & Fitzgerald, M. (2008). How people live with or get over being suicidal: a review of qualitative studies. *Journal of Advanced Nursing*, 64(2), 114-126.

JAN REVIEW PAPER

How people live with or get over being suicidal: a review of qualitative studies

Richard Lakeman & Mary FitzGerald

Accepted for publication 4 June 2008

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- 4.2.2. Lakeman, R., & Fitzgerald, M. (2009). The ethics of suicide research: The views of ethics committee members. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 30(1), 13-19

The Ethics of Suicide Research The Views of Ethics Committee Members

Richard Lakeman^{1,2} and Mary FitzGerald¹

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Abstract. *Background.* Good quality, ethically sound research is needed in order to better understand, appropriately respond to, and reduce the incidence of suicide. There is, however, a lack of clarity around the nature of ethical problems associated with suicide research and how to resolve them. This is a formidable challenge for ethics committee members in approving and monitoring research. *Aims.* To describe the views that members of health research ethics committee hold regarding ethical problems and ethical practice in research involving people who are, or who have, been suicidal. *Methods.* Ethics committee members were invited to complete an online survey addressing the risks, benefits, and ethical problems associated with suicide research. Findings were aggregated into themes using an inductive form of content analysis. *Results.* Concerns of ethics committees centered on accessing the population, potential harm to participants or the researcher, researcher competency, maintaining confidentiality, providing support to participants, and responding sensitively to the needs of family. *Conclusions.* Ethical research involving suicidal people requires both procedures to protect participants, and consideration of ethics as an ongoing negotiated process. The findings of this research provide a snapshot of views held by a number of ethics committee members.

Keywords: suicide, research, ethics, research ethics, ethical review

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- 4.2.3. Lakeman, R., & Fitzgerald, M. (2009). Ethical suicide research: A survey of researchers. International Journal of Mental Health Nursing, 18(1), 10-17.**

FEATURE ARTICLE

Ethical suicide research: A survey of researchers

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4.2.4. Lakeman (submitted for publication) Positively framing death and carrying on: A grounded theory of homeless sector workers response to the sudden death of service users.



Abstract

Homeless sector workers often encounter the deaths of service users. A modified grounded theory methodology was used to explore how workers make sense of, respond to, and cope with sudden death. In depth interviews were undertaken with 15 paid homeless sector workers who had experienced the death of someone with whom they worked. Transcripts of interviews and field notes were analysed using the constant comparative method and a theory which described the positive framing of death emerged. Dealing with death and trauma is not something that most workers expect when they begin work but exposure to the death of a service user heightens expectations that other service users may be harmed. How workers cope or positively frame death depends on several interlinked processes. These include how the death is encountered, how the worker and others mark the death and the extent that the vulnerability of self, peers and service users is recognised and responded to. Successfully framing death enables the worker to continue working in the sector whilst maintaining enthusiasm for their work and compassion for service users.

Introduction

Homeless populations around the world have been found to have much higher rates of both morbidity and mortality relative to those who are securely housed. Homeless people tend to have high rates of alcohol and drug dependence and associated problems, communicable diseases, psychiatric disorder and exposure to violence and trauma (Kushel, Evans, Perry, Robertson, & Moss, 2003; Schanzer, Dominguez, Shrout, & Caton, 2007). Rates of suicidal thoughts and suicide attempts have also been found to be exceptionally high, with some surveys finding rates 10 times higher than the general population (Desai, Liu-Mares, Dausey, & Rosenheck, 2003; Haw, Hawton, & Casey, 2006; Fitzpatrick, Irwin, Lagory, & Ritchey, 2007). Research has consistently found that homeless or marginally housed individuals have a shorter life expectancy and are more likely to die of homicide, suicide, trauma, acquired immunodeficiency syndrome (AIDS) related conditions, drug overdose and other alcohol and drug related problems relative to the domiciled population (Cheung & Hwang, 2004; Haw, Hawton, & Casey, 2006; Hwang, Orav, O'Connell, Lebow, & Brennan, 1997; Morrison, 2009; Nordentoft & Wandall-Holm, 2003). People who work in the homeless sector are likely to encounter individuals at extreme risk of death and to be regularly exposed to the deaths of service users during the course of their work.

Exposure to death in the workplace has been found to be highly traumatic for workers (Kinder & Cooper, 2009) and people who help survivors may themselves be traumatized in the process (Sabin-Farrell & Turpin, 2003). Some groups such as emergency personnel are regularly exposed to mutilation, death, human suffering, and pain. The impact of exposure to trauma and sudden death on health professionals and emergency workers has been explored particularly in relation to 'emotional labour' that is, dealing with the strong emotions of self and others (Stayt, 2009), stress and coping (Alexander & Klein, 2009), and post traumatic stress responses (Jonsson & Segesten, 2004). The experience of health professionals who care for the seriously ill, dying, and bereaved has been the subject of

extensive study (see Papadatou, 2000) but the experiences of welfare workers and non-health professionals has received little attention.

Homeless sector workers may respond to trauma and sudden death of service users differently to other occupational groups because of the nature of their work and the people whom they serve. Workers are less likely to share clear professional identities and role demarcations as people who work in hospitals or emergency services. They provide services to people who are often marginalized and excluded from mainstream society in situations which are fraught with risk. Their relationships with service users are likely to be different (sometimes more intense and sometimes fleeting) and for some service users the homeless sector worker may be the most significant person in their lives as relationships with family, friends, or professionals may be tenuous or strained. Some workers such as those who work in street outreach or in shelters in which drug or alcohol intoxication of service users is tolerated, homeless workers are exposed to exceptionally high levels of risk and uncertainty. How front-line homeless sector workers experience and deal with the deaths of people whom they are charged with helping is the topic of exploration in this project.

Local Context

There are at least 250 agencies delivering services to homeless people in Dublin. Some, such as emergency shelters, work exclusively with people deemed to be homeless whilst others such as alcohol and drug treatment services serve a broader population. Services may be considered on a continuum (from low to high threshold). Low threshold services are those that have few if any conditions associated with access and tend to be available to whoever needs them. These include street outreach services, emergency shelters, needle exchange programmes, sexual health services, soup kitchens, and homeless drop in services. High threshold services tend to serve fewer people and have conditions relating to access (e.g. requiring a referral from another agency or requiring adherence to rules such as abstaining from drugs or alcohol). These include

residential alcohol and drug treatment facilities and longer term housing. Services may also involve varying degrees of intensity of involvement with homeless people. Intensive forms of case management and residential drug treatment tend to involve more intensive relationships with service users than drop-in services or those that provide a discrete service such as methadone dispensing. However, the strength of attachments between people in these various services is not solely a function of the threshold or intensity of the service provided (as shall be discussed later).

The Homeless Agency attempts to count the number of people sleeping in public spaces in Dublin City on a regular basis. Between 2007 and 2009 the minimum number counted (which is likely to considerably underestimate the actual number) has varied between 98 and 115 people on a given night (Homeless Agency, 2009). Many of these individuals are likely to episodically use one of the 15 emergency accommodation facilities in the city. Most of the 2366 adults reported as homeless in Dublin in 2366 accessed emergency accommodation or were in longer term transitional accommodation (Homeless Agency, 2009).

Since 2006 the Homeless Agency has maintained a death notification policy that requires homeless services to report the death of a service user within the Dublin area. From January to December 2007, 53 deaths were reported (41 men and 12 women) aged between 26 and 59. These individuals were residing in homeless accommodation or were in recent contact with homeless services before their death (Homeless Agency, 2008). This suggests, and interviewees in this research confirmed, that workers in any of the homeless services are likely to encounter the death of a service user frequently. Detailed information on the causes of death is not publically available but it appears that the most common causes of death related to alcohol use in men and drug overdose in women.

Methodology

The methodology employed in this project was most closely aligned to classical grounded theory as first outlined by Glaser and Strauss (1967) and further

elaborated by Glaser (1978, 1992 , 1998, 2001). Glaser and Strauss (1967), argued for an increased emphasis on generation or discovery of theory derived from data in the social sciences rather than on the verification of “thought up” or logically deduced theories. An assumption of grounded theory is that human behaviour is characterised by latent patterns or processes that grounded theory seeks to make visible and explain. Conceptualisation rather than description is at the heart of grounded theory, which Glaser (2001, p25) asserts transcends the descriptive in “... its ability to generate ‘wise’ propositions that explain behaviour in an area, especially its main concern, its ability to organise and make meaningful many seemingly disparate incidences...”. He goes further by asserting that grounded theory is concerned with the generation of concepts that are abstract in terms of time, place and people. Corbin and Strauss (2008, p306) take a softer line in relation to abstraction in grounded theory, suggesting that concepts devoid of context are “...like jelly donuts devoid of jelly” and that contextualization of concepts is necessary for readers to fully understand the research. This project does err towards conceptual description rather than theory in places so as such it might be more properly described as a modified grounded theory.

Several related techniques, characteristic of grounded theory were used in this project. A form of sampling called “theoretical sampling” (Glaser, 1998) involved allowing the emerging theory to guide where to go next, what data to collect or further review so as to arrive at the main concern of the participants as quickly and efficiently as possible The constant comparative method of analysis involved processes of both coding and theoretical sampling. In-depth interviews with front-line homeless sector workers were the primary source of data. Numerous memos were made about the data, concepts and properties (substantive codes) and their relationships to capture, track, preserve, and develop conceptual ideas (Glaser, 1998, p.180). The aim was to analyse and code in order to generate an emergent set of categories (a higher level concept) and their properties. Sampling or data collection and analysis was an iterative or near constant process. From the outset, each indicator was compared to others, assigned a conceptual code and then

indicator was compared to each concept. The data was revisited many times in order to elaborate, saturate and verify the emerging categories (this is known as substantive coding).

Transcripts of interviews were subject to an initial, painstaking line by line coding in keeping with Glaser's (1978) recommendations. Subsequent coding was guided by theoretical sampling. Early coding produced mostly "in-vivo" codes, that is, derived from the language of participants e.g. "lighting a candle" or "paying respects". As these incidents were compared these gave rise to more conceptual "in vitro" codes reflecting a higher level of conceptual abstraction e.g. "marking death". Glaser (1978, p57) suggested that the researcher ought to be mindful of particular questions when reviewing the data, such as, "What is this data a study of?"; "What category or property of a category, of what part of the emerging theory does this incident indicate?" and "what is actually happening in the data?" As a consequence the core category, 'Framing death and moving on' and subordinate categories emerged from the data, rather than being forced by applying preconceived theories or ideas.

Ethical Considerations

The project received ethical approval from both Dublin City University and James Cook University Ethics committees. It was recognised that discussing experiences associated with sudden death might be traumatic for people so a free and confidential consultation with a local counselling service was offered to interviewees. No respondents availed themselves of this opportunity. The potential for re-traumatisation was reduced by the sensitivity of the interviewer who had a background in psychotherapy as well as mental health work in the homeless sector.

Recruitment and Interviewees

Homeless sector workers were recruited through an advertisement in a sector wide newsletter and via information sheets left at various agencies. People then

contacted the researcher directly for further information. Approximately 40 people made contact via e-mail or phone and discussed their experiences. Sixteen homeless sector workers were interviewed in depth at a place of their choice for between 40 minutes and 2 hours. Initially convenience and availability dictated who would be interviewed but latter theoretical sampling was employed. The interviews commenced with the worker being invited to share any thoughts or observations about sudden death in the sector and then usually one or more experiences were explored in depth. In keeping with the grounded theory methodology no schedule of questions was used, rather emerging themes in analysis guided choice of questions. The interviews were recorded and transcribed and approximately 100 detailed memos were made relating to interviews.

The ages of interviewees ranged from late 20s to mid 50s and their experience working in the homeless sector ranged from 2 years to over 30 years. A small number of interviewees identified a professional affiliation such as psychiatry or social work. The majority did not have a professional affiliation, although most had completed some university level education in areas such as addiction studies. Some were employed in low threshold outreach capacities focusing on particular target groups such as those with HIV, sex workers, people sleeping in public spaces or with alcohol problems. Others worked in supported accommodation including emergency shelters, high support hostels for individuals or homeless families, and residential alcohol and drug treatment facilities involved in providing intensive therapy. All had experience directly providing some kind of service to people who had subsequently died. Some had attended the funeral or had discovered the body of a service user on the day they were interviewed.

Findings

The products of a grounded theory study are conceptual and ought to be of a higher level of abstraction than description. Nevertheless, in presenting the findings some quotes from interviewees are used to illustrate concepts. The main concern of participants was to positively frame the death of service users and move on.

This and associated processes are illustrated in Figure One. Some participants were able to reflect on a completed process of framing death, whilst others were immersed in the process. The straight line reflects work as usual although homeless sector work takes place against a backdrop of expectation that harm may befall service users. Encounters with death always demand a response and a deviation from the usual rhythms and responsibilities of work. The processes of responding to death, marking death and recognising and responding to vulnerability are interlinked processes which bring people more closely in contact with the deceased (or the death encounter) and may be considered components of the core concern of workers to positively frame death. These are not necessarily linear processes (following one after another) but may occur simultaneously, have greater salience at particular points in time and be returned to. Positively framing the life and death of the service user is both an end product of the aforementioned processes and a process in its own right. If successfully resolved the worker is able to carry on their work, revisiting the framed picture at their leisure without being preoccupied or overly distressed by death.

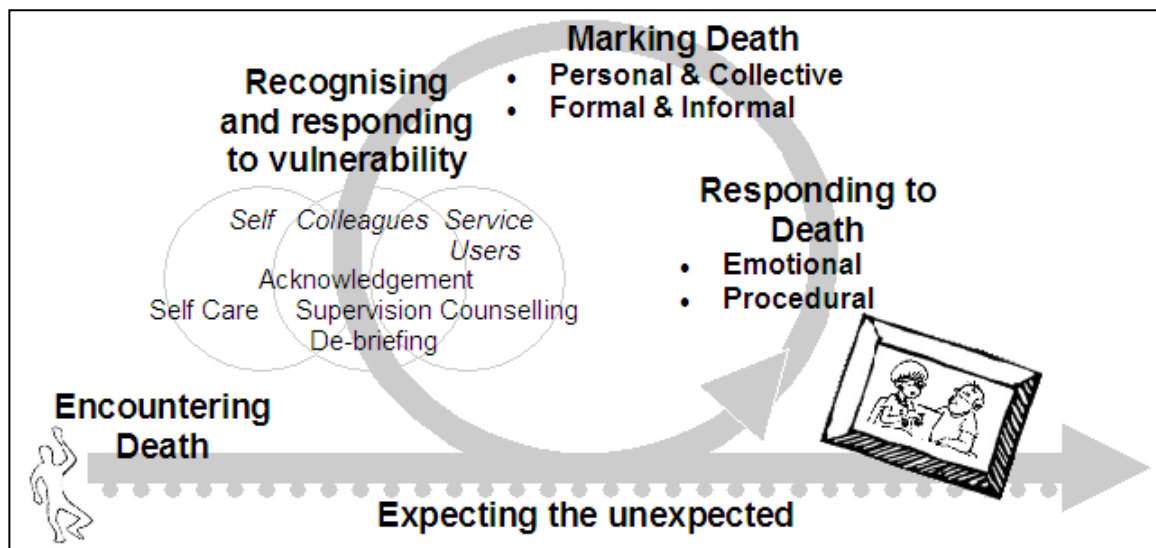


Figure One: The processes involved in framing positively framing the death of a service user.

Expecting the unexpected

Even before workers directly encounter the death they hold expectations about their work and the likelihood of harm befalling service users. The concept “expecting the unexpected” describes the paradox that homeless sector workers understand that service users are often at high risk of death and when it occurs it is almost always accompanied by shock. This realisation of the vulnerability of service users to harm can come to workers quite abruptly. Rarely do workers commence employment expecting to encounter death and seldom is this possibility discussed when people began employment or during their orientation to the workplace. Some people described a moment in which they realised that the people whom they worked with could not possibly sustain the levels of drinking, drug taking, or risky behaviour without some serious consequences.

People who are homeless for long periods of time inevitably experience many losses. In long term accommodation or care environments some workers noted being initially surprised at how frequently and casually service users spoke of the deaths of friends, family, and acquaintances. In drug treatment environments these losses are not so often acknowledged or there may be superficiality to discussions in which the impact of death and loss on oneself is not spoken of. Sudden death is the “ghost in the room” in many discussions with homeless people. The frequency of death and loss amongst some groups such as intravenous drug users can be very high. One experienced worker [IN6] recalled working with someone close to her own age and discussing a photograph of children taken in the 1950s. All of the acquaintances and family members had died in this photo leaving the service user the lone survivor. All had died from alcohol, drug use, or violent assault. In contrast to service users who had lost the majority of their friends in some deprived areas, she noted that she had lost one personal friend in her life time.

Exposure to the stories of service users, other staff and a recognition of the vulnerability of service users in a sense primes workers to expect and deal with death. However, when confronted by sudden death people noted that it often

wasn't whom they expected or when. This illustrates the paradox of expecting the unexpected. Encountering death of a service user can in turn lead to a heightened sense of expectancy in future and if death is not worked through adequately or framed positively a sense of futility may ensue.

Encountering Death

How death is encountered makes a substantial difference to how it can be dealt with. Whether the person witnessed or is present at death, how the body is discovered and in what circumstances are dimensions of encountering death. In residential facilities a terminal illness may be diagnosed or the person may become acutely ill and is admitted to hospital. The homeless sector worker may observe the service user's deterioration, and accompany them to consultations with health professionals. The person may die in hospital. To some extent this expectancy of death attenuates the emotional impact of the person's death. Dying and death is medically contained and the worker is in a similar position to those who may work in palliative care or aged care. The emotional labour of caring for the person is or ideally should be acknowledged by colleagues through gestures of support. The degree to which dying or suffering is witnessed is a property of encountering death.

Sudden, unexpected death, in contrast is associated with more ambivalent and sometimes conflicted responses. Some kinds of death as a result of overdose, suicide, and homicide are particularly shocking. Homeless sector workers rarely see coroners' reports and the actual cause of death (even whether the death is classed as suicide) often remains unclear for workers. People noted that opiate overdoses often occurred when people seemed to be doing well and perhaps had been abstinent for some time. The death of someone who appears to be doing well, improving or the death of a child can be particularly difficult. As one worker who had encountered many deaths of young people commented "sometimes there is no dignity in dying" [IN7].

The directness of the encounter with death varies as well. For some, the news can be broken in passing by service users or other workers face-to-face, over the phone, or formally through staff meetings or briefing sessions. Rarely, workers may be called at home by staff or emergency workers to assist in identification of the body. Sometimes, the worker may not hear of the death for some time, and there may be no opportunity to see the deceased. More direct encounters include discovering the body or being with the service user when they die. Discovering the body can be particularly difficult especially when there are signs of trauma or body fluids. Encountering the broken body is a more visceral, shocking experience and some respondents spoke of experiencing intrusive recollections of the dead body.

Responding to death

The initial reactions to encountering death vary as a function of the personal vulnerability of the worker, the relationship that the worker had with the service user, their role in the agency, how the death was encountered, and how recent was the death. Workers need to respond according to the procedures laid out and death also provokes a psychological response. Almost everyone spoke of being shocked or surprised and going into “autopilot” when discovering a body or first hearing the news of death. On encountering death people took solace from following procedures (where they are clearly laid out). Minimally, this involved verifying if the information received was true in the case of a service user been reported dead by another service user. When a worker discovers a body procedures include securing the scene, notifying police, ambulance, and the line manager. The police or ambulance personnel typically direct how the body needs to be handled from that point forward. Once the death has been officially confirmed there, is then a need to notify other staff, other service users as appropriate, and mobilise support for them.

A common psychological response was to feel guilty and to projected blame onto agencies that failed to intervene to protect service users. Workers generally appreciated that they could not and did not intervene to save the person from harm

or death but that in many cases more could have been done to help or protect them. The person was seen as responsible for their choices and actions, but rarely did respondents speak of being angry with the deceased. More often, people spoke of being angry with services that were perceived to have failed the service user in some way such as failing to provide shelter, not trying hard enough to engage with the person, or not marking the death in a respectful way.

People described experiencing the full gamut of emotions around the death of service users, from little emotional response to being overwhelmed by grief. Strong emotional responses typically occurred days or weeks after encountering death when the initial shock or surprise subsided. Emotional responses were typically triggered by encountering an event that reminded them of the deceased, or was particularly stressful. Workers may carry particular hopes or aspirations for service users that are shattered when the service user dies. For example, one worker with a lengthy history working in the sector and who stated that he was rarely emotionally effected by the work, described having a professional relationship with a service user over several years:

The social worker rang me up and said, 'oh have you heard about [the person]?' And I said, 'no.' And, 'well he died last night in [the hospital]'. And my immediate response was, thank goodness he didn't die alone, thank goodness he was surrounded by people who cared about him and he was in a place where he was getting care.... the next day my colleague rang me on the way into work and he said, 'have you seen the paper?'.... And there was a big article about [the person] who had died in a hospital in Dublin and died in the waiting room on his own. Now that kind of really upset me... the one thing I never wanted to happen for him was that he would die alone.

[IN2]

In order to carry on with necessary work, and perhaps also to prevent one from being overwhelmed with emotion, several people spoke of putting their emotions, ambiguous or disturbing images, or thoughts and memories “in boxes” or “pushing

them back”. Although, initially functional or helpful in maintaining equilibrium most ultimately found that it wasn’t helpful in the longer term. There was a need to experience rather than suppress thoughts and feelings. One person stated she felt numbed as a consequence of attempting to put so many thoughts and feelings in boxes and this was interspersed by emotions and thoughts flooding unbidden through flashbacks (akin to post traumatic stress responses).

Marking Death

Marking death serves a therapeutic function in that it helps people to experience emotions and is part of properly framing death. Dealing with the sometimes conflicting thoughts and feelings associated with the death of a service user poses particular challenges. One worker commented that she found it easier to deal with the death of a friend or personal acquaintance because she “knew where to park it” [IN8] and it is clearer how one can and ought to respond.

How death is marked or memorialised is in part culturally determined. In Irish society, a “good turnout” at a funeral is recognised as a sign of respect for the deceased. Some workers (most notably those aligned to one of the professions) described making a conscious decision not to attend the funerals of service users. Others stated they do attend funerals or their decision to attend would be conditional on how well they knew the service user or their personal feelings towards them. At least for some people marking death with other people is an important means of closure.

People were aggrieved if they were not given the choice to attend funerals or if they thought that the death was not marked respectfully. For example, when the death of a service user is announced at a team meeting and immediately followed by more mundane matters. Funerals can be difficult for the homeless sector worker who may have insights into the person’s history or behaviour that carries shame or stigma. Out of respect for the family and the deceased this knowledge cannot be shared or processed at the funeral and sometimes the worker’s role in relation to

the deceased is highly sensitive. For example, one worker spoke of attending a funeral and making herself known to the mother of the deceased...

...I felt really uncomfortable afterwards because I knew that he was up in the [park] selling himself and his mother didn't know that, I found that really difficult to have that information and this mother didn't know that about her son.... I kind of struggled with that a little bit...[IN4]

Funerals can also sometimes be difficult when only a small number of people turn up or the attendees are only from the homeless sector. The extent to which people have lived marginalised lives is brought home to the worker. There may also be complications around the circumstances of a death that preclude the possibility of attendance at funerals by both other service users and workers. In one instance, a person's identity was unable to be confirmed and no funeral arrangements could be made. A worker stated,

So eventually I just organised it myself [the memorial service], and it was great, it was nice. It wasn't just for him, it was for all people but his name was mentioned and the residents loved it, it was very important for them... it gave some closure to it because up to then there was nothing, he died and that was it. [IN5]

People also spoke of small things that they personally did to mark death, for example lighting a candle or spending a few moments in quiet reflection at some point during the working day. In Dublin, there are more communal means of memorialising or remembering those whom have died. For example some workers attend annual church memorial services dedicated to homeless people or victims of drug related deaths. A publication entitled the "Brass Munkie" written by and for drug users routinely includes a remembrance page and stories about people who have died. This is read by both service users and workers.

Recognising and responding to vulnerability

Workers were acutely aware of the vulnerability of other service users in relation to the death of a friend or acquaintance and this sensitivity is heightened immediately post bereavement. Many service users utilise self-destructive methods of coping and events such as the death of a friend or acquaintance leave some people vulnerable to exacerbation of drinking, illicit drug use, or reckless behaviour. Some respondents cited examples of dramatic breakdowns in the cohesion of therapeutic groups when a member of the group died. Workers took great care with how they broke the news of death to service users and facilitated opportunities for them to express their thoughts and feelings.

In well functioning work teams the emotional vulnerabilities of colleagues are recognised. People may be particularly vulnerable because of past experiences, such as the suicide of a family member, miscarriage, personal bereavement, the accumulation of stress, or personal identification with a service user. All respondents described at least one relationship with someone whom had died that they recalled was characterised by special bonds. These relationships could all be characterised as “professional” but the worker had a particularly warm relationship, held high hopes for or worked particularly well with the service user. Astute and sensitive colleagues would recognise these bonds. People appreciated it when their vulnerability was recognised by others through a kind word, an enquiry as to their well-being, permission to leave work early or an invitation to talk about how they were feeling. Some spoke of ringing up or making a point of contacting a worker whom they knew would be affected by the death of a particular service user. Some workers had established semi-formal networks with people from other agencies who worked with particular service users. The frequency of meeting would be increased after a service user died and these would take on a more supportive function.

Many respondents had refused the offer of formal debriefing or counselling, at least initially, and worried that they might be perceived as “weak” or “unprofessional”. Those who had experienced formal debriefing or counselling or supervision from someone not in a line-management position reported it as being immensely

valuable if for no other reason than it is a safe environment to express any thoughts or feelings, rational or irrational, without fear of judgement or sanctions. Some workers reported that similar needs were met through informal peer networks, although most of these workers acknowledged they felt lucky and such networks were not available to all.

Strategies to care for one-self were described by one as “critical” to enduring the traumas associated with front-line homeless sector work and particularly the deaths of service users. Some more experienced workers spoke about maintaining clear boundaries in their working relationships and between their working and home lives. Maintaining compassion, hope, and a friendly, optimistic and professional demeanour is essential to effective work in the homeless sector but it is helpful to make a clear distinction between being friendly and being friends, and to make a demarcation between home life and professional life. Fostering a positive personal/home life helps in coping with the traumas of working life. People spoke of exercise such as going to the gym, kick boxing, or walking and various activities with loved ones as helping to ‘switch off’ from work.

Personal counselling was of value to many people to help distinguish between the professional and personal problems, and supervision to prevent encroachment of work related issues into people’s personal lives. This is an ongoing struggle for many people who make a personal investment in helping others, and often spend lengthy periods of time with people and come to know them well. Framing the death of a service user as a professional loss rather than a personal one enabled the worker to more easily continue in their role. If failings or blame is to be apportioned, framing the failure as a service / system or professional failing rather than a personal one at least enables the worker to begin to address service problems or weaknesses.

The importance of acknowledging successes (however small) in the job was highlighted as a self-care strategy.

... what kind of compensates for the work that I do... are those joys that come along when you see somebody just finally getting to the point of being drug free and who starts making good decisions about their future... or families that are reunited because someone has got stable on methadone.[IN6]

Others had combined activities in their work which gave more immediate rewards with front line outreach work. It may be unreasonable to expect most people to continually engage in low threshold outreach work over a long period of time without some personal cost.

Positively framing the death of a service user

The successful resolution of the aforementioned processes is positively framing the death of a service user. Workers who had longevity in their roles in the homeless sector and who appeared to maintain their compassion and enthusiasm for their job have particular ways of framing their work and their relationship to deceased service users. They tend to articulate an awareness and acceptance of the limitations of their power and role in relation to the deceased service user and service users generally e.g. “You can only do as much as you can...” [IN1] and focus their attention on what assistance they can provide to others e.g. “ ...there is nothing more I can do for that person now but the living still need looking after.... It is an acceptance, this is part of life” [IN2]. Homeless sector workers realise that they cannot save people and at best can influence people toward making good decisions.

Acknowledging work that has been done well or contributions made by workers or services to a quality life (if not death) is important. One worker described how a former homeless man and heavy drinker was housed in transitional accommodation,

He got the best service that we could possibly give him here, we kind of went above and beyond a lot of times... he was happy... he had his own apartment... he had his own pictures up in his own apartment [IN3]

However, the traumatic and seemingly senseless deaths of some service users pose challenges to positively framing the person's death and making sense of their life. People acknowledged becoming discouraged, despondent or angry at times. Some spoke of channelling this anger into advocacy for others or to improve their performance.

There was one fellow who was shot dead... Yeah I think something happened inside me when that happened because I really did get affected by that, definitely something kind of... It made me question, Jesus is this the job for me and is this what I want to do? But in a way it has kind of pushed me harder to try even better or to try and stick with people and see how they are doing and things like that. [IN4]

Debriefing, personal counselling and clinical supervision were valued particularly for their role in assisting people to frame the death and the ambiguous thoughts and feelings around the deceased person:

...at the debriefing... you can say what you want and you can allow yourself to be completely irrational and be angry about it, that is fine. It is important to vent, like everyone needs to vent but you have to have a safe place to do it and I don't think internally is a safe place regardless of how brilliant the organisation is, it is not safe. [IN5]

Confronting death can challenge people's capacity to carry hope or continue to invest in others. The importance of maintaining hope for others was repeatedly highlighted:

I think it is really important that people always keep the vision, no matter the circumstances, how awful it is for homeless people, or how awful it is for the

drug users or the sex workers, that there is always a vision ahead that things can get better or things can change. [IN6]

Although framing the death of a service user is an ongoing cognitive process of sense making, it is also an outcome of a process that begins with expectancies about the job and about the possibilities of encountering death. When a service user dies vulnerabilities of both self and others are laid bare. Death can be traumatising and requires both a specific response (marking death in some way) and the mobilisation of general self care resources. A successful response or outcome of these processes is a positive frame in which an image of a deceased person and the homeless sector worker is captured and preserved much like a picture frame on a mantle piece or wall assists in preserving and sustaining a memory. The frame enables the person to be remembered and revisited rather than details being suppressed or strong emotions spilling out unbidden. Many factors impinge on the process of framing the life and death of homeless service users, or to process the death in the way that people might when working in other capacities or with other populations. A positive frame enables the homeless sector worker to keep on going in their work with optimism.

Limitations

How to establish the credibility of a grounded theory study has been well described in the literature (Charmaz, 2006; Corbin & Strauss, 2008; Glaser & Strauss, 1967). Glaser and Strauss (1967) suggested that a grounded theory should fit the phenomena, be understandable, be sufficiently abstract to apply to a variety of contexts and it should provide control by stating the conditions which the theory applies. A grounded theory does not aim to represent or faithfully describe the views of participants; rather it seeks to reveal and explain social process which may be hidden. The credibility of a grounded theory depends on “grab and fit”. That is, whether the concepts make sense and fit with the data and the real world experience of the social actors involved. These findings were presented to a diverse selection of homeless sector workers undertaking a course of study on

case management and the expressed consensus was that the theory appeared to fit with their experiences and made sense. Diligence in the application of open coding, comparative analysis, memoing and theoretical sampling go some way to ensure that the theory generated fits the data.

One limitation of the methodology of Grounded Theory is that it faithfully accounts for what is going on in a social field, but the resulting theory may not address what ought to be happening. For example, this theory holds that encountering death provokes a personal emotional response, and demands a procedural response (as a worker). This theory falls short of determining what the optimal initial emotional response is (a concern that some participants had) or what the best kind of policies or procedures are. Similarly, marking death in some way collectively and personally is helpful in terms of positively framing death. However, the theory does not reveal how one ought to mark death. The level of abstraction of this theory does not describe how the various sub-processes (expecting, encountering, responding, and marking death) contribute to positively framing death. It is possible for example, that psychological theories relating to attribution may provide a different and useful account of the process. There are also limits to the extent that each concept can be explored in a one publication. Further, elucidation of the attributes of each concept would assist in illuminating the theoretical links and operationalising concepts for future research and verification with different groups.

Discussion / Conclusions

The grounded theory in this study accords with findings relating to how other groups respond to death but there are subtle differences relating to the role of worker and service user. The work of the homeless sector worker intersects with other social care and health workers. However, homeless people have been found to have particular concerns around dying, death and end of life. These include fears of dying anonymously, alone, and without remembrance and a generally positive attitude towards developing advance directives or 'living wills' (Song, Bartels, et al., 2007; Song, Ratner, et al., 2007). Although homeless people can

experience a “good death”, that is an awareness, acceptance and preparation for death (Beverley, Charles and Margaret, 1995) by all those concerned death is more likely to be unexpected and traumatic. In research involving other groups the mode of death has been found to make a difference to how people cope and grieve. Reed (1998) conducted a survey of survivors of sudden loss from suicide or accident and concluded that the mode of death and the availability of social support are important determinants of grief symptomatology. Similarly, aspects of the way death was encountered in this study affected emotional response and how the death was ultimately framed.

The impact of caring for dying people by health professionals has been explored (Redinbaugh et al., 2003a) and the process has been conceptualized as ‘grieving’ (Papadatou, 2000). Although respondents in this study sometimes used the term grief (for want of a better word) to describe some feelings, the processes described were different from and broader than conventional understandings of grief and loss. Grief is understood to be triggered by losses such as personal bonds, valued relationships, the non-realization of professional goals, realization of one’s own mortality and the emergence of past unaddressed losses (Papadatou, 2000). Workers do grieve in this sense but how they do so is affected by the marginalized social position of the homeless person and indeed themselves as workers in the sector. Traditional rituals such as funerals help many people accept the reality of loss (Worden, 2001) but the homeless sector worker often cannot engage in such rituals in the same way as family members and others.

The homeless service user typically inhabits the margins of society and for the most part is invisible except for the occasional intrusion into our collective consciousness through newspaper headlines or requests for spare change. The homeless sector worker (even those with conventional professional identities) are also to a large extent invisible and are relatively powerless to address or control the circumstances that lead people to be at risk of death. The homeless sector worker must sometimes confront the death of the service user that is coloured by violence, gross injustice, and death with little dignity in which the worst fears of

individuals are sometimes realized. It is hardly surprising that the experience of dealing with such issues is sometimes marginalized and dealing with the impact sometimes difficult.

Homeless workers also tend to have different relationships with service users that vary in attachment, intimacy, and role expectations to those of other professional groups. Nevertheless, some of the concepts derived from this grounded theory have resonance with research undertaken with physicians, nurses and others. It was suggested that the way that death is encountered affects the response to the death and the process of framing the experience. Physicians who have found particular patient deaths to be emotionally powerful (and these have been categorized into the good, overtreated or shocking/unexpected death) have reported changes in their clinical behaviour and career paths (Jackson et al., 2005). Doctors who cared for patients for longer periods of time report stronger emotional reactions and were more vulnerable to feelings of loss (Redinbaugh et al., 2003).

O'Hara et al. (1996) examined the impact of death on a small cohort of nurses working in long term hospital wards and found that they coped by sharing feelings, framing death positively, and framing their work as contributing to a good death. Those who were more affected by death tended to “take their stress home” and to consider their relationships with patients as more personal. Ekedahl and Wengström (2006) concluded that being careful about maintaining professional boundaries was an important strategy in coping with the deaths of patients by 15 nurses who worked in cancer care. Although, homeless workers may have more difficulty in framing their work as contributing to a good death, they can frame their work with the person and others in positive terms. Making a “boundary demarcation” is similar to both the self care strategies described by homeless sector workers (such as fostering a positive personal life) and the positive framing of their relationship with the deceased, which in some instances involved seeing the relationship as professional rather than personal.

Exploration of the phenomenology of nursing students encountering death for the first time revealed how part of the process involved “integrating patient death into the realm of professional practice” or reconstructing a view of work which incorporated patient death (Kelly, 1998). This has similarities to the task of “framing” discovered in this study in which both the deceased individual is remembered, the relationship with the worker and the worker’s relationship with their work is also reflected upon. How workers can be supported in positively framing death and their work can be inferred from the theory: It is likely to be helpful to raise the possibility of encountering death or trauma of service users during workplace induction; Clear policy and procedures relating to what to do when death is encountered ought to be in place; The worker needs to consider, and make known to others, how and when they would like to be notified if a service user is involved in a traumatic incident; Workers ought to be encouraged to mark the death in a personal way, and ought to be offered the opportunity to participate in collective activities to memorialize the death. Workers ought to receive some training around maintaining personal and professional boundaries. Clinical supervision should be available to frontline staff in difficult front-line roles, and one-to-one professional psychological debriefing should be available to everyone following traumatic incidents; Importantly, individual workers and organizations need to be able to review events leading up to death and trauma, to learn from experience and prevent harm to others. For some, positively framing death becomes easier with time. Rather than suppressing thoughts, feelings, and images, the main concern of the homeless sector worker confronting sudden death is framing the experience as intensely human, acknowledging the tragedy and indignity of death, but also preserving hope and optimism that they can make a difference to those who remain.



A homeless person's shelter in Dublin under a Tesco sign stating 'Every little helps'

References

- Alexander, D. A., & Klein, S. (2009). First responders after disasters: A review of stress reactions, at-risk, vulnerability, and resilience factors. *Prehospital & Disaster Medicine, 24*(2), 87-94.
- Beverley, M., Charles, W., & Margaret, C. (1995). Threats to the good death: The cultural context of stress and coping among hospice nurses. *Sociology of Health & Illness, 17*(2), 222-241.
- Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: Sage.
- Cheung, A. M., & Hwang, S. W. (2004). Risk of death among homeless women: A cohort study and review of the literature. *CMAJ, 170*(8), 1243-1247.
- Corbin, J., & Strauss, A. (2008). *Basics of Qualitative Research* (3rd ed.). Thousand Oaks, CA: Sage.
- Desai, R. A., Liu-Mares, W., Dausey, D. J., & Rosenheck, R. A. (2003). Suicidal ideation and suicide attempts in a sample of homeless people with mental illness. *Journal of Nervous & Mental Disease, 191*(6), 365-371.
- Ekedahl, M., & Y., Wengström. (2006). Nurses in cancer care -- coping strategies when encountering existential issues. *European Journal of Oncology Nursing, 10*(2), 128-139.
- Fitzpatrick, K. M., Irwin, J., Lagory, M., & Ritchey, F. (2007). Just Thinking about It: Social Capital and Suicide Ideation among Homeless Persons. *Journal of Health Psychology, 12*(5), 750-760.
- Glaser, B. G. (1978). *Advances in the Methodology of Grounded Theory: Theoretical Sensitivity*. Mill Valley, CA: Sociology Press.

- Glaser, B. G. (1992). *Emergence vs Forcing: Basics of Grounded Theory Analysis*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (1998). *Doing Grounded Theory: Issues and Discussions*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (2001). *The Grounded Theory Perspective: Conceptualisation Contrasted with Description*. Mill Valley, CA: Sociology Press.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. London: Aldine Transaction.
- Haw, C., Hawton, K., & Casey, D. (2006). Deliberate self-harm patients of no fixed abode: A study of characteristics and subsequent deaths in patients presenting to a general hospital. *Social Psychiatry & Psychiatric Epidemiology*, 41(11), 918-925.
- Homeless Agency. (2008). *Findings from Death Policy Notifications in 2007* Dublin: The Homeless Agency.
- Homeless Agency. (2009). Rough Sleeper Count. *Update: The Newsletter of the Homeless Agency*, (62), 5.
- Hwang, S. W., Orav, E. J., O'Connell, J. J., Lebow, J. M., & Brennan, T. A. (1997). Causes of Death in Homeless Adults in Boston. *Ann Intern Med*, 126(8), 625-628.
- Jackson, V. A., Sullivan, A. M., Gadmer, N. M., Seltzer, D., Mitchell, A. M., Lakoma, M. D., et al. (2005). 'It was haunting ...': Physicians' Descriptions of Emotionally Powerful Patient Deaths. *Academic Medicine*, 80(7), 648-656.
- Jonsson, A., & Segesten, K. (2004). Daily stress and concept of self in Swedish ambulance personnel. *Prehospital & Disaster Medicine*, 19(3), 226-234.

- Kelly, C. T. (1998). *The lived experience of female student nurses when encountering patient death for the first time*. Unpublished Ph.D., Adelphi University.
- Kinder, A., & Cooper, C. L. (2009). The costs of suicide and sudden death within an organization. *Death Studies, 33*(5), 411-419.
- Kushel, M. B., Evans, J. L., Perry, S., Robertson, M. J., & Moss, A. R. (2003). No Door to Lock: Victimization Among Homeless and Marginally Housed Persons. *Arch Intern Med, 163*(20), 2492-2499.
- Morrison, D. S. (2009). Homelessness as an independent risk factor for mortality: Results from a retrospective cohort study. *Int. J. Epidemiol., 38*(3), 877-883.
- Nordentoft, M., & Wandall-Holm, N. (2003). 10 year follow up study of mortality among users of hostels for homeless people in Copenhagen. *BMJ, 327*(7406), 81-.
- O'Hara, P. A., Harper, D. W., Chartrand, L. D., & Johnston, S. F. (1996). Patient death in a long-term care hospital: A study of the effect on nursing staff. *Journal of Gerontological Nursing, 22*(8), 27-35.
- Papadatou, D. (2000). A proposed model of health professionals' grieving process. *Omega: Journal of Death & Dying, 41*(1), 59.
- Redinbaugh, E. M., Sullivan, A. M., Block, S. D., Gadmer, N. M., Lakoma, M., Mitchell, A. M., et al. (2003). Doctors' emotional reactions to recent death of a patient: Cross sectional study of hospital doctors. *BMJ, 327*(7408), 185-.
- Reed, M. D. (1998). Predicting grief symptomatology among the suddenly bereaved. *Suicide and Life-Threatening Behavior, 28*(3), 285-301.

- Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: implications for the mental health of health workers? *Clinical Psychology Review, 23*(3), 449-480.
- Schanzer, B., Dominguez, B., Shrout, P. E., & Caton, C. L. M. (2007). Homelessness, Health Status, and Health Care Use. *Am J Public Health, 97*(3), 464-469.
- Song, J., Bartels, D., Ratner, E., Alderton, L., Hudson, B., & Ahluwalia, J. (2007). Dying on the Streets: Homeless Persons' Concerns and Desires about End of Life Care. *Journal of General Internal Medicine, 22*(4), 435-441.
- Song, J., Ratner, E., Bartels, D., Alderton, L., Hudson, B., & Ahluwalia, J. (2007). Experiences With and Attitudes Toward Death and Dying Among Homeless Persons. *Journal of General Internal Medicine, 22*(4), 427-434.
- Stayt, L. C. (2009). Death, empathy and self preservation: The emotional labour of caring for families of the critically ill in adult intensive care. *Journal of Clinical Nursing, 18*(9), 1267-1275.
- Worden, J. W. (2001). *Grief Counselling and Grief Therapy: A Handbook for the Mental Health Practitioner* (3rd ed.). New York: Routledge.

4.3. Family and Carer Participation in Mental Health Care

The family is the most significant and formative influence on an individual's development and wellbeing. Good enough parenting and an adequate social environment during our formative years equips us with the psychosocial resources to deal with adulthood. It is well established that childhood trauma and neglect predisposes the child to emotional and interpersonal difficulties which can endure into adulthood (Read et al., 2005; Read, Mosher, & Bentall, 2004). Despite the obvious importance of families in providing for the needs of family members, psychiatry and psychiatric services have a history of ambivalence towards families and their involvement in the care of adult service users (Tennant, 1993).

How problems or issues are framed determines the extent to which families are involved in the formalised health care of individuals. For example, Arnold and Rotheram-Borus (2009) compared the components on six programmes focusing on reducing HIV risk amongst homeless runaway youths. In some programmes family involvement did not feature at all as the problem or issue was framed as an individual problem solving or access to services issue. Whereas some programmes viewed the family as having poor problem solving skills or the youth's behaviour was viewed as part of a systemic failing. In these instances improving family problem skills, or engagement of the youth in a positive relationship with family was the primary focus of the work. People seek help or come into contact with adult mental health services for a myriad of reasons but presently the dominant frame to make sense of problems is biomedical. That is, problems are seen as principally within individuals and specifically their biochemistry. Such a view casts family as carers, or carrying a 'burden of care', informants and / or in need of education about the individual's illness and treatment. This view (and language of 'burden') appears to have been embraced by family members and lobby groups (Wynaden et al., 2006) as well as professionals (Huang & Slevin, 1999).

Of course, families and carers are not neutral bystanders or detached observers of ill relatives and can affect and be affected by other family members in both positive and negative ways. Over the last 30 years a robust finding of research has been that people diagnosed with schizophrenia are negatively affected by critical comments and emotional over involvement of family members and others involved in their care. Indeed, high 'Expressed Emotion' (EE) ratings from key relatives has been associated with relapse in depression, bipolar affective disorder and poor treatment outcomes in alcohol abuse and post traumatic stress disorder (Wearden et al., 2000). Similar patterns of expressed emotion (correlated with similar negative outcomes for service users) have been found in staff who work with people experiencing psychosis (Barrowclough et al., 2001; Bebbington & Kuipers, 1994; Kuipers, 2006; Onwumere et al., 2009). Whilst the mechanisms of action underpinning the impact of EE on relapse is unclear, characteristics of the social milieu or environment, and particularly the emotional climate of the family appear pivotal to the recovery or relative well-being of individuals who are diagnosed with mental illness.

'Family interventions' have gained popularity in mental health services and a reasonably strong body of evidence supporting their usefulness as a component in a range of treatment programmes. A recent Cochrane review of family interventions (Pharoah et al., 2006) concluded that family interventions have been found to reduce hospitalisation, encourage compliance with medication, improve general social skills and reduce the level of EE within families. Family 'psychoeducation' programmes focusing on mutual support, education, dealing with crisis, and enhancing problem solving skills also tend to be well regarded by families and individuals (Dixon et al., 2001). Many approaches to working with families have been derived from family therapy which traditionally takes a systemic or ecological lens to view problems. Keith, (2003) notes that it is unfortunate that this lens has been lost and argues that the power of family therapy to make sense of and resolve problems has

subsequently been attenuated. Regardless, it seems that involving the family in meaningful ways in psychiatric care, and helping families better cope with stress and relate amicably with each other is exceptionally important. The chapter in this section (Keen & Lakeman, 2008) outlines some selected theories of family work and principles of collaboration with individuals and families.

This section also includes two publications arising from a project to improve the quality of participation of family / carers in an adult mental health service. The history of the project is addressed in some detail in Lakeman (2008d). The seeds of this project were planted in September 2001 when a group of three families approached the Mental Illness Fellowship of North Queensland with stories of being excluded from the professional care and not being listened to by mental health professionals. Two young people had completed suicide, despite family members seeking help from adult services. Some survivors perceived that they had not been listened to and that their knowledge of their family member had not been taken into account in care planning. At around the same time, a member of the public raised concerns with the health representative of the Queensland Government's Ministerial Regional Communities Forum regarding the lack of information provided to himself and his family when his teenage daughter was admitted to the psychiatric unit at Townsville Hospital following a suicide attempt. Despite the young woman living with her family they were not informed of her discharge.

A senior staff member at the Department of Communities convened meetings with other family members, forged links with the Mental Illness Fellowship and the Health Services. This culminated in a Ministerial Regional Community Forum held in Ayr in February 2003 which was attended by the then Minister for Health Wendy Edmond who endorsed the formation of a local steering committee to develop a set of practice standards relating to family involvement in adult mental health services. My involvement in the project was as principle project officer when a sum of money had been obtained to roll out and evaluate

the practice standards. In many ways this was a messy but pragmatic approach to the task. The project was driven by a reference group with high expectations of making sweeping changes in everyday practice and influencing the culture of the organization. My position was as both a member of the organization (an 'insider') with a part time dual role to both promote the practice standards, and to evaluate them in a detached and dispassionate way within the one year life of the project. Constraints on the project included, negotiating a promotion and evaluation protocol that was acceptable to the reference group and the institutional ethics committee, as well as administrative tasks such as employing a further part time project officer with lay caregiver/family experience. If more time and material resources were available a different research design would have probably been employed. Ultimately a mixed method design was used, mixing qualitative interviews of family members / carers with a quasi experimental pre and post implementation chart audit of family participation. Clearly, there was no control group, and despite some positive changes being found, it cannot be assumed that these positive changes have been sustained. Nevertheless, it is reassuring to know that the introduction of (essentially a simple) policy which raises the expectation of family being involved in adult care can at least in the short term appear to positively influence practice.

- 4.3.1. Keen, T., & Lakeman, R. (2008). Collaboration with patients and families. In P. Barker (Ed.), Psychiatric and mental health nursing: The craft of caring (2nd ed., pp. 149-161). London: Arnold.**

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CHAPTER 18

Collaboration with Patients and Families

Tom Keen* and Richard Lakeman**

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- 4.3.2. Lakeman, R. (2008). Family and carer participation in mental health care: perspectives of consumers and carers in hospital and home care settings. Journal of Psychiatric and Mental Health Nursing, 15(3), 203-211.**

Family and carer participation in mental health care: perspectives of consumers and carers in hospital and home care settings



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- 4.3.3. Lakeman, R. (2008). Practice standards to improve the quality of family and carer participation in adult mental health care: An overview and evaluation International Journal of Mental Health Nursing, 17(1), 44-56.**

FEATURE ARTICLE

Practice standards to improve the quality of family and carer participation in adult mental health care: An overview and evaluation

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4.4. Other Projects

- 4.4.1. Lakeman, R., & Matthews, A. (2010). The views and experiences of members of new communities in Ireland: perspectives on mental health and well-being. Translocations: Migration and Social Change, 6(1), http://www.translocations.ie/volume_6_issue_1/index.shtml.**

As a 'serial migrant' I have a personal interest in the impacts of migration and the adjustment experience. Arriving in Ireland at the height of what was known as the 'celtic tiger', a time of unprecedented economic growth and inward migration was a very interesting time. As mentioned in the report Ireland had a long history of net outward migration and population decline in the 20th century relative to other European states, many of which have had decades to adjust to multi-culturism. This trend reversed abruptly and was also characterized by an influx of non-Irish nationals from different cultures. This sudden and dramatic change in the demographic profile of a traditionally white and mostly Catholic nation challenged both public services (health, welfare and education) and Irish citizens themselves. Development of public services in response to these challenges occurred in a virtual research vacuum. The following research report is a product of a project which aimed to develop the capacities of members of new communities to research and articulate their own needs. The first research project the group attempted following report was the first project that these groups tackled and it looked very broadly at mental health and the experience of migration and post-migration adjustment.

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The views and experiences of members of new communities in Ireland: perspectives on mental health and well-being.

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Abstract

Ireland has a long history of outward migration but in recent years Ireland has become a destination of choice for migrants from the rest of the world. This has posed a challenge to Irish institutions and Irish society. This paper reports on the findings from a community development project undertaken in partnership between Cairde (a non government resource and advocacy organisation for ethnic minority groups) and Dublin City University. Members of new community groups in Dublin who were affiliated with Cairde took part in focus groups exploring their perceptions regarding mental health, mental ill-health and their experiences of mental health care provision. Participants focused more on their everyday experiences affecting their health and well-being rather than presenting their difficulties from within an illness paradigm. Whilst most participants had experience of accessing health services they had little contact with specialist mental health services. So while the study was designed to focus on conceptions of mental health/ill-health and services, the findings highlight structural inequalities that some migrants face in relation to legal status, accessing educational, occupational opportunities, and social service eligibility; all aspects of their everyday lives that cause them distress and fear.

Key words: mental health and well-being; migrants' perceptions; qualitative focus group research

Introduction

In a little over a decade there has been a transformation of Irish society from a relatively homogeneous monoculture, with a population which was 95 percent white and Roman Catholic to a significantly more heterogeneous, multicultural society in which non-native born people made up nearly 11 percent of the population (Central Statistics Office., 2006). People from 188 different countries were living in the State at the time of the census in 2006. Of the 420,000 non-Irish people residing here on census day in April 2006, the largest group were UK nationals, who numbered 112,000. Ireland's historical demographic profile has been one of near continuous population decline and outward migration since the 1840s. From the 1960s the population grew rapidly with large scale inward migration (of both returning Irish nationals and others) and from the 1990s Ireland enjoyed high economic growth and a rapidly expanding labour market. The numbers of people claiming asylum in Ireland also grew from a handful in the early 1990s to over 10000 per year until 2003, drawn largely from Nigeria, the Democratic Republic of Congo, Algeria and more latterly, Romania (Mac Einri & White, 2008).

In Ireland there has been a growing interest and literature concerning psychological aspects of migration particularly to do with refugees and asylum seekers (Ryan, Benson, & Dooley, 2008; Ryan, Dooley, & Benson, 2008). Ryan, Dooley, and Benson (2008, p.16) point out that the human stories and voices of people (refugees) themselves are largely absent from the literature of psychology generally and in Ireland that have only been a handful of community based surveys (Mac Einri & White, 2008) to inform the development of health and welfare services.

This project sought to explore the meaning and determinants of mental health in

new communities in Ireland from the perspectives of migrants themselves. Cairde, a non-government community development and advocacy organisation in Ireland working to reduce health inequalities amongst ethnic minorities was a partner in this project. The overall intent of this study was not only to undertake a needs assessment relating to the mental health needs of communities but to build the capacity of communities and community groups to commission, undertake, analyse and report on research of interest and concern to them. Cairde set up an Ethnic Minority Health Forum in 2002 comprised of some 35 groups, with an aim to make a positive impact on the health and wellbeing of ethnic minority communities. At a forum meeting it was agreed that mental health was a shared concern and priority and this research was designed to meet that need. This paper reports on a qualitative analysis of migrants' perceptions on mental health and well-being.

Previous research on the mental health and well-being of migrants has highlighted the need to understand the diversity of experiences of migrants, based on the personal story of the person but also of their experiences of social integration in the country in which they now live. As Murphy (1977) has noted the mental health of migrant groups is determined not only by the psychology of individuals but by factors associated with their country of origin, the migration experience and the country of destination. Understanding these factors is necessary to understanding the adjustment experience of any group. For example, Blomstedt, Johansson and Sundquist (2007) found that the country of birth had a profound influence on self-reported mental health in a Swedish cross-sectional national survey, with Polish and Eastern European immigrants having twice the likelihood of reporting psychiatric illness compared to a Swedish born reference group and some other immigrant groups. Bhugra (2004) proposed that personal and group factors contribute to resilience and vulnerability which can interact to produce psychological distress and the exacerbation of mental ill-health at different stages in the migration process (pre-migration, migration, post-migration and acculturation).

Whilst, the notion that immigrants in general are at greater risk of mental health

problems is now disputed or at least seen as a simplification (Silove, 2004), pre-migratory and migratory traumatic experiences do predispose refugees and asylum seekers to post traumatic stress responses and mood disorders. The constellation of depressive, anxious, somatoform and dissociative symptoms seen in many immigrants has been coined the 'Ulysses syndrome' (Carta et al., 2005). This syndrome develops over time in response to multiple stressors, losses or obstacles faced during the migration process, including the individual's reception in the host country. Those who choose to migrate for higher education or economic betterment will face different stressors to those who are forced to flee their homeland as political exiles or refugees.

The relationship between migration, mental health, mental disorder and aspects of social integration is complex. For example, Munk et al. (1997) undertook a large community survey of residents in Oslo (a traditionally low inward migration and mono-cultural city). Not surprisingly they found that immigrants from non-western countries tended to have higher levels of psychological distress than immigrants from other western (and presumably culturally similar) countries. Data derived from the same study was used to examine the differences in psychological distress and a range of psychosocial indices between Pakistani immigrants and Norwegian nationals (Syed et al., 2006). They found that when poor social support and low economic status were controlled for (together) the difference in distress between groups was eliminated. They concluded that social support and economic conditions are important mediators of mental health. These data tend to support a view that social and economic wellbeing and cultural identity are inextricably linked to perceptions of mental health. The collaborative study on the topic of the mental health of migrants aimed to add to this research, based on the stated concerns of the groups affiliated with Cairde for research in this area.

Methods

A qualitative design was chosen as the appropriate way to explore this topic. Focus groups were chosen as the method of data collection for this study. Focus groups are a qualitative research method that is an alternative to individual interviews. The

focus group method enables participants to comment, explain, disagree, and share attitudes and experiences (Curtis & Redmond, 2007). Focus groups are concerned with the interactions between members as well as what they say and were deemed particularly useful for exploration of complex social phenomena (Powell & Single, 1996).

Expedited approval was obtained from Dublin City University Human Ethics Committee to undertake this as a low risk project. Ten community leaders from Cairde's Ethnic Minority Forum took part in focus group facilitation training and subsequently facilitated the recruitment and conduct of focus groups exploring mental health in their communities. Focus group questions were developed collaboratively between the community leaders during a training day (See Table 1). Leaders provided verbal explanations regarding the purpose of the focus groups to potential participants, and obtained verbal consent for participants to contribute. Copies of the questions to be discussed in the focus groups were provided to potential participants in their first language and they who were given considerable time (days in most instances) to consider whether or not they wished to be involved.

Participants

Seventy five individuals (44 females and 31 males) took part in ten focus groups carried out over several months in the first half of 2008. Each community leader conducting a focus group recruited members of their own community, as defined by them, for each focus group. Recruitment was conducted by focus group leaders through their existing social networks, that is, through their involvement with groups who otherwise met together for other purposes e.g. community advocacy, worship, cultural celebration or social activity. Some of the members of these various social and religious groups were invited by the focus group leader to become involved in the present study and those interested then participated in a research focus group. The immigration status of members varied within and between groups. Some members were asylum seekers, or recognised refugees, whilst others had full citizenship or were on working visas. Details of country of origin, languages spoke,

gender composition, and religion of participants is outlined in table 2.

Data analysis

The aim of the analysis was to provide a comprehensive and parsimonious representation and rich description of the perceptions and viewpoints of focus group participants. Transcripts were made of the audio recordings of all focus groups and these were imported into the software package QSR N-Vivo (version 9) to facilitate what Miles and Huberman (1994) describe as data reduction, or the process of selecting, focusing, simplifying, abstracting and transforming the data. Three project members reviewed all data using the focus group questions as starting points. Then each sentence of each transcript was allocated one or more codes or labels which best represented the perception, opinion, assertion or expression. When a sufficient number of codes were generated and a unifying concept appeared to emerge, elected codes were aggregated under that concept. Thus a tree like structure grew with the central concept (or top level category) being the question or concept (e.g. components of good mental health) from which various branches emerged (e.g. Having good relationships, occupation etc) which in turn were populated by exemplars and connected back to the transcribed text. The analysts also read the transcripts and coded data with a view to discerning differences within and between groups. The authors of this report read and reviewed coded parts of the transcript independently and met to discuss differences of opinion (these were few and readily resolved through discussion). Finally the narrative account that follows was written ensuring that all content elements were included and higher level categories were illustrated with verbatim examples from the transcribed text.

Results

Components of “good mental health”

Focus group participants discussed the meaning of good mental health. Indicators of positive mental health included positive emotions such as feeling happy, relaxed, and contented, and having positive or optimistic thoughts about the future.

When you have a hope that tomorrow day is good, not waiting for bad things to happen, when you are not waiting – just living (a participant from the 'Slavianka' Russian speaking women's focus group).

Whilst there was an acknowledgement of mental health encompassing rationality, the capacity for judgment and 'normal functioning' of the brain, the emphasis of all focus groups was on extra-psychic factors. The most dominant themes (that is discussed with the most intensity and mentioned most frequently) related to mental health were having security and good relationships with others.

Security had different connotations depending on the phase of migration process of individuals but was considered by all as being an essential component of mental health. Asylum seekers identified insecurity over their immigration status and the constant threat of deportation as being inconsistent with positive health and indeed described negative impacts on mental health. Some participants who had experienced pre-migratory trauma stated that good mental health was not being exposed to war or ongoing violence. More generally good mental health was associated by almost all migrants with having sufficient and secure resources to meet basic needs and being able to build and maintain a home.

When I have the necessities in life, like shelter, food, water. To be able to go outside and feel safe, having a home (a participant from the West African Network, women's focus group).

Having good relationships with friends, family and the wider community were cited as important. This included being able to communicate, being respected by others, being around understanding people and particularly being with family. Being able to provide for ones' family, enjoying leisure activities together and establishing the

routines and rhythms of everyday life were construed as important for personal mental health.

Mental health and happiness were tied to having opportunities to work, to learn and to help others. Some cited recognition by others (e.g. employers and professional regulatory bodies) of skills, qualifications and experience as pivotal to realising these opportunities. This was particularly so for those on working visas who felt under-employed. Others had spent time in the State's direct provision accommodation centres. These are places where people are accommodated whilst waiting for their applications for refugee status to be processed (which in some instances can take years). These participants stressed the importance of being able to direct one's own life e.g.

(Mental health is...) when you can change you situation, when you are depending on yourself, not on decisions of others (a participant from the Somali community focus group)

Others spoke of engaging in satisfying activities such as art and creativity and worship and how this helped people feel connected to the wider community.

...The church gave me some advice and guidance, I feel more integrated now as a part of the church. (a participant from the West African men's focus group)

Conceptions of mental ill-health

Some groups (e.g. participants from the Romanian women's focus group) stated that mental ill-health was the opposite of mental health and did not elaborate much further. In some focus groups participants made reference to other people who manifested extremes of distress or unusual behaviour that they considered 'crazy' or ill. However, in the brief discussion of mental ill-health held in each focus group emphasis was on the less extreme, everyday manifestations of distress and psychosocial ill-health, particularly as related to the experiences of migration to

Ireland. Anxiety, having interrupted sleep, problems with thought form and content (e.g. obsessions or ruminations), and intrusive recollections of traumatic events were all considered manifestations of ill-health.

I think that anxiety is the best defining concept. That constant fear... that you are not going to get home safe, that you are taking a flight and you are afraid, that tomorrow you will be out of the job, that you won't find any work. You know how it is in Ireland, you work for 7 days and then next week there's no work. And this fear that you may be out of the job, and then the landlord comes and kicks you out of the house. (a participant from the Romanian community women's focus group)

Yearning for family and friends was a distressing experience. For some refugees this was compounded by uncertainty about the welfare of family and friends left behind. For others the distress and yearning associated with separation from children was acutely felt.

(I feel distressed)...when I call home and talk to my other children who are not here. When I have to tell them that I can't bring them here. (a participant from the 'Slavianka' Russian speaking women's focus group).

Depression, unhappiness, a-motivation, anger and loss of hope were cited as other examples of mental ill-health.

I don't believe in anything or in anybody, including the health system. I thought about suicide once, when situation was very bad for me, but my religion would not forgive me for that. So I did not do anything to myself. I hope that my story or my experience that I have shared here will serve a good purpose, will show to everybody how hard the life is here for us (visibly shaking). (a participant from the Algerian community focus group)

The most important things affecting mental health

Participants were directly asked about the most important things affecting mental health. They responded in relation to their overall well-being and how this was

negatively affected by immigration policies and status. Fitting in with Irish society was also a related factor identified by participants. Throughout their discussions, participants vividly described the effects of these various factors in emotive and expressive terms. They described feelings of frustration, worry, feeling “not together”, incompleteness, anger, wanting to scream, sadness, isolation, unhappiness, anxiety, stress, disappointment, disempowerment, depression, rejection and worthlessness.

It is hard to deal with disappointment and crushing of your dreams and aspirations on psychological level. I feel sometimes that you have made wrong decisions in your life and lives of other people in your family (a participant from the Russian speaking men's focus group).

The effects of immigration policies on the lives of the participants were directly discussed in all groups.

... being treated differently, not like a human being. This causes hurt, anger, upset. 'I was treated badly at Dublin Airport, I was asked questions for over an hour although I had passport and everything was ok. (a participant from the West African Network – women's focus group)

Participants made reference to dealing with officials in accommodation or immigration and provided accounts of not being believed, treated well or given adequate explanations. Some of the participants within African groups described their perceptions that officials and health professionals did not acknowledge or accept their distress, because they appeared stoic.

Immigration status and the consequences of immigration policies in terms of ability to work, study, and also to feel secure, were raised. Participants expressed their frustration at the waiting and uncertainty about the future which is involved in immigration processes.

... Talking to Department of Justice about my citizenship is very frustrating. I have been here for a long time, applied for naturalization and now waiting – again. Half of your life spent in waiting for responses from justice (a participant from the Algerian community focus group).

Those in direct provision described the restrictions and lack of freedoms associate with that, as well as the restriction on working while in the asylum process.

I have no job, no nothing, the asylum process makes me unhappy because it prevents me from living normal life like other people (a participant from the Eritrean community focus group)

There were several references by those in direct provision to feelings that they were being treated like animals and that this reflected people's views of them. The experience was also described as isolating and prison-like. Participants stated that they just wanted to be treated normally, like everyone else. They also stated that they wanted to be independent and look after themselves but were prevented from doing so. They did not feel cared for by those with whom they interacted in direct provision. Others described feeling belittled or treated like a child:

In my country is not like here... You have a responsibility to look after yourself, there is no social welfare. If you have a job - you eat, you do things. If you don't – you'll die. Here they treat you like a child, taking control over your life if you an asylum seeker. They tell you when to eat and what to eat, they do not allow you to work or study – you loose respect for your own abilities (a participant from the Congo Lisanga focus group)

Others stated that they were unhappy at being perceived as wanting benefits when they did not have any opportunity to work. Those who could work expressed their frustration at getting jobs that did not fit their qualifications. Work was described as a means to financial security but also providing a routine and structure as well as fulfilling family roles, for both men and women.

Participants referred to having difficulties making ends meet, getting into debt, not having choices, the pressure of high bills for accommodation, heating, fuel and childcare. Poverty therefore was strongly linked to immigration status- whether in direct provision or in lowly-paid jobs due to discrimination or a lack of recognition of qualifications and skills.

...Because if you are poor and you don't have any work, you've got no money; and if you've got no money, you cannot take care of your family, you don't have anything to eat, you become anaemic, and then your brain no longer functions properly (a participant from the Romanian community, men's focus group)

Access to affordable and secure private rental accommodation was cited as problem for others who were undertaking low paid jobs.

The importance of integration and acceptance by Irish people was highlighted. Those in direct provision felt particularly isolated and apart from other people. Experiencing racism also affected the extent to which people felt part of a wider community:

You feel like an outsider, discrimination gives you a lack of confidence. Once you have a negative experience, you don't have any hope that you can be a part of the society (a participant from the West African Network – men's focus group)

A language barrier was stated to make it more difficult to be a part of Irish society and this affected adults and children. The role of the media in highlighting difference was also given as a factor affecting integration. This sense of isolation seemed heightened when there were family difficulties, more specifically the absence of family:

I also frequently have headaches, because I think about home and family - that's hard. You always have this feeling that you are not together, not

complete if you worry about your family (when they are not here but somewhere else) (a participant from the Algerian community focus group)

Participants who suffered in their own countries because of their religion or who had been imprisoned also described suffering further trauma within this isolating environment. Some participants described gambling and alcohol as ways of coping with isolation whilst acknowledging that gambling made the financial situation worse for them. Using alcohol was identified as a way of alleviating distress but to the detriment of mental health.

People's immigration status forced roles to change within families and for some men not being able to provide for their family and inactivity caused additional stress beyond that associated with poverty.

When men where in their home country they work and are out all the time, but when they come here they are in hostel; they are here all the time doing nothing, and the children wonder what's going on. He wants to work but he can't (not allowed). (a participant from the Congo Lisanga focus group)

Financial stressors were identified as causing family break-ups, and also challenging women to adopt new roles within the family.

Discrimination

Discrimination and racism was explored and discussed in depth within all groups (space constraints preclude more than a cursory overview in this paper). Group members varied in their perceptions of the extent of the problem and Europeans on working visas recounted different experiences to asylum seekers and non-European people.

We are immigrants, foreigners and new to here – what would you expect? In any country people are very wary of newcomers... That's why they give us low jobs – who else will do them for that money? (a participant from the

Russian speaking men's focus group)

Many participants believed that they were perceived as inferior by Irish people or were viewed in stereotypical fashion by some people. Participants identified the news media as being largely responsible for the promulgation of stereotypical images.

I think it also a media (fault). If you are from Russia or Soviet Union country and you are a woman – means that you are looking for a rich husband or you are mail order bride or came to work in lap dancing club. That's where discrimination starts – when people look at you through their own lenses and see what they want to see. It doesn't bother me any more. Sometimes I am saying I am not from Moldova but from Italy – the language is similar. (a participant from the 'Slavianka' Russian speaking women's focus group)

Discriminatory experiences were recounted relating to many areas of everyday life. One person described it as a systemic problem

It is a problem with a whole system here, with the lack of support for the new communities... This means that anything that you do or want to do is a problem: finding a job, getting out of social welfare, being discriminated and abused, having problems with housing and landlords, not having opportunities to study or get educated – it is all parts of the same big problem... (Algerian Community)

The most frequently cited examples of discrimination occurred around employment. Some migrants groups experienced difficulty obtaining employment even with a good grasp of English and having excellent qualifications. Participants reported being employed in menial jobs and being unable to practice in their chosen profession.

When I called for the job, when they heard my accent they said – oh no...the job is gone. I saw it advertised after – again. But you can't prove anything – it was a one-to-one conversation. This makes me feel –like why

trying? What can I do? I can speak English, but not as a person who lived here all their life. (a participant from the Russian Speaking – women’s focus group)

Some participants recounted stories of people not being interviewed or employed because of their names and when employed being treated differently to other workers. Others spoke of racist taunts or being ‘set up’ by other employees. One woman who attempted to start her own business confronted more overt racism:

I wanted to open a shop, start my own business to make my and my family life better in Ireland. I had a lot of problems; people were screaming at me to close shop down, people insulted me on the daily basis. Eventually, the shop went bankrupt; They (local people) made me close the shop down. (a participant from the Algerian community focus group)

For some participants language was a difficulty that mitigated against employment or advancement. This was particularly so for women with dependent children. Lack of inexpensive and accessible English language classes and few childcare options confined women to the home and contributed to alienation from economic and community life.

Participants also recounted examples of racism and abuse as they went about their day to day business. Some participants had been taunted by strangers on the street e.g. ‘Go back to your own country’ or ‘monkey show me your tail’. Others reported having doors slammed in their face or people ignoring greetings or spitting at them. Participants also described overtly racist behaviour from officials such as police and general practitioners which was particularly distressing

Another time, someone called me a “Paki” and told me to “go back to your country”. It was a police sergeant. Because I did not have identification with me, I was arrested, but I’ve done nothing wrong. I have been living in Ireland for 12 years, I have fluent English – I have citizenship here and I don’t have to carry an identification... They let me go... I go to sleep every

night and it stands in front of my eyes. (a participant from the Algerian community focus group)

For some participants accessing private rental accommodation even if they possess the means was exceptionally difficult due to discriminatory behaviour of private landlords and agents.

Yes. I have been to an agency when we were looking for a house. And the person there looked at us and started to talk to us as if we were retarded. She said: (pronouncing the words slowly and one at a time) 'We-do-not-have-any-apartments-for-you. Do-you-understand-me? This was funny because I understand English perfectly. (a participant from the Romanian women's focus group)

Participants in all focus groups agreed that discrimination had negative effects. Discrimination had primary effects such as loss of opportunity, loss of income, insecure housing, and insecurity. At least as profound were the reported effects on self confidence, self-esteem and mood.

Of course discrimination affects our health – mental and physical – very negatively. When people make you feel as a second class citizen it is very demeaning; and when it happens too many times – you start to believe in it yourself. It impacts on your confidence and ability to do normal things, like any other person. (a participant from the 'Slavianka' Russian speaking women's focus group)

...these insults reach deep inside your soul. Injustice is always frustrating and infuriating (a participant from the Romanian community women's focus group)

Participants spoke of feeling stressed, anxious, worried and experiencing physical problems as a consequence of discriminatory or racist incidents, being unable to provide for themselves and facing an uncertain future. For some their enthusiasm for life diminished.

The way professionals are treated is bad, skills are not recognized. Your gifts and your talents die, your interest dies down. Then you become frustrated and depressed. (a participant from the West African Network men's focus group)

Other participants described feeling angry...

...the aggressiveness grows in you and the psychological stability is affected. You snap out much quicker. You tend to take revenge on others because of what is happening to you, because you think it's only fair that you 'pay back in the same currency' (a participant from the Romanian community, men's focus group).

However, more usually participants reported feeling hopeless, despairing or suicidal...

I had a lot of negative experiences in this country, which brought a lot of anger in me... My family broke down and I only see my children occasionally. I am a young man but have very little hope that anything will be ever good for me here. (a participant from the Algerian community focus group)

How to improve mental health in new communities

Participants identified a range of structural things that could be changed to improve their experiences of living in Ireland broadly. These included policy changes to secure access to essential services, increasing information about services, and enhancing integration so that they felt they belonged within Irish society.

The structural changes that were most highlighted revolved around securing access to housing, education, employment and childcare, which were all affected by immigration policies. The affordability and accessibility of adequately sized

homes was emphasised. Those who had been in direct provision still found that they had accommodation problems after they left that system:

Housing; the housing system for newcomers is bad, the process you go through before one is accepted – very long. If you are single – you have to wait even longer. It is hard not to have a place of your own, a place that you can call home. First, there were years in Direct Provision and there is no end to it now.... (a participant from the West African Network, men's focus group)

Accessible and affordable childcare was judged to assist with finding work and accessing education.

...when you do not have an opportunity to work. I feel disgusted with myself but I can't do anything. It is impossible to survive, too expensive to go to work. I can't even afford to go study – all the same problem – childcare. (a participant from the Russian speaking women's focus group)

Participants' spoke about access to education in terms of their children's basic education and, also, adults' continuing education:

...give the chance for our children to go to school. Give our kids the right to go to school no matter what religion or immigration status they are. Also to give us the chance to study, to work to be like everyone else. We are not different than anyone. (a participant from the Congo Lisanga focus group)

Being in work and particularly having an adequately paid job was linked to overall wellbeing and happiness by many participants, and demoralization when unable to find work.

There was little mention about the formal mental health services. However in some groups there was a need identified for information about mental health and mental health services, to prevent situations deteriorating.

I think that information is the key. And prevention is important. There should be something done before it is too late as like with people who are suicidal. I think that's why there are so many suicides in Ireland – because unless they save you half way through... nobody cares if you are showing symptoms of depression, no health professional will, on their own accord, do something about it. My partner had a depression... GP prescribed Prozac - that was it (a participant from the Russian speaking men's focus group)

This need for information about services also applied more broadly to all health services, where it was stated that access to information would assist in health promotion and community development.

For ethnic minority communities more skills related to health needed. How to organize around health, having health information about services... We need training courses on how we can change health of our communities, how we can organize ourselves. (a participant from the Algerian community focus group)

Information about services generally was seen to need improvement:

Yes, and to give information to immigrants how to go about the services... I don't know what to do if I feel not together or stressed... I drink and forget about every thing (a participant from the Russian speaking men's focus group)

Language support services which included the provision of essential information in a range of languages as well as opportunities to learn, improve and practice English were identified as important to enable access to services as well as to increase integration into Irish life.

If things – information, leaflets and forms - were in different languages, like in England they are more diverse than Irish society – it would be easier to

cope. Also if interpreters were available when going places or accessing services.... (a participant from the Somali community focus group)

The desire for enhanced integration and a feeling of belongingness was described in many ways, linked with a sense of contributing to society, being respected and being treated well. Participants stated that they wished for the opportunity to be independent and to practice their talents and contribute to society:

Some feel let down by the conditions they are living in, a lot of people have talents and want to contribute but they are let down by the system or community (a participant from the Eritrean community focus group).

Participants want to be heard- by the media and by Irish people; and that interaction would help increase mutual understanding.

We do not get an opportunity to mix with other people, to understand people. We just locked up in direct provision centres and it is expensive for us even to come to the city centre. (a participant from the Somali community focus group)

There was a need identified for places to meet and interact, and this could include churches, social places, offices and internet access (to assist with employment seeking in particular) as well as a need to talk within communities and with Irish people. This was seen as a way of strengthening communities through developing trust, solidarity, identity and enhanced integration.

Racism and discrimination were seen as obstacles to integration. The need to shift the way ethnic minority groups are perceived by Irish people, the media and officials was also identified.

The mentality of how Irish people see us. They think we sleep in the trees or in jungle. In the shops they follow us even if we are getting something for only 5 cent. They think we are animals. They have to take this out of their mind (a participant from the Congo Lisanga focus group)

Discussion

This research was descriptive, and a-theoretical rather than conceptual or theoretically grounded. The chosen method did not enable the researchers to return to participants and explore or develop concepts further and this is acknowledged as a weakness of this study. At best these findings might be described as 'displays of perspective' which are negotiated and developed between members (Reed & Payton, 1997). They also present the voices of participants, which has typically been absent from research on migrant mental health and thus presenting these findings may be considered a form of restorative epistemic justice (Fricker, 2007). The composition of the focus groups were fairly heterogenous, representing people at different stages of migration and with quite different pre-migratory experiences. There may have been benefits from focusing on understanding the experiences of particular sub-groups such as asylum seekers or just those with experience of the direct provision system.

Interestingly, despite differences in group composition within and between focus groups there were considerable similarities in the concerns and perspectives of participants. For example in all groups the effects of perceived racism, particularly in interactions with official agencies was vividly described and considered noxious to mental health. Reported experience of racism and institutional discrimination has been found to be related to poor physical and mental health (Karlsen & Nazroo, 2002). A public health approach to addressing the mental health status of minority groups or communities must address personal and institutional racism.

Considerations of ethnicity, race and culture need to be central to mental health care provision (Sewell, 2009) if migrants are to engage with mental health services (something that participants were extremely reluctant to do). An emphasis on 'cultural safety' (Papps & Ramsden, 1996) in the education, supervision and regulation of health professionals may provide a means to tackle institutional racism and directly promote positive mental health in the health and welfare sector.

Uncertainty and insecurity were also ubiquitous experiences that were particularly apparent and challenging for those awaiting adjudication of their immigration status in direct provision centres but also for others in relation to having insecure employment and housing tenure. This uncertainty is a source of stress which taxes and challenges people's capacities to cope. Respondents in this research largely described emotion focused efforts to cope. In relation to dealing with the uncertainty of this phase of the migratory experience this may well be the most productive way to cope as there is little that individuals can do to solve the problem. For some the waiting took a considerable toll and some people described losing their sense of personal agency and assuming a hopeless/helpless orientation.

The long term effect on mental health of waiting for immigration status to be clarified and the associated problems of powerlessness, poverty, prevention from realizing educational and occupational goals and living with the threat of possible deportation has not been explored in great depth in research. Ryan, Benson, and Dooley (2008) undertook a longitudinal study examining levels and predictors of distress amongst a community sample of people seeking asylum in Ireland and found that the only people to show a decrease in distress at 12-24 months follow-up were those who had obtained a secure legal status in that time (e.g. being granted residency or refugee status).

In this study whilst medical or psychological conceptions of mental health were acknowledged by respondents, access to resources (be they social, family, material etc) were more dominant themes and were spoken of as both determinants and indicators of mental health. This is consistent with Ryan, Dooley, and Benson's (2008) theoretical assertions that constraints on the use of or access to resources is a major structural factor associated with post-migration adaptation and well-being. They argue (p.15) that "Negative psychological outcomes are likely to arise when the host environment places constraints on or depletes the migrant's existing resources, while offering few opportunities for resource gain". This was most obvious for people in direct provision who were unable to work, pursue

education or pursue goals. However for others who had resolved their immigration status concern about fitting in, accessing work, school, housing and educational resources remained salient. Whilst those who participated in these focus groups may not be 'representative' of migrants generally it was clear that poverty, particularly relative to Irish nationals was perceived as a contributor to poor mental health

An additional branch of this study (not reported here) examined people's experiences with accessing health services. There was a very low level of awareness of and access to formal mental health services of any kind and indeed a suspiciousness of services generally. Of those who accessed psychological support or counselling this was generally highly valued. There was a profound need for access to specialist trauma counselling for some people as well as need for low level/non-specialist psychological support and care, primarily preventative services, particularly delivered in an outreach capacity.

The participants in this study specifically identified what changes could improve their general experiences of living in Ireland. These include structural changes such as facilitating access to education, housing and employment (all fundamentally linked to speedy resolution of immigration and legal status), increased information about health services in general and other social services; and increased opportunities for integration, independence and a chance to contribute to society and be understood and respected.

The data for this study were collected in the first half of 2008. Since then, the global recession and in particular the quite dramatic Irish economic downturn makes achieving such changes unlikely. While migration to Ireland will likely decrease under current conditions, those who have made their lives in Ireland (like those in this study) will face increasing difficulties in this environment. These conditions may also increase the racism reported in this study, at both the social and institutional levels, with a general social sense of discontent. The perceptions and experiences clearly expressed in this research make uncomfortable reading

and without structural and attitudinal change, the lives of those who spoke through this research are unlikely to improve.

Acknowledgements

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References

- Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavica*, 109(4), 243-258.
- Blomstedt, Y., Johansson, S.-E., & Sundquist, J. (2007). Mental health of immigrants from the former Soviet Bloc: a future problem for primary health care in the enlarged European Union? A cross-sectional study. *BMC Public Health*, 7(1), 27.
- Carta, M. G., Bernal, M., Hardoy, M. C., Haro-Abad, J. M., & group., R. o. t. M. H. i. E. w. (2005). Migration and mental health in Europe (the state of the mental health in Europe working group: appendix 1). *Clinical Practice and Epidemiology in Mental Health*, 1(13), 14.
- Central Statistics Office. (2006). *Census 2006: Volume 4 - Usual Residence, Migration, Birthplaces and Nationalities*. Dublin, Ireland: Stationary Office.
- Council of Europe. (2002). *7th Conference of Ministers Responsible for Migration Affairs*. Helsinki.
- Curtis, E., & Redmond, R. (2007). Focus groups in nursing research. *Nurse Researcher*, 14(2), 25-37.
- Fricker, M. (2007). *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford: Oxford University Press.
- Karlsen, S., & Nazroo, J. Y. (2002). Relation between racial discrimination, social class, and health among ethnic minority groups. *American Journal of Public Health*, 92(4), 624-631.
- Mac Einri, P., & White, A. (2008). Immigration into the Republic of Ireland: a bibliography of recent research. *Irish Geography*, 41(2), 151 - 179.
- Mathers, C. D., Vos, E. T., Stevenson, C. E., & Begg, S. J. (2001). The burden of disease and injury in Australia. *Bulletin of the World Health Organization*, 79(11), 1076-1084.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

- Munk Jorgensen, P., Fink, P., Brevik, J. I., Dalgard, O. S., Engberg, M., Hansson, L., et al. (1997). Psychiatric morbidity in primary public health care: a multicentre investigation. Part II. Hidden morbidity and choice of treatment. *Acta psychiatrica Scandinavica*, 95(1), 6-12.
- Murphy, H. B. (1977). Migration, culture and mental health. *Psychological Medicine*, 7(4), 677-684.
- Papps, E., & Ramsden, I. (1996). Cultural Safety in Nursing: the New Zealand Experience. *Int J Qual Health Care*, 8(5), 491-497.
- Powell, R. A., & Single, H. M. (1996). Focus Groups. *Int J Qual Health Care*, 8(5), 499-504.
- Reed, J., & Payton, V. R. (1997). Focus groups: issues of analysis and interpretation. *Journal of Advanced Nursing*, 26, 765-771.
- Ryan, D., Benson, C., & Dooley, B. (2008). Psychological distress and the asylum process: A longitudinal study of forced migrants in Ireland. *The Journal of Nervous and Mental Disease*, 196(1), 1-9.
- Ryan, D., Dooley, B., & Benson, C. (2008). Theoretical perspectives on post-migration adaptation and psychological well-being among refugees: Towards a resource-based model. *Journal of Refugee Studies*, 21(1), 1-18.
- Sewell, H. (2009). *Working with ethnicity, race and culture in mental health*. London: Jessica Kingsley Publishers.
- Silove, D. (2004). Mental health problems in migrants and refugees. *Australian Doctor*, July 16, 31-38.
- Syed, H. R., Dalgard, O. S., Dalen, I., Claussen, B., Hussain, A., Selmer, R., et al. (2006). Psychosocial factors and distress: a comparison between ethnic Norwegians and ethnic Pakistanis in Oslo, Norway. *BMC Public Health*, 6, 182.
- United Nations. (2002). *Number of world's migrants reaches 175 million mark*. New York: Press Release (POP/844).

Table 1: Focus Group Discussion Guide

Introductory questions:	<p>What is “good mental health”?</p> <p>What is “poor or bad mental health”?</p>
1	<p>What do you think are the most important things affecting a person’s mental health here in Ireland?</p> <p>How do you feel (your community) people are treated in Ireland?</p>
2	<p>If you could change anything to improve mental health in your community, what would it be?</p>
3	<p>Do you think discrimination and prejudice affects a person’s mental health and wellbeing?</p> <p>PROBES: How does it do this? Can you give any examples?</p>
4	<p>Think of the last time you had contact with a doctor, health worker or social worker... How did you feel about your experience?</p>
5	<p>If you feel anxious, stressed or unhappy what do you do?</p> <p>PROBE: Would you ever look for help from Irish health or social worker when you feel like this?</p>
6	<p>Any other comments or questions?</p>

Table 2: Focus group composition

Group Name	Country of origin	Language	Religion
Congo Lisanga	Congo	French, Lingala	Christian
Algerian Community of Ireland	Algeria	Arabic/French	Islam
Russian Speaking Women 'Slavianka'	Ukraine, Estonia, Russia, Estonia, Latvian, Belarus, Moldova	Russian / Ukrainian /Latvian/ Belarusian/ Moldovan	Russian Orthodox:4 N/A: 4
Russian Speaking Men	Moldova, Ukraine, Latvia, Lithuania, Russia	Moldovan, Russian, Ukrainian, Latvian, Lithuanian	Orthodox: 2 N/A: 4
WANET (West African Network)	Angola/Ghana	Portuguese, Twi	Christian
WANET (West African Network)	Morocco, Algeria, Sudan, Syria, Mauritius, Egypt, Saudi Arabia, Indonesia, Iran, Algeria, Turkey	Arabic, Creole, Indonesian, Persian, Turkish	Islam
Eritrean Community	Eritrea, Iraq, Sudan	Arabic	Islam
Somali Community	Somalia	Somali, Swahili, Arabic	Islam
Romanian Community	Romania	Romanian	Orthodox
Romanian Community	Romania	Romanian	Orthodox

4.4.2. Lakeman, R., & Glasgow, C. (2009). Introducing peer-group clinical supervision: An action research project. *International Journal of Mental Health Nursing*, 18(3), 204–210.

It has also long interested me how health professionals can be assisted to sustain themselves in the work they do generally. As a professional, particularly in relation to developing psychotherapeutic roles I have found clinical supervision valuable and have adapted a form of peer group supervision (Lakeman & Glasgow, 2009) for use by workers in the homeless sector, trainee nurses, qualified nurses and mixed professional groups. This report provides a description of this form of supervision and how it was introduced into a practice setting with no history of clinical supervision of any kind.

FEATURE ARTICLE

Introducing peer-group clinical supervision: An action research project

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4.5. Recovery

Psychiatry, psychotherapy and mental health services have been prone to fashions, trends, political whimsy, scandals, critique and reform like few areas of public service. A peculiar characteristic of the field is the modification of language to describe both the focus of the field and activities of people within it. For example asylums became psychiatric hospitals and then mental health units or services, attendants became nurses and latter case managers, and inmates became patients and then variously clients, consumers, survivors or service users. Terms such as 'care' have fallen out of fashion (long overdue a revival) but 'mental health recovery' (sometimes simply described as 'recovery' or 'personal recovery') is a concept that is in the ascendancy and has captured the imagination of policy makers, workers and people with experience of mental health and social problems.

This modification of language might make one a little cynical, particularly when services are uncritically renamed or re-branded without any obvious shift in philosophy or practice. 'Recovery' hints at something good and is a play on both positive medical outcomes (the person recovered from x), an objective healing process (the person is recovering from x), and a subjective process (I am in recovery). Not surprisingly the term recovery can become a catch phrase for all good practice and consequently it can lose its usefulness for workers who might argue that they have always been doing recovery focused care. It is worth noting that the idea of mental health recovery championed by people who have used mental health services germinated in response to psychiatric discourse and practices that have sapped the hope and denied the resources and capabilities of people often compelled to receive treatment and containment.

The following report is of a commissioned piece of research which was intended to help clarify the term mental health recovery and operationalise recovery focused care for mental health for health staff and educators.

- 4.5.1. Lakeman, R. (2010). Mental Health Recovery Competencies for Mental Health Workers: A Delphi study. Journal of Mental Health, 91(1), 55-67**

RESEARCH AND EVALUATION

Mental health recovery competencies for mental health workers: A Delphi study

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5. Conclusions

This portfolio is comprised of six discrete research projects on a range of topics using different methods, a meta-synthesis and a collection of published commentary. Being a collection of mostly peer reviewed and published works all have been judged by peers and editors as having integrity. In relation to the published research reports, different methodologies call for different ways to judge quality and have different inherent limitations. As much as space has allowed the limitations of the research projects have been acknowledged within the publications themselves. It remains then, to consider this body of work as a whole, rather than to reiterate what has already been discussed in relation to each individual project. It is also useful to reflect on how this portfolio reflects and contributes to meeting the objectives of this course of study (outlined in table one) and the significance of the body of work in relation to extending understanding of ethics, power, participation, recovery and clarifying or extending the 'proper focus of nursing' (as outlined in section three)

5.1. Strengths and limitations

One fair criticism of this collective body of work is that it reflects an opportunistic approach to research. The traditional approach to doctoral work is to confine oneself to one content or topic area following a predictable, although not necessarily entirely linear process of reviewing the literature, refining one or more research questions, choosing a methodology, designing a research protocol, obtaining approval, undertaking data collection and analysis and then writing a report based loosely on those steps. I was involved in a range of projects that were mostly funded or commissioned and all were supported by my employer. This created advantages in that the

research was desired and supported by others, and I was able to integrate undertaking the research into my daily work. This is in accord with the aims of the professional doctorate to “help candidates make a significant contribution to nursing practice (management, education or clinical)” and to enable adaptation and adjustment throughout the programme to “...suit the demands of the workplace” (JCU, 2009).

Course Objectives:

Students will demonstrate enhanced leadership by:

- making a significant contribution to the profession through their studies;
- being competent to undertake and report applied research;
- demonstrating an ability to: generate, access, and use knowledge in order to influence, in positive ways, the delivery of nursing services;
- being able to use a range of applied research methods relevant to their professional context;
- demonstrating an advanced ability to appreciate the contribution of research to nursing practices and health service policy and politics;
- demonstrating an ability to make discretionary decisions regarding the evidence behind nursing practice and policy;
- promoting professional nursing in disciplinary and multidisciplinary forums through: committees, debate, conference presentations, publications, seminars and workshops;
- having a contextual understanding of the impact of contemporary issues related to health service research, in particular, programs of research, areas of priority, multidisciplinary research and consumer involvement in research agendas;
- identifying and promoting ethical conduct in research and clinical governance matters.

Table one: Course objectives for James Cook Universities Doctor of Nursing Science. Source: (JCU, 2009)

There were however a number of potential disadvantages in the multiple project approach to research, particularly in relation to negotiating a methodology and timeframe that didn't necessarily fit with my inclinations or interests. For example, the Irish Institute of Mental Health Recovery requested

a study based on a Delphi methodology. Whilst I am very much interested in the idea of recovery, I am not favourably disposed to reducing education down to competencies or enamoured by the Delphi technique, nevertheless this was what the sponsors sought and I hope I have argued with sufficient rigor for the utility of the approach in addressing the question. In terms of administration and logistics each project also required the development of a proposal and applications to at least one (although generally two) ethics committees. The content areas of the projects were also only loosely related and this posed additional challenges in terms of reviewing literature in multiple areas.

A criticism that may be levelled at this body of work is that it has considerable breadth but lacks depth. By this I mean the projects commenced without the philosophical reflection that is expected to go hand in hand with doctoral study. When initially presenting some ideas about the research directions I planned to take near the commencement of this doctoral journey, one person challenged myself and others to make clear our ontological positions and epistemological assumptions. Not to do so, she argued or to state as I did, that I was something of a fence sitter, perhaps a pragmatist or if pushed a 'critical realist', reflected intellectual laziness. This task of staking out ones position in relation to the nature of reality or entities and how particularly social reality can be known is of course something of a preoccupation for many qualitative researchers and their students. Indeed Guba and Lincoln (1994) assert that no one should commence inquiry without being clear about what paradigm informs their approach. I have resisted explicitly expressing an allegiance to any particular paradigm or philosophical camp in my published work and in a doctoral portfolio such as this it is not a requirement. However, the commentary papers in this portfolio express some strong positions in relation to epistemology and idea of evidence based practice and ontological and epistemological assumptions are implicit in the published research.

Guba and Lincoln (1994) suggest that there are four broad inquiry paradigms

which differ in terms of ontology, epistemology and the kinds of methodology that might be congruent with these world views: positivism, post-positivism, constructionism, and various schools of critical social theory. Constructivist and Critical social theory world views in particular problematise the other positions, their claims of objectivity and their methods of inquiry. To some extent those that ascribe to these positions need to make an explicit case or argument for their positions, because they take a critical stance towards the traditional positivist view of science and because as Guba and Lincoln (1994) point out, positivists and post-positivists tend to have considerable power and influence in the academic sphere, controlling avenues for publication and so forth. Thus one needs to argue one's case for a methodology, although increasingly this is unnecessary as various qualitative methodologies have gained respectability. Some have also pointed out that some positions are not irreconcilable and that there are not always clear demarcations between broad paradigms. For example, Paley (1998) argues that Heidegger's phenomenology is based on the premise that humans are essentially self interpreting but realistic approaches to knowledge generation are not incompatible with Heidegger's ontology.

A review of the published works in this portfolio will reveal a number of sympathies and leanings with different, but I believe reconcilable ontological positions. In the introduction to this portfolio I expressed an interest in constructionism, or broadly the idea that we construct our social realities. I often appeal to Foucault (1970, 1975, 2006), particularly in relation to discourse and power. I don't however attempt to undertake a rigorous discourse analysis or the kind of historical archaeology that Foucault demonstrated. However, as Gergen (1999, p.85) notes "The frequent foregrounding of discourse blurs the significance of the background – from whence it derives it's potency" or in other words from a research point of view what people say is not the full story, how, when and where a story is told can also be significant. A focus entirely on discourse can obscure the importance

of the medium of communication. In Lakeman (2008c) I appeal to McLuhan (1994) in arguing how the kinds of tools we select in mental health care both reflect, and shape our reality (and importantly our views of suffering and helping). McLuhan's theories reflect a form of technological rather than social constructionism. The media itself influences social relations in ways which are somewhat independent of the content. Although in relation to using psychological scales and measures in mental health these could be said to contribute to and sustain a technocratic biomedical discourse. As Abraham Maslow was credited as saying, "If you only have a hammer, you tend to see every problem as a nail".

The idea that we might construct social objects including understandings about truth, proper conduct, social rules and roles, through various communicative processes is an appealing one. To a point I agree with this but I would stop short of the more extreme position that all social objects are socially constructed and that they don't exist until brought to life linguistically. Similarly, it stands to reason that there may be numerous ways to view a problem, numerous truth constructions, and truth is to some extent relative. However, I also stop short of the claim that all truth claims are equally valid or right. Such claims have implications not only for research but for practice.

For example, I have long held an interest in hearing voices (see: Lakeman, 2001c) and an admiration for the 'Hearing Voices Network' (HVN) and how this collective has helped many people adapt to, cope with and make sense of the experience. The HVN holds that adaptation to voices tends to follow phases e.g. people often initially experience voices as frightening (startling), they then develop a frame of reference to make sense of this experience (organization) and finally there is an acceptance of the voices (stabilization). The HVN view voices as 'real', inherently meaningful and any frame of reference people develop as valid. Parker et al. (1995) suggest that it is at the point of explanation that voice hearers and professionals appear to diverge in

a battle of discourses. If the voice hearer construes the voices to be the result of telepathy, a direct communication with God or a communication from a former abuser all positions are equally valid. Whilst, I do not accept the extreme mainstream bio-psychological view that all voices are merely symptoms or residuals of pathology it seems to me that the way voices are explained will make a considerable difference to how voices are responded to. This is borne out by research which suggests that people who perceive voices as all powerful, all knowing and with malevolent intent are more likely to be distressed by them (Chadwick & Birchwood, 1995a, 1995b; Lakeman, 2000c). It stands to reason that if someone perceives a voice as having authority they may be more likely to comply with commands. So explaining a voice that is commanding one to do a harmful act, as the voice of God who wishes them well, may be a less useful frame of reference than other more benign explanations.

A more convincing ontological position to me than the extreme relativist (anything goes) or essentialist positions (all is real, measurable and knowable) is contingent realism as outlined by Williams (2009). Williams proposes and argues that social objects are socially constructed and real, social objects are real but contingent, social objects are dynamic, social objects are continuous with thought objects and physical objects and the causal efficacy of social objects depends on their relationship to other social objects. Social objects are real because they have consequences although some social objects such as 'laws' have more causal efficacy than others such as 'voluntary codes'. There is common cultural and linguistic agreement about the characteristics of social objects. Crucially, social objects have a contingent existence that is, prior to their being brought into being they have only a probability of existing and following they increase or reduce the probability of other objects (both social and physical) being brought into being.

Grounded theory was the methodology I selected to examine sudden death and homeless sector workers. Grounded theory was chosen for some

practical reasons e.g. little is known empirically about how homeless sector workers deal with sudden death and existing concepts such as 'grief' didn't seem to adequately explain the processes that I had encountered working in the sector. Grounded theory assumes a realist ontological position in relation to the social world, that there are social patterns or processes to people's behaviour which exist independent of the researcher and can be discovered by following a rigorous process of analysis (Glaser & Strauss, 1967). Indeed, Glaser and Strauss (1967) argue that grounded theory was developed in response to the 'thought up' theories and deductive methods of inquiry in the social sciences that were *de rigueur* at the time. The products of grounded theory can be thought of as contingent. For example, the core concern of respondents in the study reported in this portfolio, 'Framing death and moving on' is a real process but contingent on other subcategories such as encountering death, marking death, recognising and responding to vulnerability and so forth. Contingent realism can bridge a range of epistemological positions and is congruent with a range of research methods

5.2. The significance of this body of work

It is difficult to project what impact the publications in this portfolio will have on practice. As Waddell (2002) notes, to the consternation of many scientists the results of so much good quality research often appear unused by clinicians and policy makers. However, the practice implications of the research in this portfolio and indeed the commentary are not technical, highly specific, or in my view particularly radical. Principally they call for the realisation of values such as humility and practices such as including people in decisions that affect them.

As well as the published work the products of these projects have also been shared in various ways. Teaching is an important role of the nurse in relation to patients (Peplau, 1952) and presently teaching nursing students as well as other health and welfare workers is my main work role. This is not a value

neutral activity and obviously my opinions and research findings will influence my teaching practice. I hope the publications in the text, '*Psychiatric and mental health nursing: The craft of caring*' (Lakeman, 2008a; Keen & Lakeman, 2008) will influence nursing students directly. The various projects have also been presented at a range of professional conferences and forums (See: Lakeman, 2006a, 2006b, 2008e, 2009a, 2009b; Lakeman et al., 2009; Walsh, Lakeman, & McGowan, 2009; Walsh, McGowan, & Lakeman, 2007). Methods of dissemination such as teaching, conference presentations, and supervision all have some influence on the thinking and behaviour of others. Whilst it is easy enough to identify how work is shared, how the thinking, behaviour and practice is affected or extended is less easy to discern.

5.3. Ethics, Discourse and Power

It was in the highly institutional milieu of the asylum that I first became aware of the importance of ethics in relation to nursing and mental health generally. As Barker and Baldwin (1991, p.3) observe, it has long been acknowledged that the institutions often work against the best interests of those in their care. Yet, the *rationalisation* of the institutional response towards people in care is typically that it is in their (the person or patient's) best interest. The term rationalisation can refer to a defence mechanism whereby one's true motivation is concealed by explaining one's actions and feelings in a way that is non-threatening and also a cognitive process of making something *seem* consistent with or based on reason (Princeton University., n.d.). However, something is not right or justified simply because we (as individuals or collectives) believe it to be right. Beauchamp (1991) asserts that moral *justification* is appropriate when ever there is a need to defend a moral conviction. Justification has many nuances but in a general sense it means to prove one's case, to show to be right, to vindicate or to present sufficient grounds for believing, acting, asserting, preferring and the like (Beauchamp, 1991). The contribution of the work on ethics in this portfolio is largely to

challenge the rationalisation of professional behaviour and seek instead moral justification.

Melia (1994) argues that under the guise of clinical judgement, the medical profession has the last word in ethical decisions as they are ultimately legally responsible for the patient's welfare. The legal, moral and social contract is between the patient and the doctor and not with the nurse. Thus if prescribed treatment is in accord with psychiatric standards (be it the administering electroconvulsive therapy, a medication or restraining someone) then nurses have no grounds for objection or non cooperation because they personally believe the prescribed treatment is not in the patients best interests... this is interfering in clinical decision making which is the mandated and proper business of doctors. Melia (1994) further argues that there is little distinctively nursing about much that is written by nurses about ethics and that there is little value in pursuing a nursing academy of ethics distinctive from medical / bioethics. My writing does not take exception to this claim and whilst presented mostly in nursing publications it applies to mental health care ethics generally. Whilst this acknowledgement of the moral agency of nurses and the instrumental nature of nursing work is not new (Lakeman, 2000d) there are some compelling reasons why nurses should tackle and take an interest in the 'bigger picture' ethical problems and also consider treatment as problematic.

In the psychiatric and mental health field as in others, nurses have managed to encroach on the field of medicines prescriptive authority in many places (albeit often under intense medical surveillance and control). Thus it is no longer a universal truth that medicine prescribes the treatment and nurses undertake it, and in such circumstances it is perfectly reasonable to be critical of treatments. Whilst psychiatry continues to hold the authority and wield the power in tertiary mental health care, in many ways the mental health field has become increasingly egalitarian. Exceptionally influential movements such as 'evidence-based practice' as applied to mental health are not so much about medicine but about the whole gamete of care and treatment options available

to people and furthermore all health professionals in mental health are expected to keep abreast of and apply evidence based practices (Deane et al., 2006; Dixon et al., 2001; Hatcher et al., 2005; Stout & Hayes, 2005). Much of the evidence base for what works in mental health is also not related to discrete and clearly defined treatments but rather of programmes or sets of interventions such as intensive case management, family psycho-education and the like which is often planned and undertaken by all kinds of health professionals (King, Lloyd, & Meehan, 2007). Whilst I have argued that evidence based practice is problematic in that it privileges particular kinds of evidence over others (Lakeman, 2008c) it nevertheless undermines authority and belief as the basis for treatment decisions.

One cause I take up in the commentary section of this portfolio is what I and Cutcliffe (2009) coin 'pharmaco-centrism', that is the positioning of pharmacology at the centre of the care and treatment of mental illness. We particularly turn our attention to the experience of depression (Cutcliffe & Lakeman, 2010). The pharmaco-centric bias in practice which sees people diagnosed with depression and leave with a prescription of antidepressants, as well as the bias in publication which portrays pharmacology as essential to people's recovery is the antithetic to evidence based practice. This is an ethical problem, not just an example of sloppy or selective science, in that it leads to hermeneutical injustice (Fricker, 2007) through impeding people from making sense of their experience and resolving their problems. Informing people from a seat of authority that they have a chemical imbalance of some kind may relieve the person of a sense of personal blame and culpability but it can effectively close the door on discovering what actually might be causing the problem. This is the task of the various schools of psychotherapy which have been found to be at least as effective as drug treatments at relieving depression and,

... help clients understand factors that have contributed to their depression; develop healthier, active daily routines; stop depressive

thing styles from dominating their mood; develop supportive relationships with family members and others, and address complex interpersonal and relationship issues. (Carr, 2008, p. 46-47).

This is not to discount the possibility that a chemical problem amenable to pharmaceutical treatment might exist but the balance of evidence in relation to depression would suggest that this shouldn't be assumed and for most people some form of psychotherapeutic or lifestyle intervention would be most helpful. Indeed this is the recommendation of most guidelines relating to depression (see: NICE, 2004). There is little question that pharmacotherapy has effects, even positive effects. Pharmacotherapy as Svenaeus (2009) argues might even circumvent much of the hard work and reflection of psychotherapy, but at least psychotherapy offers some kind of choice about who one wants to be.

For nurses the implications for education and practice development of problematising a pharmaco-centric view and highlighting the evidence base in favour of psychotherapy is to reinvigorate the idea of the counselling or psychotherapeutic role of the nurse emphasised by Peplau (1952) and de-emphasise the surveillance and assessment roles which have become over extended. An extreme bio-deterministic view of the aetiology and treatment of mental health positions the nurse as a technician, administering treatments and waiting and watching for their effectiveness. Whilst good relationships with service users are desired, the relationship is principally a vehicle to achieve compliance and order. Our current state of knowledge about the treatment of depression turns this orientation entirely on its head. If people get better (and they generally do) it is often a consequence of the relationships people have with nurses and others, not the prescribed treatment. It is an ethical imperative that educators and nurses acknowledge this and return psychotherapeutic skill development and associated ways of formulating problems (see: Crowe, Carlyle, & Farmar, 2008) and solutions back to the forefront of nursing education and practice development. Clinical Supervision

is but one technology (see Lakeman and Glasgow, 2009) to achieve this end.

The dogma of pharmacotherapeutics (in contrast to evidence based pharmacotherapeutics) leads to a form of distributive injustice or a utilitarian problem in terms of how to distribute the most efficacious treatments to the most number of people. A pharmaco-centric bias embedded within many public health care systems sees limited resources devoted to distributing and monitoring drugs with limited proven efficacy, whereas access to competent psychotherapeutic assistance is available only to those with resources and an inclination to pay. The inclination to seek out alternative treatments and explanations is attenuated by messages (often received from a respected health professional) that the problem is biochemical and thus a biomedical discourse is sustained. Once, people would have been trapped in this system but as was noted earlier, information and communication technologies have to some extent demystified professional knowledge and enabled people to network, share experiences and draw their own conclusions about how to construe problems and how these might be resolved. In Ireland there appears to be a high demand from some sections of the community for psychotherapeutic services (provided by charities, private organisations etc) based on informed decisions to seek these rather than medication. There is in my view a class divide in that those with limited resources are more likely to have limited choices.

However, individuals are constrained by discourse as well as class or economics. The mainstream biomedical discourse doesn't simply hold that depressed people are chemically imbalanced. Rather, discourse shapes and constrains the subjectivities available to us and positions us in relation to others in terms of knowledge, power, rights, duties and obligations (Burr, 2003). In part the paper relating to service user participation (Lakeman, Walsh, McGowan, 2007) was an exhortation for at least some service user/survivor activists to stay outside mainstream biomedical discourse, as operating within positions them as patients in relation to doctors and nurses,

or subordinate in a hierarchy of employees. This positioning obviously has implications for the nature and degree of critique which they can offer to and about mental health services. For example, it is not surprising that even with the burgeoning number of paid roles for service users in mental health, the service user movement have become virtually impotent in affecting system change. Interestingly, Stewart et al (2008) recently asserted that paid consumers are being placed in untenable positions in terms of their advocacy roles with vague job descriptions and little training. Predictably, and in a (belated) parallel process to nurses and other service users they call for more education and more support.

A consideration of discourse also begs the question, 'Whose interests are served by a particular discourse or set of practices?' This is not always apparent and any kind of archaeology of fresh material is frequently met by defensiveness from some people. The article 'Psychiatric nursing is not for sale' (Lakeman, 2010a) makes a case that the interests of the pharmaceutical industry are principally about the maximising of profits for shareholders regardless of what beneficent gestures particular companies might make. I argue that nurses are easily manipulated to present arguments in favour of particular drugs or in favour of a pharmaco-centric view generally, which benefits the pharmaceutical industry. Amongst a number of (hardly radical) recommendations I recommend that nurses declare in full their interests in relation to pharmaceutical company sponsorship when publishing as is now the convention in medicine. The paper was peer reviewed and accepted for publication (see figure three) but within a week of going to print was pulled from publication. No explanation was publically made in the journal (despite my requesting one) but among the correspondence from the editor which included assertions that the paper was libellous was a telling statement:

Presumably there are many scientists and researchers working in the pharmaceutical industry who believe that their science is honest and that it is done for the benefit of mankind. They would not see themselves as part of a global scam perpetrated on the public by the pharmaceutical industry to maximise its profits.

I think the editor is correct about the intentions of research scientists but this is largely irrelevant and the statement gives away assumptions about the rosy, collaborative and collegial relationship that many people perceive within the psychiatric industry and also the defensiveness that ensues when this image is challenged. The intentions of individuals were not being critiqued and a global scam was not proposed. However, good intentions are not sufficient to ensure ethical practice (The proverb, 'The road to hell is paved with good intentions' comes to mind). A consideration of interests and in particular that stands to benefit or be harmed in relation to either a specific incident or more general issue is a prerequisite for ethical professional behaviour, as illustrated in the decision making model presented in Lakeman (2008a).

In the next issue of Mental Health Practice

June 2009

Nursing and the pharmaceutical industry

Richard Lakeman argues that the relationship between nursing and the pharmaceutical industry is problematic because corporations hold commercial interests that are incompatible with those of nursing and service users.

He explores the pharmaceutical companies 'courting' of nurses, which he says is intended to influence prescribing practices, to promote the view that psychiatric drugs are essential, and to sanitise the image of the industry.

He argues that nursing's image, the public trust it enjoys and good relationships with service users may be tarnished unless nurses rethink their relationship with the industry.



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Figure Three: An advertisement for a paper that almost wasn't published

Nurses may not construe their work as having a particularly ethical dimension or they may rationalise or offer a justification for breaching the autonomy of a service user in various ways. However, it has also been found is that education of nurses around ethics appears to enhance ethical activism or nurses attempting to make hospitals more receptive to nurses' participation in ethics deliberations (Dodd, et al., 2004). So by at least raising these various issues in this portfolio or framing some everyday problems as ethical, this might enhance the participation of nurses in ethical decision making.

5.4. Participation and recovery

Encouraging the participation of service users and family/carers is meaningful ways in mental health care also has ethical dimensions. Participation beyond tokenism demonstrates respect for people's autonomy, self-determination, choices and preferences. Shared decision making between service users and

health professionals whereby the expertise of different parties is recognised and mutually acceptable care and treatment options negotiated is a model of practice that has only recently gained widespread interest in mental health services. Schauer et al (2007) state that shared decision making and self-determination are critical components of recovery and active participation is essential in psychiatric rehabilitation. Involving service users and carers in the planning, implementation, delivery and evaluation of mental health services is an expressed aim of policy in the United Kingdom (Dickens et al., 2006) and Australia (Goodwin & Happell, 2008).

How shared decision making can be realised when a person is being compelled to receive treatment, when they are reluctant or under duress, or their capacity to process information or provide informed consent is in question, are ongoing everyday challenges for many mental health workers. Involuntariness of treatment is associated with feeling excluded from treatment decisions (Kallert, 2008). Involving family and carers, particularly in the aforementioned circumstances poses further problems. Goodwin and Happell (2008) describe 'carers' of people experiencing a mental illness as an indispensable part of the mental health workforce and Australian State and Commonwealth policy outlines the rights of carers to participate in mental health services at all levels as partners with health professionals. It has been noted that carers, professionals, and service users can have conflicting views about the nature of problems and how people ought to participate in care (Cleary, Freeman, & Walter, 2006; Goodwin & Happell, 2006). For example, Jakobsen and Severinsson (2006, p.500) in a small qualitative study of parental involvement in community mental health care of adult children in Norway found that some parents believed that community teams did not listen to them, and "...went too far in treating their son or daughter as a responsible individual, put to much faith in his or her words and overtly respected his or her reluctance to accept supervision and help."

The dynamics that can occur within families and between health professionals, families and service users are often complex and any one model of collaboration or involvement is unlikely to meet the needs of everyone. The needs and preferences of family members with adults with mental illness are diverse and the provision of support, information, and care needs to be tailored to individual families (Drapalski et al., 2008). One also needs to be open to the possibility (as I have argued repeatedly) that some problems might better be viewed and treated as shared or relational rather than within one family member. More generally, however, Cleary, Freeman and Walter (2006, p. 190) suggest that simply improving communication between health professionals and carers "...would make caring more rewarding and manageable, improve carers' quality of life, and reduce their feelings of frustration, helplessness, isolation, and resentment". This was one of the main goals of the family participation project reported in this portfolio (Lakeman, 2008b, 2008d) in which significant improvements in the frequency of contact between health professionals and carers did occur and importantly carers were more involved in treatment planning. When interviewed carers also generally valued and commended the contact they had with mental health services.

The family and carer participation project demonstrated that a change in policy mandating prima facie family/carers involvement in adult mental health services did lead to improved services. Although whether or not these improvements were or will be sustained is uncertain. A further significance of the various projects collated in this portfolio relates to the process of participant involvement in the research. Hayman and Fahey (2007) conclude that involving carers in policy and service development has spin offs in terms of improving staff understanding of carer issues. In the carer participation project a consortium of stakeholders including carers, consumers, and advocacy and service organisations collaborated to develop practice standards. Involving service users, family and carers in different ways can

contribute to an ethos of involvement and can bring a welcome openness to mental health systems. Sharfstein and Dickerson (2006) argue that the 'consumer movement' may not have greatly contributed to major policy shifts in mental health in the United States but that 'consumer' involvement has improved care and led to professionals taking greater care in many small ways.

The processes of engagement with both participants and collaborators in the various research projects reported in this portfolio were congruent with values of participation, and mutual respect. In a recently published handbook on service user involvement, a member of the Irish Institute of Mental Health Recovery had the following to say about involvement in the Delphi study on mental health recovery:

...We decided to commission an academic from Dublin City University, to design a Delphi Study in collaboration with the institute to seek the views of groups and individuals... The proposal was worked up together and everybody's voice influenced the process. For me the relationship was built out of respect for me and my experience and respect for my colleagues who also had their own experiences. I felt that I had an equal input into the process which empowered me to collaborate and utilize our collective experiences. My role became more than a former service user, to being a valued member of a group with an equal part in the process. This type of involvement really empowered me and the members of the institute to work together to bring about a change in all our thinking on what recovery and its real potential really could mean to all of our practices, and the recovery pathway for people encountering emotional distress... (Wallcraft, Schrank, & Amering, 2009, p.208)

Actually engaging with people as competent informants or experts and presenting this view in the public sphere may have some influence in subtly

shifting the balance of power in the relationships between health professionals and service users. As Roberts (2009) asserts, the challenge for mental health nurses is to facilitate greater, more active user participation by practicing in a manner that elicits the resources, capabilities and potential that service users possess so that the restrictive sense of psychiatric categories and categorization is transcended or overcome.

Participation in research is another concern furthered in this portfolio. A review of the literature addressing how people lived with or overcame suicidality (Lakeman & Fitzgerald, 2008) revealed a paucity of research which involved engaging directly with suicidal or formally suicidal people. This is an exceptionally important area of research which has the potential to inform the psychotherapeutic work of health and welfare workers and better tailor responses to suicidal people. Participation in research may be considered a right (Happell & Roper, 2007) associated with full citizenship. However, suicidal people are often excluded from research, possibly because suicidality demands a response from researchers and that involving them in research protocols might impede passage through institutional ethics committees. As Warren and Allan (1997) observe 'getting through' ethics committees can cause considerable anxiety. The survey of researchers (Lakeman & Fitzgerald, 2009a) and ethics committee (Lakeman & Fitzgerald, 2009b) members solicited and summarised the main ethical (and sometimes pragmatic) problems associated with suicide research and how these have been addressed. This ought to serve to help people considering undertaking research on suicide or involving suicidal people to consider and address issues to the satisfaction of ethics committees and ensure the safety of participants.

Many people who come to be involved in mental health or other welfare services may be said to experience a form of epistemic injustice (Fricker, 2007). That is their testimony is considered invalid or lacking credibility. In some populations testimony is rarely sought and from some research

paradigms the idea of testimony is irrelevant. In drug trials for example it is exceptionally rare for people's experiences of taking a drug to be explored at all, rather biometric or psychometric measurements are taken from subjects. Todres (2003) proposes that both culture and science enable us to take a view of human identity that focus on 'parts' and to collude with a cultural trend to view humans as objects that fit into efficient systems. Consequently, social systems and institutional responses to problems can evolve without reference to those whom are affected. This is particularly true of two groups who were the focus of research projects in this portfolio, homeless sector workers who had experienced the death of service users and members of new communities in Ireland.

In both examples local and national policy has been developed without being informed by the people affected. The significance of these projects will to some extent depend on how the findings are used. In the sudden death project the next phase (in progress) will involve developing and evaluating interventions to help workers deal with this aspect of their work. In the research involving new communities the members of the communities themselves will directly choose how they use the findings. The communities now have greater capacity to undertake their own research. In both projects, participation had personal benefits for at least some of the participants. Most participants in the sudden death research spontaneously volunteered that they appreciated the opportunity to talk about their experiences (as difficult as that was for some people) and that it was helpful in some way, for example one participant said she felt unburdened and another said it was like counselling. The significance of the various research projects might also be considered in terms of personal benefits with respect to harms. Whilst the personal benefits were unintended they were nevertheless tangible for those involved.

A salutogenic orientation should inform health systems as well as the work of individual practitioners. For example I have argued, that we ought to promote

the right conditions for people to thrive, rather than simply containing people when they become ill (Lakeman, 2008). This is the proper focus of a mental health system. In relation to working with individuals the proper and most productive focus is to consider and try to facilitate the conditions (be they environmental, psychological or interpersonal) to enable the person to recover and thrive. This may involve drawing on, developing or promoting personal resources to enable people to comprehend, manage, and find meaning in their lives. The review of research relating to recovering from or managing suicide (Lakeman & Fitzgerald, 2008), despite dealing with a phenomena at the dis-ease end of the continuum most directly addresses a salutogenic perspective.

Mental health recovery, whilst hard to define, appears to be congruent with a salutogenic orientation. Clearly, however some practices might be considered recovery focused (or salutogenic) and others more illness focused (pathogenic). The main significance of the Delphi study on recovery competencies (apart from realising its expressed aim to identify the most important competencies to inform workforce development) is to demark recovery focused practices from others. To date, there has been little research or critical commentary on how others might help facilitate mental health recovery. Onken et al (2007, p.10) acknowledge that interactions with others can "... help or hinder the ability of the individual to access hope, take action in self determined ways, develop agency, and create meaning and purpose in life pursuits". This is broadly congruent with the competencies identified in the Delphi study. I have previously suggested that some practices such as standardised routine outcome measurement are incompatible with and indeed might impede mental health recovery (Lakeman, 2004). Happell (2008a, 2008b) has explored this further through focus groups with service users and concluded that the outcome measures used routinely in Australia do not necessarily measure the aspects of care and treatment considered useful or beneficial by consumers and are inconsistent with a recovery

approach. It remains to be seen whether the competency set identified as most important by experts by experience are taken up, further developed or elaborated.

5.5. Future directions

Each of the published pieces of work in this portfolio are discrete pieces of work but are also parts of ongoing projects and merely stopping points on a long professional journey. New stages of some projects already beckon. For example, I and colleagues are anticipating developing and evaluating an intervention for homeless sector workers relating to dealing with sudden death; I have several cohorts of students involved in peer group supervision; and I and colleagues have commenced a study examining discrimination and mental health in Ireland. New causes relating to justice and human rights demand attention and as a nurse and neophyte academic finding a balance between teaching, research and practice is a task of ongoing negotiation.

It is interesting to be contemplating pooling these pieces of work together in this portfolio at this time and reflecting on the past few years of labour. I arrived in Ireland at a time of unprecedented and for me bewildering and disorientating growth and optimism in 2007. Unbeknown to me, and it appears those that were responsible for governing this country this was the peak of an economic and social roller coaster ride and in three short years Ireland has become a very different (but perhaps historically familiar) place, being mired in recession, with four hundred thousand people currently unemployed, an ongoing exodus of foreign workers, and public sector workers (such as nurses and lecturers) anticipating further rounds of pay cuts and tax increases. It seems to me that now more than ever this country needs a salutogenic approach to health and well-being, a reinvigoration of and popularization of the traditional nursing concerns relating to creating the right conditions for people to grow, develop and thrive.

This portfolio comprised of commentary and research addresses a range of causes (Donnor, 2005) which have engaged my passion and enthusiasm. Whilst, to some extent opportunistic in terms of project choice they do nevertheless embody and share a concern with promoting ethical practice and research, enhancing collaboration and participation, and clarifying and furthering the proper focus of mental health care. The published work has all been peer reviewed and evaluated as worthy of publication. The body of work demonstrates considerable breadth and depth in terms of applying a range of applied research methods. Not least in importance, I hope that there is at least something within this body of work which might engage the interest of most people with an interest in mental health.

6. References

- Andresen, R., Caputi, P., & Lindsay, O. (2006). Stages of recovery instrument: development of a measure of recovery from serious mental illness. . *Australian & New Zealand Journal of Psychiatry*, 40(11-12), 972-980.
- Antonovsky, A. (1987). *Unraveling the Mystery of Health: How People Manage Stress and Stay Well*. San Francisco: Jossey Bass.
- Antonovsky, A. (1992). Locus of control theory. *Journal of Advanced Nursing*, 17(8), 1014-1015.
- Antonovsky, A. (1993). The structure and properties of the Sense of Coherence scale. *Social Science & Medicine*, 36(6), 725-733.
- Antonovsky, A. (1996). The salutogenic model as a theory to guide health promotion. *Health Promotion International*, 11(1), 11-18.
- Arnold, E. M., & Rotheram-Borus, M. J. (2009). Comparisons of Prevention Programs for Homeless Youth. *Prevention Science*, 10(1), 76-86.
- Barker, P. (1989). Reflections on the philosophy of caring in mental health. *International Journal of Nursing Studies*, 26, 131-141.
- Barker, P. (1999). Where care meets treatment: common ethical conflicts in psychiatric care. In P. Barker (Ed.), *The philosophy and practice of psychiatric nursing* (pp. 199-212). Edinburgh: Churchill Livingstone.
- Barker, P. (2001). The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric & Mental Health Nursing*, 8(3), 233-240.

Barker, P. (2003). The Tidal Model: psychiatric colonization, recovery and the paradigm shift in mental health care. *International Journal of Mental Health Nursing*, 12(2), 96-102.

Barker, P. J., & Baldwin, S. (Eds.). (1991). *Ethical Issues in Mental Health*. Cheltenham, UK: Stanley Thornes (Publishers) Ltd.

Barker, P., & Buchanan-Barker, P. (2005). *The Tidal Model: A guide for mental health professionals*. London: Routledge.

Barker, P., & Buchanan-Barker, P. (2008). The Tidal Commitments: extending the value base of mental health recovery. *Journal of Psychiatric & Mental Health Nursing*, 15(2), 93-100.

Barrowclough, C., Haddock, G., Lowens, I., Connor, A., Pidliswyj, J., & Tracey, N. (2001). Staff expressed emotion and causal attributions for client problems on a low security unit: An exploratory study. *Schizophrenia Bulletin*, 27(3), 517-526.

Beauchamp, T. (1991). *Philosophical Ethics: An Introduction to Moral Philosophy* (2nd ed.). New York: McGraw-Hill.

Bebbington, P. E., & Kuipers, L. (1994). The clinical utility of expressed emotion in schizophrenia. *Acta Psychiatrica Scandinavica*, 89(382), 46-53.

Bergmans, Y., Langley, J., Links, P., & Lavery, J. V. (2009). The perspectives of young adults on recovery from repeated suicide-related behavior. *The Journal of Crisis Intervention and Suicide Prevention*, 30(3), 120-127.

Bickley, H., Kapur, N., Hunt, I. M., Robinson, J., Meehan, J., Parsons, R., et al. (2006). Suicide in the homeless within 12 months of contact with mental health services : a national clinical survey in the UK. *Social Psychiatry & Psychiatric Epidemiology*, 41(9), 686-691.

Blazer, D. G. (2005). *The Age of Melancholy: 'Major Depression' and Its Social Origins*. New York: Routledge Taylor & Francis Group.

Bourdieu, P. (1979). *Distinction: A social critique of the judgement of taste* (R. Nice, Trans.). London: Routledge & Kegan Paul.

Brinded, P. M. J. (2000). Forensic Psychiatry in New Zealand: A Review. *International Journal of Law and Psychiatry*, 23(5-6), 453-465.

Broekaert, E. (2006). What future for the Therapeutic Community in the field of addiction? A view from Europe. *Addiction*, 101(12), 1677-1678.

Brown, L. D. (2009). Making it sane: using narrative to explore theory in a mental health consumer-run organization. *Qualitative Health Research*, 19(2), 243-257.

Bunt, G. C., Muehlbach, B., & Moed, C. O. (2008). The therapeutic community: an international perspective. *Substance Abuse*, 29(3), 81-87.

Burns, T., Creed, F., Fahy, T., Thompson, S., Tyrer, P., & White, I. (1999). Intensive versus standard case management for severe psychotic illness: a randomised trial. UK 700 Group. *Lancet*, 353(9171), 2185-2189.

Burns, T., Fiander, M., Kent, A., Ukoumunne, O. C., Byford, S., Fahy, T., et al. (2000). Effects of case-load size on the process of care of patients with severe psychotic illness. Report from the UK700 trial. *Br J Psychiatry*, 177, 427-433.

Burr, V. (2003). *Social Constructionism* (2nd ed.). Hove, UK: Routledge.

Chadwick, P., & Birchwood, M. (1995a). The omnipotence of voices II: the beliefs about voices questionnaire (BAVQ). *British Journal of Psychiatry*, 166, 773-776.

Chadwick, P., & Birchwood, M. (1995b). The omnipotence of voices: a cognitive

approach to auditory hallucinations. *British Journal of Psychiatry*, 164, 190-201.

Chaplow, D. (2004). Walking the tightrope: perception, fact and inquiry. *Australasian Psychiatry*, 12(4), 320-324.

Chomsky, N. (1967). The responsibility of Intellectuals (<http://www.chomsky.info/articles/19670223.htm>). *The New York Review of Books*, Feb 23.

Christensen, R. C., & Garces, L. K. (2006). Taking issue. Where is the research on homeless persons and suicide? *Psychiatric Services*, 57(4), 447-447.

Clarke, L. (1994). A further critical description of the therapeutic community. *Journal of Clinical Nursing*, 3(5), 279-288.

Clarke, L. (1999). *Challenging ideas in psychiatric nursing*. London: Routledge.

Clarke, L. (2008). *Reading mental health nursing: Education research, ethnicity, & power*. Edinburgh: Elsevier.

Cleary, M., Freeman, A., & Walter, G. (2006). Carer participation in mental health service delivery. *International Journal of Mental Health Nursing*, 15(3), 189-194.

Cochrane-Brink, K., Lofchy, J. S., & Sakinofsky, I. (2000). Clinical rating scales in suicide risk assessment. *General Hospital Psychiatry*, 22(6), 445-451.

Crowe, M., Carlyle, D., & Farmar, R. (2008). Clinical formulation for mental health nursing practice. *Journal of Psychiatric & Mental Health Nursing*, 15(10), 800-808.

Cutcliffe, J., & Lakeman, R. (2010). Challenging Normative Orthodoxies in Depression: Huxley's Utopia or Dante's Inferno? *Archives of Psychiatric Nursing*, 24(2), 114-124.

Cutcliffe, J. R., & Barker, P. (2004). The Nurses' Global Assessment of Suicide Risk (NGASR): developing a tool for clinical practice. *Journal of Psychiatric Mental Health Nursing*, 11(4), 393-400.

Davies, P. (2008). In praise of salutogenesis: the missing component of most public health work. *Journal of Epidemiology & Community Health*, 62(7), 572-572.

Deane, F. P., Crowe, T. P., King, R., Kavanagh, D. J., & Oades, L. G. (2006). Challenges in implementing evidence-based practice into mental health services. *Australian Health Review*, 30(3), 305-309.

Dickens, A., Miles, A., & Watkins, M. (2006). Improving user/carer involvement in commissioning and reviewing mental health services. *Mental Health Review*, 11(1), 16-20.

Department of Health and Children. (2006). *'A Vision for Change': Expert Group on Mental Health Policy* Dublin: Government Publications Office.

Desai, R. A., Liu-Mares, W., Dausey, D. J., & Rosenheck, R. A. (2003). Suicidal ideation and suicide attempts in a sample of homeless people with mental illness. *Journal of Nervous & Mental Disease*, 191(6), 365-371.

Dixon, L., McFarlane, W. R., Lefley, H., Lucksted, A., Cohen, M., Falloon, I., et al. (2001). Evidence-based practices for services to families of people with psychiatric disabilities. *Psychiatric Services*, 52(7), 903-910.

Dodd, S.J., Jansson, B. S., Brown-Saltzman, K., Shirk, M., & Wunch, K. (2004). Expanding Nurses' Participation in Ethics: an empirical examination of ethical activism and ethical assertiveness. *Nursing Ethics*, 11(1), 15-27.

Drapalski, A. L., Marshall, T., Seybolt, D., Medoff, D., Peer, J., Leith, J., et al. (2008). Unmet needs of families of adults with mental illness and preferences regarding family services. *Psychiatric Services, 59*(6), 655-662.

Dziopa, F., & Ahern, K. (2009). What makes a quality therapeutic relationship in psychiatric/mental health nursing: a review of the research literature. *Internet Journal of Advanced Nursing Practice, 10*(1), 1-19.

Elsom, S., Happell, B., & Manias, E. (2006). The clinical nurse specialist and nurse practitioner roles: room for both or take your pick? *Australian Journal of Advanced Nursing, 24*(2), 56-59.

Essex, C. (1994). Nurse in New Zealand reinstated after whistle blowing. *British Medical Journal, 308*(6932), 811a-812.

Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: identifying the critical dimensions. *Community Mental Health Journal, 41*(2), 141-158.

Finfgeld, D. L. (2004). Empowerment of individuals with enduring mental health problems: results from concept analyses and qualitative investigations. *Advances in Nursing Science, 27*(1), 44-52.

Fitzpatrick, K. M., Irwin, J., Lagory, M., & Ritchey, F. (2007). Just Thinking about It: Social Capital and Suicide Ideation among Homeless Persons. *Journal of Health Psychology, 12*(5), 750-760.

Fitzsimons, S., & Fuller, R. (2002). Empowerment and its implications for clinical practice in mental health: a review. *Journal of Mental Health, 11*(5), 481-499.

Foucault, M. (1970). *The Order of Things: An Archaeology of the Human Sciences*. New York: Pantheon.

Foucault, M. (1975). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). New York: Vintage Books.

Foucault, M. (2006). *Psychiatric power: Lectures at the Collège de France 1973-1974* (G. Burchell, Trans.). New York: Palgrave Macmillan.

Fricker, M. (2007). *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford: Oxford University Press.

Gergen, K. J. (1999). *An Invitation to Social Construction*. London: Sage.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. London: Aldine Transaction.

Goffman, E. (1991). *Asylums: Essays on the social situation of mental patients and other inmates* (2nd ed.). New York: Penguin.

Goodwin, V., & Happell, B. (2006). Conflicting agendas between consumers and carers: the perspectives of carers and nurses. *International Journal of Mental Health Nursing*, 15(2), 135-143.

Goodwin, V., & Happell, B. (2008). Psychiatric nurses' attitudes toward consumer and carer participation in care: part 2--barriers to participation. *Policy, Politics, & Nursing Practice*, 9(4), 249-256.

Grant, A. (2006). Undergraduate psychiatric nursing education at the crossroads in Ireland. The generalist vs. specialist approach: towards a common foundation. *Journal of Psychiatric & Mental Health Nursing*, 13(6), 722-729.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. Lincoln, S. (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks, CA, US: Sage Publications.

Hales, A., Karshmer, J., Montes-Sandoval, L., & Fiszbein, A. (1998). Continuing education. Preparing for prescriptive privileges: a CNS-physician collaborative model. Expanding the scope of the psychiatric-mental health clinical nurse specialist. *Clinical Nurse Specialist: The Journal for Advanced Nursing Practice*, 12(2), 73-82.

Happell, B. (2001). Comprehensive nursing education in Victoria: rhetoric or reality? *Journal of Psychiatric & Mental Health Nursing*, 8(6), 507-516.

Happell, B. (2008a). Meaningful Information or a Bureaucratic Exercise? Exploring the Value of Routine Outcome Measurement in Mental Health. *Issues in Mental Health Nursing*, 29(10), 1098-1114.

Happell, B. (2008b). How Do We Know It Works? Mental Health Service Evaluation, Recovery and Routine Outcome Measurement. *International Journal of Psychiatric Nursing Research*, 14(1), unpaginated.

Happell, B. (2007). Appreciating the importance of history: a brief historical overview of mental health, mental health nursing and education in Australia. *International Journal of Psychiatric Nursing Research*, 12(2), 1439-1445.

Happell, B., & Gough, K. (2007). Undergraduate nursing students' attitudes towards mental health nursing: determining the influencing factors. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 25(1-2), 72-81.

Happell, B., Pinikahana, J., & Roper, C. (2003). Changing attitudes: the role of a consumer academic in the education of postgraduate psychiatric nursing students. *Archives of Psychiatric Nursing*, 17(2), 67-76.

Happell, B., & Roper, C. (2003). The role of a mental health consumer in the education of postgraduate psychiatric nursing students: the students' evaluation. *Journal of Psychiatric & Mental Health Nursing*, 10(3), 343-350.

Happell, B., & Roper, C. (2007). Consumer participation in mental health research: articulating a model to guide practice. *Australasian Psychiatry*, 15(3), 237-241.

Harwitz, D., & Ravizza, L. (2000). Suicide and Depression. *Emergency Medicine Clinics of North America*, 18(2), 263-271.

Hatcher, S., Butler, R., & Oakley-Browne, M. (Eds.). (2005). *Evidence-Based Mental Health Care*. Edinburgh: Elsevier.

Haw, C., Hawton, K., & Casey, D. (2006). Deliberate self-harm patients of no fixed abode: a study of characteristics and subsequent deaths in patients presenting to a general hospital. *Social Psychiatry & Psychiatric Epidemiology*, 41(11), 918-925.

Hayman, F., & Fahey, A. (2007). Involving carers in mental health service development. *Australasian Psychiatry*, 15(3), 191-194.

Holmes, C. A. (2006). The slow death of psychiatric nursing: what next? *Journal of Psychiatric & Mental Health Nursing*, 13(4), 401-415.

Hounsell, J., & Owens, C. (2005). User researchers in control. *Mental Health Today*, 29-32.

Huang, M., & Slevin, E. (1999). The experiences of carers who live with someone who has schizophrenia: a review of the literature. *Mental Health & Learning Disabilities Care*, 3(3), 89-93.

Hume, D. (2003). *A Treatise of Human Nature: Being an Attempt to introduce the experimental Method of Reasoning into Moral Subjects* (First Published 1739). 10th Ed. Retrieved 19/8, 2009, from <http://www.gutenberg.org/dirs/etext03/trthn10.txt>

Jakobsen, E. S., & Severinsson, E. (2006). Parents' experiences of collaboration with community healthcare professionals. *Journal of Psychiatric & Mental Health Nursing*, 13(5), 498-505.

JCU. (2009). Doctor of Nursing Science - 79402. Retrieved 12 Dec, 2009, from http://www.jcu.edu.au/nursing/pgresearch/JCUPRD_036344.html

Jones, M. (1956). The concept of a therapeutic community. *American Journal of Psychiatry*, 112(8), 647-650.

Jones, R., Gruer, L., Gilchrist, G., Seymour, A., Black, M., & Oliver, J. (2002). Recent contact with health and social services by drug misusers in Glasgow who died of a fatal overdose in 1999. *Addiction*, 97(12), 1517-1522.

Kallert, T. W. (2008). Coercion in psychiatry. *Current Opinion in Psychiatry*, 21(5), 485-489.

Keen, T., & Lakeman, R. (2008). Collaboration with patients and families. In P. Barker (Ed.), *Psychiatric and mental health nursing: The craft of caring* (2nd ed., pp. 149-161). London: Arnold.

Keith, D. V. (2003). Biometaphorical psychiatry: Family therapy and the poetics of experience. In P. S. Prosky & D. V. Keith (Eds.), *Family Therapy as an Alternative to medication: An Appraisal of Pharmaland* (pp. 3-24). New York: Brunner-Routledge.

Kelly, J. F., Magill, M., & Stout, R. L. (2009). How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behavior change in Alcoholics Anonymous. *Addiction Research & Theory*, 17(3), 236 - 259.

Kent, S., Fogarty, M., & Yellowlees, P. (1995). A review of studies of heavy users of psychiatric services. *Psychiatric Services*, 46(12), 1247-1253.

King, R., Lloyd, C., & Meehan, T. (Eds.). (2007). *Handbook of Psychosocial Rehabilitation*. Oxford: Blackwell.

Kuipers, E. (2006). Family interventions in schizophrenia: Evidence for efficacy and proposed mechanisms of change. *Journal of Family Therapy*, 28(1), 73-80.

Ladson-Billings, G., & Donnor, J. (2005). The moral activist role of critical race theory scholarship. In N. K. Denzin & Y. Lincoln, S. (Eds.), *The Sage Handbook of Qualitative Research* (3rd ed., pp. 279-301). Thousand Oaks, CA: Sage.

Lakeman, R. (1996a). The ethics of bathing. *Kai Tiaki: Nursing New Zealand*, 2(2), 13-15.

Lakeman, R. (1996b). Psychiatric nursing. The Internet: facilitating an international nursing culture for psychiatric nurses. *Computers in Nursing*, 16(2), 87-89.

Lakeman, R. (1997a). Dangerousness & mental illness: The implications for nursing practice. *Vision*, 3(4), 10-14.

Lakeman, R. (1997b). Using the Internet for data collection in nursing research. *Computers in Nursing*, 15(5), 269-275.

Lakeman, R. (1998). Commentary. Beyond glass houses in the desert: a case for a mental health 'care' system. *Journal of Psychiatric and Mental Health Nursing*, 5(4), 324-328.

Lakeman, R. (1999). Commentary on 'Where care meets treatment: common ethical conflicts in psychiatric nursing'. In P. Barker (Ed.), *The philosophy and practice of psychiatric nursing* (pp. 213-216). Edinburgh: Churchill Livingstone.

Lakeman, R. (2000a). Advanced nursing practice: experience, education and something else. *Journal of Psychiatric and Mental Health Nursing*, 7(1), 89-94.

Lakeman, R. (2000b). Charting the future today: psychiatric and mental health nurses in cyberspace. *Australian and New Zealand Journal of Mental Health Nursing*, 9(1), 42-50.

Lakeman, R. (2000c, 3-7 September). *Coping with voices: An explanatory pilot study*. Paper presented at the Australian and New Zealand College of Mental Health Nurses 26th International Conference - Mental Health Nurses for a Changing World: Not just Surviving Broadbeach, Queensland [Online: <http://www.geocities.com/psynurse.geo/papers/HPCope.htm>].

Lakeman, R. (2000d, 3-7 September). *Nurses are more than tools: instrumentality and implications for nursing ethics*. Paper presented at the Australian and New Zealand College of Mental Health Nurses 26th International Conference - Mental Health Nurses for a Changing World: Not just Surviving., Broadbeach, Queensland. URL: http://www.testandcalc.com/Richard/resources/Nurses_as_tools-Paper_ANZCMHN_2000.pdf.

Lakeman, R. (2001a, 21-22nd Nov). *Getting our ACT together (Plenary workshop)*. Paper presented at the Does Community Care Work? An International Mental Health Conference, Wanganui Convention Centre, NZ [Online: [http://www.testandcalc.com/Richard/resources/Lakeman%20\(2001\)%20Getting%20Our%20Act%20Together%20-%20Paper.pdf](http://www.testandcalc.com/Richard/resources/Lakeman%20(2001)%20Getting%20Our%20Act%20Together%20-%20Paper.pdf)]

Lakeman, R. (2001b, 1 Sep). *The internet and nursing: Research and reflection (Presented by videoconference)*. Paper presented at the Network of Psychiatric Nursing Research (NPNR) 7th Annual Conference, Oxford, U.K.

Lakeman, R. (2001c). Making sense of the voices. *International Journal of Nursing Studies*, 38(5), 523-531.

Lakeman, R. (2001d). Towards Assertive Community Care. <http://www.nq->

anzcmhn.org/papers/act.htm. Retrieved 14/12, 2007

Lakeman, R. (2002, 18 - 20 Sep). *Psychiatric nursing in a shrinking world: The impact and implications of the Internet and computer mediated communication on the field of psychiatric nursing practice, research and education (Plenary)*. Paper presented at the Royal College of Nurses, 8th International Network of Psychiatric Nursing Research Conference: Research Journeys: Travelling Together, St Cross Building, Oxford, UK.

Lakeman, R. (2004). Standardized routine outcome measurement: Pot holes in the road to recovery. *International Journal of Mental Health Nursing*, 13(4), 210-215.

Lakeman, R. (2006). An anxious profession in an age of fear. *Journal of Psychiatric and Mental Health Nursing*, 13(4), 395-400.

Lakeman, R. (2006a, 30 Aug - 1 Sep). *Enhancing family & carer participation in mental health care: The impact of practice standards*. Paper presented at the 16th Annual TheMHS Conference: Reach Out - Connect. , Townsville Convention Centre, North Queensland, Australia

Lakeman, R. (2006b, 30 Aug - 1 Sep). *I am different hear me roar: A critical examination of trends towards standardised treatment and homogenised care*. Paper presented at the 16th Annual TheMHS Conference: Reach Out - Connect. , Townsville Convention Centre, North Queensland, Australia

Lakeman, R. (2008a). Ethics and nursing. In P. Barker (Ed.), *Psychiatric and mental health nursing: The craft of caring* (2nd ed., pp. 607-617). London: Arnold.

Lakeman, R. (2008b). Family and carer participation in mental health care: perspectives of consumers and carers in hospital and home care settings. *Journal of Psychiatric and Mental Health Nursing*, 15(3), 203-211.

Lakeman, R. (2008c). The medium, the message, and evidence based practice. *Issues in Mental Health Nursing*, 29(3), 319–327.

Lakeman, R. (2008d). Practice standards to improve the quality of family and carer participation in adult mental health care: An overview and evaluation *International Journal of Mental Health Nursing*, 17(1), 44-56.

Lakeman, R. (2008e, 7-9 October). *Suicide research and the ethics of engagement*. Paper presented at the 34th International Conference of the Australian College of Mental Health Nurses: 'Mental Health Nursing - A Broad Canvas: The art of mental health nursing in the age of technology and science', Melbourne.

Lakeman, R. (2009a, 24-25 September). *A bad outcome: A discussion about research, outcome measurement and suicide [Keynote]*. Paper presented at the Mental Health service users and research: Measuring success – different perspectives (RCN International Network for Psychiatric Nursing Research (NPNR) Conference), St Cross Building, University of Oxford.

Lakeman, R. (2009b, 4 - 5 November). *What health professionals need to do to help people in mental health recovery: Consensus from experts by experience [Keynote]*. Paper presented at the Making thriving a reality: Towards and beyond mental health recovery Brookfield Health Sciences Complex, University College Cork, Cork, Ireland.

Lakeman, R. (2010a). Mental health nursing is not for sale: Rethinking nursing's relationship with the pharmaceutical industry. *Journal of Psychiatric & Mental Health Nursing*, 17(2), 172-177.

Lakeman, R. (2010b). Mental Health Recovery Competencies for Mental Health Workers: A Delphi study. . *Journal of Mental Health*, 19(1), 62-74.

Lakeman, R., & Curzon, B. (1997). Society, disturbance and mental illness. In

P. Barker & B. Davidson (Eds.), *Ethical Strife* (pp. 26-38). London: Arnold.

Lakeman, R., & Cutcliffe, J. (2009). Misplaced epistemological certainty and pharmaco-centrism in mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 16*(2), 199-205.

Lakeman, R., & FitzGerald, M. (2008). How people live with or get over being suicidal: a review of qualitative studies. *Journal of Advanced Nursing, 64*(2), 114-126.

Lakeman, R., & Fitzgerald, M. (2009a). Ethical suicide research: a survey of researchers. *International Journal of Mental Health Nursing, 18*(1), 10-17.

Lakeman, R., & Fitzgerald, M. (2009b). The ethics of suicide research. *Crisis: The Journal of Crisis Intervention & Suicide Prevention, 30*(1), 13-19.

Lakeman, R., & Glasgow, C. (2009). Introducing peer-group clinical supervision: An action research project. *International Journal of Mental Health Nursing, 18*(3), 204–210.

Lakeman, R., Matthews, A., Munck, R., Redmond, M., Sanders, T., & Walsh, J. (2008). *New communities and mental health in Ireland: A needs analysis*. Dublin Ireland: Dublin City University.

Lakeman, R., Matthews, A., Munck, R., Redmond, M., Sanders, T., & Walsh, J. (2009, 16-18 April). *New communities and mental health: conversations, conceptions and concerns*. Paper presented at the The British Sociological Association Annual Conference, Cardiff City Hall, Cardiff.

Lakeman, R., & Murray, P. (2000, 28 April - 3 May). *The internet and its impact on nursing: Research and reflection on the benefits and pitfalls of computer-mediated communication*. Paper presented at the 7th International Congress of Nursing Informatics - One step beyond: The evolution of technology and

nursing, Aotea Centre, Auckland, NZ.

Lakeman, R., Walsh, J., & McGowan, P. (2007). Service users, authority, power and protest: a call for renewed activism. *Mental Health Practice*, 11(4), 12-16.

Langeland, E., Riise, T., Hanestad, B. R., Nortvedt, M. W., Kristoffersen, K., & Wahl, A. K. (2006). The effect of salutogenic treatment principles on coping with mental health problems: a randomised controlled trial. *Patient Education & Counseling*, 62(2), 212-219.

Langeland, E., Wahl, A. K., Kristoffersen, K., & Hanestad, B. R. (2007). Promoting coping: salutogenesis among people with mental health problems. *Issues in Mental Health Nursing*, 28(3), 275-295.

LeBel, J. (2006). Seclusion & Restraint - Rediscovering Pathways to Compassionate Care. *American Academy of Child & Adolescent Psychiatry News*, Jan/Feb([Online]
http://www.aacap.org/cs/root/member_information/practice_information/jan/feb_2006_aacap_news_seclusion_restraint_rediscovering_pathways_to_compassionate_care).

Leonard, K. L. (2008). Is patient satisfaction sensitive to changes in the quality of care? An exploitation of the Hawthorne effect. *Journal of Health Economics*, 27(2), 444-459.

Lindstrøm, B., & Eriksson, M. (2005). Salutogenesis. *Journal of Epidemiology & Community Health*, 59(6), 440-442.

Main, T. F. (1957). The Ailment. *British Journal of Medical Psychology*, 30(3), 129-145.

Main, T. F. (1983). The concept of the therapeutic community: Variation and vicissitudes. In M. Pines (Ed.), *The Evolution of Group Analysis* (pp. 197-217).

London: Routledge and Kegan Paul.

Marriner-Tomey, A., & Alligood, M. R. (2005). *Nursing Theorists and Their Work* (6th ed.). St. Louis: Mosby, Inc.

Marshall, M., & Lockwood, A. (2000). Assertive community treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews*, CD001089.

McAndrew, S., & Samociuk, G. A. (2003). Reflecting together: developing a new strategy for continuous user involvement in mental health nurse education. *Journal of Psychiatric & Mental Health Nursing*, 10(5), 616-621.

McLuhan, M. (1994). *Understanding Media: The Extensions of Man*. Cambridge, Massachusetts: The MIT Press.

Meehan, J., Kapur, N., Hunt, I. M., Turnbull, P., Robinson, J. O., Bickley, H., et al. (2006). Suicide in mental health in-patients and within 3 months of discharge: National clinical survey. *The British Journal of Psychiatry*, 188(2), 129-134.

Melia, K. M. (1994). The task of nursing ethics. *Journal of Medical Ethics*, 20(1), 7-11.

Mental Health Commission. (2005). *A Vision for a Recovery Model in Irish Mental Health Services*. Dublin: Mental Health Commission.

Menzies-Lyth, I. (1988). The functioning of social systems as a defence against anxiety. In I. Menzies-Lyth (Ed.), *Containing anxiety in institutions. Selected essays* (Vol. 1, pp. 43-85). London: Free Association Books.

Ministry of Health. (1997). *Guidelines to the Mental Health (Compulsory Assessment & Treatment) Act 1992*. Wellington, NZ: Ministry of Health, Mental

Health Services.

Mistral, W., Hall, A., & McKee, P. (2002). Using therapeutic community principles to improve the functioning of a high care psychiatric ward in the UK. *International Journal of Mental Health Nursing*, 11(1), 10-17.

Morrall, P. (1998). *Mental health nursing and social control*. London: Whurr Publishers.

Morrison, E. F. (1990). The tradition of toughness: a study of nonprofessional nursing care in psychiatric settings. *Image: Journal of Nursing Scholarship*, 22(1), 32-38.

Morrison, E. F. (1992). A coercive interactional style as an antecedent to aggression in psychiatric patients. *Research in Nursing & Health*, 15(6), 421-431.

Morrison, E. F. (1993). Toward a better understanding of violence in psychiatric settings: debunking the myths. *Archives of Psychiatric Nursing*, 7(6), 328-335.

Morrison, E. F. (1994). The evolution of a concept: aggression and violence in psychiatric settings. *Archives of Psychiatric Nursing*, 8(4), 245-253.

NICE. (2004). *Depression: management of depression in primary and secondary care*. London: National Institute for Health and Clinical Excellence.

Neale, J. (2000). Suicidal intent in non-fatal illicit drug overdose. *Addiction*, 95(1), 85-93.

Nielsen, P., Lakeman, R., & Quadrell, M. (2001, 2-3 June). *Promoting growth and development in a harsh climate*. Paper presented at the The North Queensland Sub-branch of the Australian and New Zealand College of Mental Health Nurses Winter Symposium, Novotel, Palm Cove, Cairns.

Nolan, P. (1993). *A history of mental health nursing*. Cheltenham, UK: Stanley Thornes Publishers.

NZ Mental Health Commission. (1998). *Blueprint for Mental Health Services in New Zealand: How Things Need to Be*. Wellington, NZ: NZ Mental Health Commission.

O'Brien, A. J., & Golding, C. G. (2003). Coercion in mental healthcare: the principle of least coercive care. *Journal of Psychiatric & Mental Health Nursing*, 10(2), 167-173.

O'Hagan, M. (2004). Recovery in New Zealand: Lessons for Australia? *Australian e-Journal for the Advancement of Mental Health (AeJAMH)*, 3(1), <http://www.auseinet.com/journal/vol3iss1/ohaganeditorial.pdf>.

O'Shea, Y. (2009). Book Summary: Clinical directorates in the Irish health service: managing resources and patient safety. *NCNM Review (National council for the Development of nursing and midwifery)*(32), i-iv.

Oades, L., Deane, F., Crowe, T., Lambert, W. G., Kavanagh, D., & Lloyd, C. (2005). Collaborative recovery: an integrative model for working with individuals who experience chronic and recurring mental illness. *Australasian Psychiatry*, 13(3), 279 - 284.

Ochocka, J., Janzen, R., & Nelson, G. (2002). Sharing power and knowledge: professional and mental health consumer/survivor researchers working together in a participatory action research project. *Psychiatric Rehabilitation Journal*, 25(4), 379-387.

Onwumere, J., Kuipers, E., Bebbington, P., Dunn, G., Freeman, D., Fowler, D., et al. (2009). Patient perceptions of caregiver criticism in psychosis: Links with patient and caregiver functioning. *Journal of Nervous and Mental Disease*, 197(2), 85-91.

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: a review of the literature. *Psychiatric Rehabilitation Journal*, 31(1), 9-22.

Ortelli, T. A. (2006). Defining the professional responsibilities of academic nurse educators: the results of a national practice analysis. *Nurse Education Perspectives*. Retrieved 10-12, 2009, from http://findarticles.com/p/articles/mi_hb3317/is_5_27/ai_n29324915/?tag=content;col1

Paley, J. (1998). Misinterpretive phenomenology: Heidegger, ontology and nursing research. *Journal of Advanced Nursing*, 27, 817-824.

Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing psychopathology*. London: Sage.

Peplau, H. E. (1952). *Interpersonal Relations in Nursing*. Putnam: New York.

Peplau, H. E. (1989a). The history of milieu as a treatment modality. In A. W. O'Toole & S. R. Welt (Eds.), *Interpersonal Theory in Nursing Practice: Selected Works of Hildegard E. Peplau* (pp. 75-79). New York: Springer.

Peplau, H. E. (1989b). Psychiatric Nursing: Role of Nurses and Psychiatric Nurses. In A. W. O'Toole & S. R. Welt (Eds.), *Interpersonal theory in nursing practice* (pp. 120-133). New York: Springer Publishing.

Peter Ellis Website. (2007). Allegations of Abuse in Institutions. Retrieved 18/8, 2009, from <http://www.peterellis.org.nz/Institutions/Psychiatric/2006/index.htm>

Pharoah, F., Mari, J., Rathbone, J., & Wong, W. (2006). Family intervention for schizophrenia. *Cochrane Database of Systematic Reviews*, CD000088.

Porter, R. (2004). *Madmen: A social history of madhouses, mad-doctors & lunatics*. Stroud, Gloucestershire: Tempus Publishing.

Prebble, K. (2001). On the brink of change? Implications of the review of undergraduate education in New Zealand for mental health nursing. *Australian & New Zealand Journal of Mental Health Nursing*, 10(3), 136-144.

Princeton University. (n.d.). Dictionary.com. WordNet® 3.0. Retrieved Dec 19, 2009, from <http://dictionary.reference.com/browse/rationalisation>

Proctor, K., & Welbourn, T. (2004). Guest editorial: time to cut the apron strings? -- the future of mental health nurse training. *Journal of Clinical Nursing*, 13(4), 411-412.

Prosky, P. S. (2003). When more is less: A common difficulty in collaborative treatment of human distress. In P. S. Prosky & D. V. Keith (Eds.), *Family Therapy as an Alternative to medication: An Appraisal of Pharmaland* (pp. 25-36). New York: Brunner-Routledge.

Qin, P., & Nordentoft, M. (2005). Suicide Risk in Relation to Psychiatric Hospitalization: Evidence Based on Longitudinal Registers. *Archives of General Psychiatry*, 62(4), 427-432.

Read, J., Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, 112(5), 330-350.

Read, L., Mosher, L. R., & Bentall, R. P. (Eds.). (2004). *Models of Madness: Psychological, social and biological approaches to schizophrenia*. London: Routledge.

Repper, J., Felton, A., Hanson, B., Stickley, T., & Shaw, T. (2001). One small step towards equality: involving users in education is a good start to the

massive task of changing professionals' attitudes to people with mental health problems. *Mental Health Today*, 24-27.

Richardson, G. (2008). Coercion and human rights: a European perspective. *Journal of Mental Health*, 17(3), 245-254.

Rickwood, D. (2004). Recovery in Australia: Slowly but surely. *Australian e-Journal for the Advancement of Mental Health (AeJAMH)*, 3(1), <http://www.auseinet.com/journal/vol3iss1/rickwoodeditorial.pdf>.

Roberts, M. (2009). Service user involvement and the restrictive sense of psychiatric categories: the challenge facing mental health nurses. *Journal of Psychiatric and Mental Health Nursing, Online*(Early View).

Robinson, J., Cotton, S., Conus, P., Schimmelmann, B. G., McGorry, P., & Lambert, M. (2009). Prevalence and predictors of suicide attempt in an incidence cohort of 661 young people with first-episode psychosis. *Australian & New Zealand Journal of Psychiatry*, 43(2), 149-157.

Rodgers, J. A. (1985). *Nursing education in New Zealand, 1883 to 1930: The persistence of the Nightingale ethos. (Masters Thesis)*. Massey University, Palmerston North.

Roper, C., & Happell, B. (2007). Reflection without shame -- reflection without blame: towards a more collaborative understanding between mental health consumers and nurses. *Journal of Psychiatric & Mental Health Nursing*, 14(1), 85-91.

Saitz, R., Gaeta, J., Cheng, D. M., Richardson, J. M., Larson, M. J., & Samet, J. H. (2007). Risk of mortality during four years after substance detoxification in urban adults. *Journal of Urban Health-Bulletin of the New York Academy of Medicine*, 84(2), 272-282.

- Samuelsson, M., Wiklander, M., Asberg, M., & Saveman, B. I. (2000). Psychiatric care as seen by the attempted suicide patient. *Journal of Advanced Nursing*, 32(3), 635-643.
- Schön, D. A. (1987). *Educating the Reflective Practitioner: Toward a new design for teaching and learning in the professions*. San Francisco: Jossey-Bass.
- Schauer, C., Everett, A., del Vecchio, P., & Anderson, L. (2007). Promoting the value and practice of shared decision-making in mental health care. *Psychiatric Rehabilitation Journal*, 31(1), 54-61.
- Sharfstein, S. S., & Dickerson, F. B. (2006). Psychiatry and the consumer movement. *Health Affairs*, 25(3), 734-736.
- Simpson, A. (2006). Involving service users and carers in the education of mental health nurses. *Mental Health Practice*, 10(4), 20-24.
- Spindel, P., & Nugent, J. (2001). The trouble with PACT: Questioning the increasing use of assertive community treatment teams in community mental health. Retrieved 14.02.01, 2001, from <http://akmhweb.org/Articles/pact.htm>
- Stacey, G., Joynson, K., & Diamond, B. (2008). *A narrative inquiry exploring the values of mental health nurses working in in-patient settings*. Nottingham: The University of Nottingham.
- Strauss, A., & Corbin, J. (1992). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sociology Press.
- Stewart, S., Watson, S., Montague, R., & Stevenson, C. (2008). Set up to fail? Consumer participation in the mental health service system. *Australasian Psychiatry*, 16(5), 348-353.

Stout, C. E., & Hayes, R. A. (Eds.). (2005). *The Evidence-Based Practice: Methods, Models, and Tools for Mental Health professionals*. New Jersey: John Wiley & Sons, Inc.

Svenaeus, F. (2009). The ethics of self-change: becoming oneself by way of antidepressants or psychotherapy? *Medicine, Health Care & Philosophy*, 12(2), 169-178.

Szasz, T. (1994). Psychiatric diagnosis, psychiatric power and psychiatric abuse. *Journal of Medical Ethics*, 20, 135-138.

Szasz, T. S. (1973). *The manufacture of madness*. Rogmore, Syt Albans: Paladin.

Szasz, T. S. (2003). *The myth of mental illness: Foundations of a theory of conduct (Revised Edition)*. New York: Perennial.

Szasz, T. S. (2007). *Coercion as cure: A critical history of psychiatry*. New Brunswick: Transaction Publishers.

Tennant, D. (1993). The place of the family in mental health nursing: past, present and future. *Journal of Advanced Nursing*, 18(5), 752-758.

The Sainsbury Centre for Mental Health. (2001). *Mental Health Topics: Assertive Outreach*. London: The Sainsbury Centre for Mental Health.

Todres, L. (2003). Humanising forces: phenomenology in science; psychotherapy in technological culture. *Counselling & Psychotherapy Research*, 3(3), 196-203.

Votta, E., & Manion, I. (2004). Suicide, high-risk behaviors, and coping style in homeless adolescent males' adjustment. *Journal of Adolescent Health*, 34(3), 237-243.

Vuckovich, P. K., & Artinian, B. M. (2005). Justifying coercion. *Nursing Ethics*, 12(4), 370-380.

Waddell, C. (2002). So much research evidence, so little dissemination and uptake: mixing the useful with the pleasing. *Evidence Based Nursing*, 5(2), 38-40.

Wallcraft, J., Schrank, B., & Amering, M. (Eds.). (2009). *Handbook of Service User Involvement in Mental Health Research*. Chichester, UK: John Wiley & Sons.

Walsh, J., & Boyle, J. (2009). Improving acute psychiatric hospital services according to inpatient experiences. A user-led piece of research as a means to empowerment. *Issues in Mental Health Nursing*, 30(1), 31-38.

Walsh, J., Lakeman, R., & McGowan, P. (2009, 15-17 April). *Outside in to inside out: The assimilation and attenuation of the service user movement*. Paper presented at the Alternative futures and popular protest (14th International Conference), Manchester Metropolitan University.

Walsh, J., McGowan, P., & Lakeman, R. (2007, 10-12 Sep). *I had a dream (but I got committee membership): authority, representativeness, collusion and protest in the service user movement*. Paper presented at the Thinking, Feeling, Being: Critical Perspectives and Creative Engagement in Psychosocial Health, Dublin City University, Ireland.

Warne, T., & McAndrew, S. (2007). Passive patient or engaged expert? Using a Ptolemaic approach to enhance mental health nurse education and practice. *International Journal of Mental Health Nursing*, 16(4), 224-229.

Warner, J. (2004, 2 Sep). *George Bush, Jon Stewart and Michel Foucault: Laughter as Political Problematization*. Paper presented at the annual meeting of the American Political Science Association, Hilton Chicago and the Palmer

House Hilton, Chicago, IL. Online:

http://www.allacademic.com/meta/p_mla_apa_research_citation/0/6/0/8/3/p60835_index.html.

Warren, R., & Allan, J. (1997). Clinical note. Getting through ethics committees: partnerships between researchers and clinicians working with mentally ill clients. *Australian & New Zealand Journal of Mental Health Nursing*, 6(1), 37-43.

Wearden, A. J., Tarrier, N., Barrowclough, C., Zastowny, T. R., & Rahill, A. A. (2000). A review of expressed emotion research in health care. *Clinical Psychology Review*, 20(5), 633-666.

Whittington, R., Bowers, L., Nolan, P., Simpson, A., & Neil, L. (2009). Approval ratings of inpatient coercive interventions in a national sample of mental health service users and staff in England. *Psychiatric Services*, 60(6), 792-798.

Williams, M. (2009). Social objectives, causality and contingent realism. *Journal for the Theory of Social Behaviour*, 39(1), 1-18.

Wilson, E. (2003). 'Eccentric and Idiosyncratic Treatment Philosophies': The Therapeutic Community at Townsville's Ward 10B, Queensland, 1973-87. *Health & History*, 5(2), 60-74.

Wood, J., & Wilson-Barnett, J. (1999). Focus. The influence of user involvement on the learning of mental health nursing students. *NT Research*, 4(4), 257-270.

Wynaden, D., Ladzinski, U., Lapsley, J., Landsborough, I., Butt, J., & Hewitt, V. (2006). The caregiving experience: how much do health professionals understand? *Collegian*, 13(3), 6-10.

Wynaden, D., Orb, A., McGowan, S., & Downie, J. (2000). Are universities preparing nurses to meet the challenges posed by the Australian mental health

care system? *Australian and New Zealand Journal of Mental Health Nursing*, 9(3), 138-146.

Yarling, R. R., & McElmurry, B. J. (1986). The moral foundation of nursing. *Advances in Nursing Science*, 8(2), 63-73.

Ziguras, S. J., & Stuart, G. W. (2000). A meta-analysis of the effectiveness of mental health case management over 20 years. *Psychiatric Services*, 51(11), 1410-1421.