Revisiting the past:
A focused ethnography
of contemporary dual diagnosis
nursing practice

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A thesis submitted in partial fulfillment of the requirements of the degree
of Master of Nursing at Otago Polytechnic, Dunedin, New Zealand

August 2005

*We shall not cease from our
exploration
And the end of all our exploring
Will be to arrive where we
started
And know the place for the first
time.*

(T. S. Eliot, 1944)

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ABSTRACT

As has been the case internationally, deinstitutionalisation of dual diagnosis (intellectual disability and mental illness) services has also occurred in New Zealand. Inpatient services have been redefined to respond to the more acute focus that has arisen out of this deinstitutionalisation process and nurses are having to redefine their roles in response.

This study was undertaken to explore and describe the culture of nursing practice in a dual diagnosis inpatient unit in one psychiatric hospital. A focused ethnographic approach was used to triangulate data gathered from fieldwork observations, review of documents and semi structured interviews. Schein's (1985) levels of culture model, was used to identify and explore the artifacts, values and assumptions evident in this nursing practice.

Analysis presents three key themes categorised as 'communication', 'assessment' and 'safety'. While these key themes are shown to be evident in the everyday practice of the nurses, how these relate to the notion of 'dual diagnosis nursing' is not clear. Therefore the major finding of this study reveals a nursing culture holding tight to traditional psychiatric and psychopaedic nursing practices and struggling to develop a distinctive culture in the absence of a defined dual diagnosis knowledge base. These findings suggest an urgent need to provide nurses with support in gaining contemporary knowledge regarding dual diagnosis nursing. Support for nurses in advancing these areas then impacts on support for the patients. It is suggested that additional research is undertaken to assess the learning needs of the nurses in order to develop clinical practice guidelines for this area. Further recommendations are made to address system issues which are contributing to the gap in knowledge.

KEY TERMS

Intellectual disability: is the term used in New Zealand for persons with an identified intellectual or developmental deficit. It is important to note that throughout the literature other English language nomenclature uses the terms 'mental retardation', 'developmentally disordered' or 'learning disabilities' and these terms may be read interchangeably in referenced material throughout this thesis.

Whilst I have attempted to use value free language this has been difficult. The use of terms such as 'disability', 'illness' and 'disorder' are used as contemporary to the time being discussed or according to the reference being cited. Where possible I have referred to those who have been diagnosed with 'disabilities' using person first language.

Patient: The current preference of consumers for mental health services regarding classifications of title is either 'consumer' or 'service user'. Consumers who identify as Maori mostly prefer 'tangata whaiora' [person seeking wellness]. Whilst I am aware that 'patient' has a disempowering connotation to some I have chosen to use this term for no actual reason other than it fits best with the term inpatient (in distinguishing the field of study) and makes the reading of the text less messy or confusing. This is the term used also most often by the study participants. My apologies to those consumers who prefer other terms.

Nursing Titles: It is also necessary to note that in this thesis I will follow this convention regarding international nomenclature also in relation to nursing titles. The professional group I refer as Intellectual Disability nurses have also been called mental retardation nurses, mental deficiency nurses, subnormality nurses, handicap nurses and psychopaedic nurses. The different terms evident will be in regard to the particular period being discussed or as cited in the literature. My preference is to use the term dual diagnosis nurses in line with the classification term used in New Zealand for persons diagnosed with such.

Nurses working with persons with mental illness are referred to as psychiatric nurses or mental health nurses. The contemporary preference is mental health nurse as it infers a positive wellness suggestion to the role. Therefore, I have elected to use the term mental health nurse however the term psychiatric nurse will be evident if cited as such in the literature.

The term dual diagnosis nurses will be used to ensure a complete distinction to the previous two singular disciplines and will refer only to nurses working with persons diagnosed with a mental illness and intellectual disability.

Gender: There are only a few male registered nurses working within the unit therefore it was important to ensure anonymity for them and so gender neutral language was used. Where necessary this has been maintained by the use of **s/he.**

KEY TO TRANSCRIPTS

The following abbreviations and rules have been used in the presentation of the research findings, including the excerpts from the transcripts of interviews with staff.

Names	Pseudonyms have been used for the names of all patients.
Italics	*Words used by the study participants*
SNA	Nurses are identified only by the use of a code e.g. (SN = Staff Nurse) A, B etc
CT	Indicates researcher
[Square brackets] or clarity.	Comments made by the researcher to provide explanation
... // ...	Material edited out.
RCpN	Registered Comprehensive Nurse
RPN	Registered Psychiatric Nurse
RPdN	Registered Psychopaedic nurse
EN	Enrolled Nurse

CHAPTER ONE Prelude to the journey

The discipline of nursing, like any other discipline, holds shared common meanings concerning taken – for - granted knowledge about how things are understood and done. These meanings make up what it means to be a nurse and, therefore, powerfully and profoundly penetrate nursing culture.

(Street, 1992, p. 267)

Introduction

Treatment and care provision in the fields of intellectual disability and psychiatry has undergone significant change over the last century. This has involved a shift from a predominantly institutional custodial milieu to a community based approach and nurses now work within a diverse range of services (Cleary, 2003; Higgins, 2004). Juxtaposed with this shift, inpatient services have also changed and nurses working within inpatient services are reviewing and at times reconstructing their roles. This study focuses on a group of registered nurses who work in one of these areas of change; a dual diagnosis inpatient unit in New Zealand.

The term 'dual diagnosis' can be misleading as it may be used in many other health contexts, for example it is frequently used to describe co-existing substance misuse with a mental health problem. The term 'dual diagnosis', as used in this study, is the idiom used to describe the presence of a mental illness concurrent with an intellectual disability (Einfeld, 1997; Mohr, Phillips, Curran & Rymill, 2002; Taylor, Hatton, Dixon & Douglas, 2004).

Personal beginnings

The roots of this study are embedded in my eight years experience working as a registered nurse in a dual diagnosis inpatient unit; the last four of those years as clinical nurse coordinator. The people with a dual diagnosis that I cared for presented me with diverse health care requirements that were in contrast to my

previous experiences in generic mental health services and I recall the complexities of the role. These complexities were chiefly related to understanding what was happening for an individual with an intellectual disability and an assumed mental illness and how to understand the impact of this mental illness on the person who may not be able to communicate this easily. As Reiss, Levitan and Szyszko (1982) explain, for some persons with an intellectual disability, symptoms of a mental illness are not always as easily presented or discerned. Although it was this complexity that interested me and offered me the most challenges in providing best care, I recall the frustration at times regarding the lack of information, particularly in relation to understanding this comorbidity, to inform my practice. I entered this field of nursing believing I was well equipped with knowledge of mental health and illness from my previous comprehensive nursing education and mental health nursing experience. I had undertaken a comprehensive education programme which provided me also with sound general health knowledge. Most often the only sources of information related to understanding dual diagnosis were the medical registrars, psychiatrists and medical classification tools, and therefore I continuously sought a nursing knowledge and evidence of best nursing practice to guide my work; however there was little to be found.

The unit I worked on was part of a wider psychiatric service and whilst there was mental health in-service education and training available, again there was no education or training specific to understanding and working with persons with a dual diagnosis. I often attended the in-service sessions and returned to my role grappling with the difficulty of relating this generic mental health knowledge to my work. There were no specific courses available locally to provide me with the information I desired and I relied on the few articles I could access through the library and the out dated texts in the unit. The unit was a busy place and finding time to read any of this limited information was a luxury that didn't often transpire. I continued nursing the people the best I knew how, never really

satisfied I fully understood all the needs of the patients. About this time I had also begun to advance my nursing qualifications in a generic sense and was conscious of the importance of evidence based practice.

In 1998, I was fortunate to attend an international forum '*On the Dawn of a New Era; Reflecting on the Past, Moving toward the Future'* related to health care and service provision in dual diagnosis. I returned from this with a broader understanding of how intellectual disability may impact on a person; how various mental disorders may manifest in persons with intellectual disability and the specific needs of some individuals. I felt enthusiastic and eager to use and share this knowledge to both inform my work and assist other nurses similarly. Unfortunately this fervour was not shared by the nurses, possibly as they had not had such opportunities. Attempts at starting up journal clubs lasted only one or two sessions. Reading or even understanding some of the literature and taking time out of one's day to take part in such things were new phenomena to some of the nurses in this area. They reminded me of the limited available time to respond to events outside the daily requirements of their roles. A 'Provincial Executive Group' of clinicians and managers from intellectual disability and dual diagnosis services from various parts of the country was set up to discuss the issues that arose regarding service provision for persons in the dual diagnosis services. However, this also did little to enhance the nurses' knowledge as the group was restricted to senior clinicians and management.

Since leaving the dual diagnosis clinical setting and transferring to my current role in nursing and health care education I have retained an interest in both mental health and intellectual disability healthcare. My teaching includes theoretical education and clinical supervision for undergraduate nursing students undertaking clinical experience with persons with intellectual disabilities. Whilst this is an important part of their nursing education what is evident is that nurses

are not prepared to work specifically in dual diagnosis and receive no particular education for this.

As part of my Masters study I undertook a paper that required me to articulate and define my scope of practice. At that time my scope had extended to include my role in education but I also attempted to do this in relation to my previous role. It was then I realised the difficulties in really understanding my previous nursing practice in dual diagnosis. I began to ask "What is this thing called Dual Diagnosis nursing?" and wondered whether I had been nursing within a psychiatric model or was it intellectual disability nursing? I was not at all clear; my insights and experiences had become historical. It became obvious to me then that those best positioned to describe this nursing practice were those who are currently performing this work; the nurses in the field.

The political climate

Aside from the personal motivations already discussed there are other significant external rationales for this study. People with a dual diagnosis represent a diverse and special population among persons with intellectual disability or mental illness. The current evidence base for mental health care for persons with intellectual disability remains unconvincing and inconsistent (Bouras & Holt, 2004; Chaplin, 2004). Mohr, et al., (2002) maintain that service provision for persons with dual diagnosis is one of the most neglected areas of healthcare in Australia. Deinstitutionalisation (moving persons from large institutions to the community) presented various issues for some persons who were shifted to the community. A few were readmitted back to the institution for various reasons; for example an exacerbation of a particular challenging behaviour or a relapse of illness. This may have been a natural occurrence for them, a response to the unfamiliar environment, or, for some, having to live in an environment that may not have been suitable or of their choosing. Nonetheless readmissions were at times seen by

the nurses as a significant failure of community care with the resultant perception that institutional inpatient care was still more effective.

The closure of the large mental health institutions has resulted also in increasing demands for limited beds for persons who become acutely unwell (Mental Health Commission, 2002). This shift in philosophy between the medical model of the institutions and the community model of deinstitutionalisation has possibly widened the gap between mental health and intellectual disability services (Parmenter, 1988 cited by Mohr et al., 2002). In the local region the closure of the intellectual disability institution has meant many persons with a dual diagnosis who may have continued to be contained within this institution are now requiring response from a small inpatient service that is part of the psychiatric service. Mohr et al., identify similar issues in Australia and state there is an "expectation of mental health services that they provide adequate services to people with an ID [intellectual disability], but most MH [mental health] professionals feel ill-equipped to do so" (p. 357).

The position of nursing

A further motive for this study is the recent changes in response to the Health Practitioners Competency Assurance Act, 2003 (Nursing Council of New Zealand, 2005a). Out of this Act the Nursing Council of New Zealand has specified scopes of practice for registered nurses. Registered nurses practice in a variety of clinical contexts depending on their educational preparation and practice experience. There is an ability to place conditions on the scope of practise of some registered nurses according to their qualifications or experience (Nursing Council of New Zealand, 2005b) limiting them to a specific area of practice. These limited scopes include the registered nurse who trained as a psychiatric nurse and may only work in mental health settings and the psychopaedic [intellectual disability] nurse who may practise only in settings which provide services for consumers [patients] with

intellectual disabilities. The role of the nurse working in dual diagnosis is not identified as a specific scope and therefore it is not really clear who is endorsed to work in this field. Throughout the country registered nurses who work with persons with intellectual disability include comprehensively educated nurses who may work in either intellectual disability or mental health services, psychopaedic trained nurses who may work only in intellectual disability services and psychiatric trained nurses who work only in mental health (Nursing Council of New Zealand, 2005b). The unit in this study is part of the mental health division and therefore the registered nurse who works in this service must be endorsed to work within mental health. This means registered 'Psychiatric' nurses and registered 'Comprehensive' nurses only are able to practice within this area. Psychopaedic nurses are not employed to work in the unit [there was one who had been employed by the service a long time ago, but this nurse has been encouraged to undertake a transition programme to gain a psychiatric endorsement]. Psychiatric nurses have not been required to undertake any education specific to intellectual disability. Considering the diversity and perhaps ambiguity regarding dual diagnosis nursing, and the reality that there is no specific education available locally for nurses who are either working in the field or planning to enter this area it seems imperative to gain an understanding of the role of the nurse working with people who have a dual diagnosis.

Deinstitutionalisation in New Zealand has impacted on the role of nurses in both psychiatric and intellectual disability inpatient units. Closure or downsizing of hospitals has resulted in many nurses redefining their roles and moving into community based care. The inpatient services that have remained have become focused on more acute care, placing pressure on the nurses who have remained within these services to redefine and develop their roles in response to this (Fourie, et al., 2005). International studies (Cleary, Walter & Hunt, 2005; Cutcliffe, 2000; Hummellvolle & Severinson, 2001; Leyshon, Clark, Epstein & Higgins, 2004) show

similar findings. What isn't clearly evident in the literature however is the role of the nurse working in dual diagnosis inpatient units. Whilst authors Ailey, (2003); Chaplin, (2004); Gabriel, (1994) and Higgins, (2004) suggest that the quality, understanding and knowledge base of staff working within dual diagnosis is critical, it appears there is a dearth of research describing how nurses in this area actually practice. The little literature that does exist is international and there is no specific New Zealand literature.

The area of study is one that has quietly and at times hesitantly followed along with the changing paradigms of both intellectual disability and mental health care that have occurred over the last several decades. The nurses however have been left to practice according to what they know from tradition and what may have been included in their initial educational preparation. No studies have occurred in the area and the contemporary research evidence for practice is minimal. I would consequently suggest that this study, whilst small, is significant in that it focuses on a neglected area of nursing practice and using a methodology which whilst requiring the researcher to interpret and present the data is collaborative in ensuring the nurses' in practice are those who convey the data.

In view of the limited research evidence in this area, I chose to adopt a qualitative ethnographic approach to address the question; 'What is dual diagnosis nursing?'

It was obvious now that to "experience the awesome complexity of clinical nursing practice [I needed] to spend time in the swamp; to lay aside preconceived expectations and unexamined habits" (Street, 1992, p. 15). In this quote Street (1992) describes Schon's (1987) analogy of professional practice as that which occupies the "high, hard ground" (Street, 1992, p. 14). This high ground is a place to resolve problems through undertaking and applying research and theory.

Although obviously critical in advancing nursing knowledge this high place is however less important to those on the lower ground "the swampy lowland" (Street, 1992, p. 15) where the realities of the role whatever they may be, take precedence. The problems or realities of the role are those that are also most important to humankind. The challenge therefore for me was to "move from the safety of easily resolved but relatively unimportant problems of the high ground and to take the risk of pursuing answers to the problems that are important" to those in practice (Street, 1992, p. 15).

Chapter Outline

There are six chapters that expound this ethnography. This Chapter provided an introduction to the research through a reflection and description of the issues that guided and eventually directed the research question. Chapter Two begins to shape the emergence of dual diagnosis nursing from the scopes of psychiatric and intellectual disability nursing. This is discussed in relation to legislative, societal and theoretical influences. The notion of dual diagnosis nursing as a subculture of the other aforementioned scopes is introduced.

Chapter Three explains the methodology - focused ethnography – and provides discussion and clarity regarding the design, outlining the methods used. Information relating to the selection and utilisation of the research processes used in the study are explained and the methods of data collection and analysis are described. Consideration of the particular issues related to the research and how these were addressed is also evident. Chapter Four presents the data analysis providing a descriptive illustration of nursing practice. The nursing practice is re-presented from fieldwork observations, interviews, documents and reflective notes. Schein's (1985) levels of culture typology provides a focus on the artifacts, values and assumptions evident in this culture. In attempting to draw out these levels, cultural patterns begin to surface and one can begin to comprehend what is

going on. It is in Chapter Five that the findings are considered in relation to current knowledge of dual diagnosis nursing. This then sets some direction for further considerations. The study concludes at Chapter Six where discussion identifies limitations of the study and presents recommendations.

Chapter Summary

In this chapter the motivations for the study have been presented. More specifically, the following areas have been outlined including the setting of the focus of enquiry, the aims of the research, the significance or potential value of the research and an outline of the remaining chapters. The following chapter sets the scene to contextualize dual diagnosis nursing.

CHAPTER TWO Historical to contemporary convergence

Events rarely if ever occur in a vacuum but rather in a social, political, cultural and economic context. What any profession or division of a profession is arises from history, its place in the system, the interplay of social forces which shape its development together with the power play of different groups that have a vested interest in its advancement.

(Naisbitt & Aburdenes, 1990, cited by O'Halloran, 2000, p. 3)

This chapter serves to set the scene for this ethnography by contextualizing dual diagnosis nursing. Studying the past is critical to contemporary understanding of healthcare delivery as this is most often a direct result of decisions made in the past (Ion & Beer, 2003). A brief glance into the history that preceded nursing persons with intellectual disabilities and mental illness begins this chapter. The history of care in both psychiatric and intellectual disability areas was frequently intertwined and the complexities arising out of this mingling will be made evident. Each of the nursing groups – intellectual disability nurses and mental health nurses – that have led to the emergence of the dual diagnosis nurse are discussed in order to provide some understanding and insight into the contemporary notion of the dual diagnosis nurse.

Constructing the origins of care

Early western historical literature regarding care and treatment for persons with either an intellectual disability or a mental illness describe periods where they were cared for compassionately, however other accounts reveal how they were mistreated and discarded (Owen & MacFarland, 2002). The introduction of Christianity and other religious beliefs changed some of the inhumane deeds that had been occurring and religious leaders preached "concern, caring and respect for all people including those who had special needs" (Owen & MacFarland, 2002, p. 24). Treatments at these times included such panaceas as bloodletting, emetics and

prayer. The first asylums which appeared in European countries about this time were supervised by religious orders (Cockerham, 2003).

In spite of religious prohibitions limiting medical research in the areas of mental illness and intellectual disability understanding and knowledge developed throughout the following centuries (Scheerenberger, 1983). By the 17th and 18th centuries encouraging medical progress was being made. Experts began to make links between heredity and birth defects in relation to intellectual disability. Ideas such as possession by evil spirits and astrological explanations gave way to theories and understandings based upon age, stage of life or physiological condition (Scheerenberger, 1983). Asylums by this time were manned by attendants with some input from physicians. Treatment became more humane and physicians such as Philippe Pinel (1745 – 1826) introduced the notion of 'moral treatment' (Cockerham, 2003). The fundamental ideology of moral treatment was that rather than being confined to cells or held in restraints, patients should be allowed to work and participate in recreational activities. According to Cockerham (p. 19) "…patients were to be taught how to behave normally within the context of sympathetic living conditions".

It was late in the 19th century that the medical model appeared with the conceptualisation of the 'germ theory' of disease and the resultant belief that if a disease had a specific pathogenic cause then treatment could be achieved within a biomedical approach (Cockerham, 2003). This biomedical theory was particularly relevant regarding mental disorder as many mental disorders were considered to be as a result of an organic dysfunction of the brain. Care response by this time included surgery in an attempt to fix perceived brain anomalies and various other chemical treatments.

The 20th century heralded novel reform, and in addition to the prevailing medical model, alternative understanding of disabilities beyond the religious and medical taxonomies emerged. For example Freud (1856 – 1939) presented some of the early notions regarding "learning, motivation and personality over purely organic approaches" (Cockerham, 2003, p. 23). This among other psychological theories too numerous to mention here presented a basis for current theoretical understanding of mental disorder. Asylums remained prevalent and provided the most common source of care and treatment. Alongside asylum care psychoanalysis was introduced. However, this was perceived to be time consuming and not always particularly effective with acute psychoses such as may be seen in persons with, for example, schizophrenia. Psychoactive drugs were also discovered and the increased use of these demonstrated the belief that "success had come through the biomedical approaches" (Cockerham, 2003, p. 24).

The emergence of psychiatric nursing

Psychiatric nursing as a profession "evolved as a result of the medicalisation of the insane" (Lakeman, 1995, p.1). The early 20th century saw attendants in psychiatric institutions being replaced by nurses in response to the belief that persons with mental disorders were sick, coinciding also with the advent of the medical model. Examinations for Psychiatric Nurses in New Zealand began in 1907 (Fennell, 2001) although there is some evidence (Shives, 2005) nurses were trained earlier than this (1880's) in other parts of the world. The training at the time focused on elementary anatomy, physiology and nursing duties related to psychiatric problems. Nurses were taught to 'take care' of patients and their functions were mostly around custodial care and management of the patient and the ward (Matheney & Topalis, 1974). The only tools available at that time for effective control of the "violent or deluded" patient were oppressive and included such procedures as restraint, sedation and punishment (Fennell, 1981, p. 140). The nurses were left to manage

the environment and were not expected to develop therapeutic alliances with the patients; a role reserved for the physician as it was perceived that any relationship the patient became involved in outside the medical one may interfere with treatment (Matheney & Topalis, 1974). Matheney and Topalis concluded nursing care was to remain mostly a supportive function whereby nurses "retain[ed] a handmaiden role, thus increasing the dichotomy between the professions" (p. 17), a response in accordance with the medical approach to psychiatry.

Despite medical dominance of nursing, nursing pioneers advocated that the philosophies of psychiatric nursing and general nursing should not exist independently from each other. The roots of this thinking can be traced back to the influential work of Florence Nightingale (Nightingale, 1859). Although Nightingale did not actually address the care of persons in asylums she presented the concept of holism "with the body and soul seen as inseparable and the patient viewed as a member of a family" (Boyd, 2005, p. 8). Nightingale recommended interactions with patients that would be perceived as therapeutic communication today. Many early nursing theorists began to encourage nurses to avoid the "false dichotomy of mind and body" (Church, 1987, cited by Boyd, 2005, p. 9), and focus on the whole.

Psychiatric nursing has continued to develop through the 20th century alongside modern perspectives and theories on understanding mental illness. Several nurse theorists focused on concepts specific to psychiatric nursing. Hildegard Peplau (1909 – 1999), was influential in introducing the idea of the nurse patient relationship (Peplau, 1952) where the interpersonal environment and communication were considered imperative in the relationship (Boyd, 2005, p. 87). Boyd suggests Peplau's theory was particularly useful in long term areas found in the institutions of those days and is believed to have led psychiatric nursing out of the custodial care mode into a theory driven professionalism. Numerous other

theories have played a part in informing psychiatric nursing practice and although they may differ in their concepts and beliefs there is general consensus. Broadly expounded these theories serve to inform and guide nurses in delivering appropriate care and treatment to enhance high level wellness. They offer a common language and agreed understanding; encourage an holistic view of healthcare and nursing and recognise the nursing response to the needs of the recipients of nursing care (Shives, 2005).

In the 1970's in New Zealand the stage was set for a changing focus to prepare nurses to work in psychiatry. Up until this time nurses who elected to train as psychiatric nurses were confined mostly to this work unless they undertook additional training. Several reviews of nursing training were undertaken, the most influential being the Carpenter Report of 1971 (Dubey, 2004). Carpenter found that the traditional methods of training nurses, whilst being useful and serving the health needs of the community well, were no longer meeting the demands of the changing health services. The report eventually led to the phasing out of the hospital based training schools and an innovative nurse training style was introduced. Nurses now entered educational establishments to undertake a comprehensive education which would prepare them to work in all areas of healthcare. The amount of preparation provided for a nurse to work in specialised areas such as psychiatry was greatly decreased, with nurses learning a more holistic, theoretical and wide-ranging understanding of illness and health care.

Psychopolitics influencing mental health nursing
Numerous social policy and legislative changes occurred over the last century which impacted on and informed nursing in psychiatry.

Deinstitutionalisation

The process of deinstitutionalisation leading to the downsizing of larger asylum type institutions has meant changing role responsibilities for nurses in these areas. Cleary (2003) in her ethnographic study in a 22 bed inpatient unit examined how mental health nurses constructed their practice in response to the challenges and changes bought about from service reforms in mental health. Cleary describes the impact of deinstitutionalisation in Australia on care provided to consumers of mental health services as complex and at times chaotic, requiring nurses to redefine their roles. Similar processes have occurred in New Zealand (Mental Health Commission, 2002). The consumer movement arising from these processes has influenced a shift from the medical model of care to a psychosocial recovery model, indicating a call for nurses to reshape how they provide their care. The changing socio cultural climate now requires a focus of care on the recovery of persons and not on long term hospitalisation.

The Recovery Approach

The Recovery Approach (Mental Health Commission, 2001) is one of the leading philosophical shifts that impacts on nursing persons with mental illness in New Zealand today. Recovery is defined in the Blueprint as the "ability to live well in the presence or absence of one's mental illness (or whatever people choose to name their experience)" (Mental Health Commission, 2001, p. 2). This approach developed from the Mental Health Commission 'Blueprint for Mental Health Services in New Zealand' 1998. This document asserts the mental health workforce must be educated and competent in the Recovery Approach. Whilst this approach is most compatible with the community paradigm of care it can be applied to any model of care that includes consumers in defining and participating in their care. The Mental Health Commission (2001, p.2) stresses inclusion of the recovery based competencies should not just be an "add-on to current curricula or training standards, they signal a fundamental change to all aspects of the practice

and education of mental health workers". This approach in practical terms is a move away from viewing mental illness as permanent or chronic to viewing it as something anyone can endure yet recover from.

Competencies to practice as a Registered Nurse in New Zealand

All nurses are required to meet competency based standards as set by the Nursing Council of New Zealand. These standards are generic and are expected of all nurses at the completion of an undergraduate nursing programme on admission to the register and for ongoing competency assessments (Nursing Council of New Zealand, 2005b). Te Ao Maramatanga: The New Zealand College of Mental Health Nurses (2005) extends these levels of competence further with a description of competency standards for professional practice in mental health nursing. These standards provide a minimum level of performance that can be expected from a nurse who has been working in mental health for the equivalent of two years and relate to the provision of practice that is culturally safe. The standards designate that the nurse: will establish partnerships as the basis for therapeutic relationships; provide care reflecting contemporary practice consistent with a therapeutic plan; promote health and wellness; is committed to ongoing education, continuing development of theory and practice; and demonstrates the qualities of identity, independence, authority and partnership (Te Ao Maramatanga: New Zealand College of Mental Health Nurses, 2005).

Achieving a 'Mental Deficiency Nursing' Certificate

Given the absence of clear delineation between persons with a mental illness and persons with intellectual disability, historical treatments and resultant changes in nursing care were similar for nurses in both psychiatric services and intellectual disability services.

Intellectual Disability nursing has existed in New Zealand also since the early 1900's, mostly within institutions, although specific nursing training was sanctioned much later (Woods, 1983). The first intellectual disability specific institution was built in the 1940's and Woods (p. 99) talks about the conditions of nursing within this area from the 1940's and 1950's in the following passage from her book. This extract describes the idea that dedication and commitment to the care was foremost.

> The devotion of nurses in hospital for the mentally subnormal under extremely difficult conditions and with very little money for the provision of care is one of these items of history. For example, nurses in the past used to take the most severely handicapped to camp under canvas for a holiday each year. I was shown severely handicapped people and told "we used to take her away every year". These nurses did not have extra time off. I remember a ward sister, about to go away on holiday, who was devoted to a very handicapped boy. He was inclined to be bronchitic because of his poor chest expansion. Sister said, "May I ask a favour? Will you listen to his chest, so I can go away happy if he is all right?"

The previous excerpt identifies the nursing philosophy that was evident in those days; the idea of the nurse as completely devoted to her charges. Within this thinking persons were maintained and cared for within the sick role. Early work for the nurses included keeping the ward physical environment clean and the fires stoked for warmth. Hunt, (2000) writes of the belief intellectual disability nurses were more attuned to patient behaviour and emotions, and more observant than their general trained counterparts. Early descriptions of the role and responsibilities of the nurses describe total care for many of their charges. This care was deficit focused rather than capacity or ability focused. Restraint was disapproved of and special procedures were in place that needed to be followed before any restraint could be applied. According to Hunt (p. 61) "The Mental Health Act of 1969 placed the onus on the medical superintendent to maintain a register recording every instance of seclusion or restraint".

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It wasn't until the 1960's that the Nurses and Midwives Act made provision for the separate registration of intellectual disability nurses (Hunt, 2000). Prior to 1960 there was some lack of clarity regarding the role of the nurse working with those termed 'mentally deficient'. Interestingly, many of the nurses that entered the new institutions were often those trained to work in psychiatry. In 1960 the term 'psychopaedic' was devised to provide a distinction between those with mental illness and those with mental retardation. Nurses working in those early times cared for the total person depending on their level of dependency. They provided practical support in activities of daily living and managed very complex health and behavioural issues.

This area of nursing was also greatly influenced by medicine who assumed an authoritative approach to care (Barber, 1987) an approach based on control.

> When nurses take custody of patients in this way, nursing care treads a path close to social control. When nurses act as agents of control they run the risk of perpetuating those very behaviours they seek to correct therapeutically, namely dependence, depersonalisation and regression. Such behaviours, when encouraged by nurses, lead to the syndrome of learned helplessness known as institutionalisation (Barber, 1987, p. 2).

Contemporary influences in intellectual disability nursing

There have been significant changes and advancement in understanding in this area of nursing over the last century. Within the dominant medical models of health, persons with intellectual disabilities were viewed as a medical concern associated with functional, sensory and cognitive impairments. Treatments within the early models included not only surgical and pharmacological interventions but they were removed from the normal environment for care and protection. This "consequent isolation nurtured a perception of disabled people as passive,

dependant, powerless and requiring non – disabled people to do things for them"
(Munford & Sullivan, 1997, p. 18). The inference was that disability is constructed
in the minds of those who are not disabled. 'Impaired' people are oppressed by
both attitudes and the built environment which deny physical, intellectual and
emotional access to the wider social milieu. In this oppressive process "'impaired'
people are socially created (negated?) [sic] as disabled people" (Munford &
Sullivan, 1997, p. 21). Some social theorists have rejected the concept of disability
in terms of impairment and deficit and maintained disability is a social construct
emanating out of the medical paradigm. However, some very prominent
philosophical shifts have also occurred in this field in response to
institutionalisation or the notion of custodial care. These shifts have been
influential in directing or altering the nursing role within intellectual disability
services.

Normalisation and Social Role Valorisation

The principle of 'normalisation' emerged from Scandinavia where in the 1950's
and 1960's families with children with intellectual disabilities insisted their
children be provided the same opportunities and prospects as other children.
Walmsley and Johnson (2003, p.45) cite Bank-Mikkelson's (1969) definition of
normalisation as "...letting the mentally handicapped obtain an existence as close
to normal as possible". Changes needed to happen within institutions in response
to the normalisation ideologies; however the difficulty was in considering
normalisation beliefs within the milieu of an institution. Wolfensberger (1972)
presented his definition of normalisation as, "utilisation of means which are as
culturally normative as possible in order to establish and/or maintain personal
behaviours and characteristics which are as culturally normative as possible" (p.
28). Wolfensberger qualified his inclusion of the words 'as possible' in recognition
that achievements were context bound, referring to considerations such as the level
of impairment for each individual, the social setting and supports and also

according to the cultural perspective. However, Wolfensberger never really remained satisfied with this theory, as it never emphasised the devaluation of persons who were seen by society to have undesirable characteristics. By 1982 he decided that the most important goal of normalisation was the "creation, support and defense of social roles for people who are at risk of social devaluation" (Wolfensberger, 1983 cited by Harnett 1997, p.101). In 1983 he proposed a theory of 'Social Role Valorisation' to enhance the tenets of normalisation. He proposed the goals of Social Role Valorisation be focused in two main areas; enhancement of people's social image or perceived value in the eyes of others and enhancement of their competencies (Harnett, 1997 p.101). Alongside these theories was the deinstitutionalisation movement: an attempt to move people out of the institutions and back into the communities.

Considerable efforts occurred to relocate persons with intellectual disability to the community and deinstitutionalisation became part of a social movement (Gilbert, 1995). The prevailing philosophy for the last twenty years is that persons with intellectual disabilities should live in the most normal setting as possible for each individual.

Genetic research and understanding
In the last three decades the rate of genetic research has expanded significantly and enormous strides are being made in understanding the congenital origins of many intellectual and developmental disorders (Owen & McFarland, 2002). This knowledge aids in the understanding of various disorders and how they manifest and is significant in guiding nurses in how they respond to individuals. An example is the genetic anomaly that causes Prader Willi syndrome. Persons who have Prader Willi develop an insatiable desire for food which may lead to physical health problems (Priest & Gibbs, 2004). The drive to appease this appetite also presents some behaviour issues for those that care for them. When nurses have an

understanding of this issue as part of the syndrome the behaviour is more easily understood and the response more appropriate to the person's needs.

Preparing nurses to work with persons with intellectual disability

Of significance regarding the preparation of nurses to work in intellectual disability in New Zealand is that the traditional apprentice student nurse model training for Psychopaedic nursing has now ceased and is incorporated to a much lesser extent within Comprehensive nursing education. Whilst there is still some attention paid to educating and providing nurses with opportunities to experience caring for persons with these issues, this is minimal within the local curriculum and constricted by the principle that the nursing focus should be more on other areas of healthcare (Reference withheld).

Deinstitutionalisation

Deinstitutionalisation has occurred similarly for this field of healthcare. Hospitals/institutions have been closed and nurses working with persons with intellectual disabilities have had to redefine their roles. Given the changes bought about by this, it is accepted those most often cared for now within inpatient services will be persons who present with complex needs. Barr (2004) presents a report overviewing the education preparation for nurses within specialist intellectual disability hospital services in the United Kingdom. These services are for persons who present with particular complex health issues including active mental illness, challenging or offending behaviour, complex physical health needs and persons who are 'institutionalised'. The aims of the services are described as being to promote recovery and facilitate the persons return to his or her previous level of independence and community-based living.   The nursing role in facilitating this involves providing support with activities of daily living, teaching new skills or boosting current skills and the administration and monitoring of treatments including medication. Many of the persons with intellectual disability

who have had to return to inpatient services and continue to be cared for by nurses are persons with a diagnosed mental illness.

Positioning nursing practice in dual diagnosis services

When intellectual disability is complicated by mental illness, the biomedical term is dual diagnosis. For many years persons served by the same mental health system were diagnosed only as either mentally ill or intellectually disabled (Doyle, 2000; Gabriel, 1994). It was initially assumed not possible to have both an intellectual disability and a mental disorder and any presenting behavioural differences or difficulties were determined to be caused only by the intellectual disability (Owen & MacFarland, 2002).

Whereas the move into the community has meant a decrease in nursing for some the impact of a mental illness as for anyone requires extended nursing input at times. Even though the concept of the comorbidity of intellectual disability and mental disorder is a theoretical matter it also presents practical concerns in regard to service provision (Bouras & Szymanski. 1997). Specific requirements in caring for this group of consumers are related to the multiple medical conditions, cognitive abilities and communication differences that may be evident, making accurate assessment more complicated. Behavioural deficits are also often erroneously attributed to the intellectual disability and mental illness is often not considered (Ailey, 2003).

Mental health nurses working with persons with dual diagnosis

Not all mental health treatment centers have dedicated dual diagnosis services and many persons with intellectual disability are cared for within generic psychiatric services. There is a growing collection of literature regarding the role of nurses working within the generic mental health services. However, there is a lesser

amount of literature related to the issues psychiatric nurses face when working with persons with intellectual disability. The process of deinstitutionalisation and the philosophy that intellectual disability is not an illness substantiates the notion that persons with intellectual disability did not require the support of health care providers any more than any one else in society.

Debate continues whether persons with intellectual disabilities should be cared for within generic psychiatric services (Longo & Scior, 2004). The White Paper (Department of Health, 2001, p. 66), developed for services for persons with intellectual disability in the United Kingdom states.

> People with learning disabilities should be enabled to access general psychiatric services wherever possible. A person with learning disability who has mental illness should therefore expect to be able to access services and be treated the same way as anyone else.

Anecdotal evidence is that consumers and their families/carers are dissatisfied with mainstream psychiatric services. Several key factors are identified including a skill deficit in generic mental health staff to adequately assess and treat persons with a dual diagnosis (Raghavan, 2004). This accentuates the question of whether care of persons with an intellectual disability is best responded to in generic psychiatric services. Longo and Scior (2004) explored patients with intellectual disabilities and carers views regarding psychiatric treatment across two settings; generic psychiatric services and specialist dual diagnosis services. Their findings were similar in that they revealed negative experiences to be more pronounced in generic settings than specialist.

Mohr, et al. (2002) designed a three day training workshop to address a previous finding that "mental health professionals feel ill equipped to provide adequate services" (p. 357) to persons with intellectual disabilities. The results of

their workshop suggested positive outcomes for persons with dual diagnosis as a result of staff training.

A review of the literature undertaken by Chaplin, (2004) reveals inconclusive evidence that generic psychiatric services best serve persons with dual diagnosis. Alongside this however, Chaplin stresses that there is a paucity of literature and research to guide clinicians as to the most suitable services for this group.

Intellectual disability nurses working with persons with dual diagnosis

Haut and Hull (2000) undertook a study to assess mental health knowledge of 54 intellectual disability nurses in one area of the United Kingdom. They found there was an explicit need to develop psychiatric skills in nurses working with dual populations. Gilbert, Todd and Jackson (1998) suggest that learning [intellectual] disability nurses operate in the absence of a "clear model of mental health" (p. 1151). They propose that a framework is necessary to provide a basis for a mental health model of care.

Nurses working in dual diagnosis inpatient units

There is general concurrence (Doyle, 2000; Gabriel, 1994; Higgins, 2004) that nurses who have gone to work with persons with dual diagnosis in the community have had to redefine their roles and respond to the changing needs of this group of people. One might therefore assume that for the nurses who stayed in the institutions, this would have been much more straightforward, requiring less adjustment. To the contrary, nurses within inpatient units are now facing major changes to the population group (Ailey, 2003). Prior to deinstitutionalisation the inpatient populace was steady and somewhat predictable. Persons often stayed for lifetimes within the units. The nurses knew the patients; they knew how to care for them and the easiest and safest responses to ensure a safe and healthy environment for all. They understood how the environment and others in the

environment impacted upon each other. Life did not change much for those people who were institutionalised. Folk who are now cared for within the inpatient units are much more transient. Inpatient admitting units have become mostly acute admitting units in line with the health policy of today. People come in crisis, most stay less time (Ailey, 2003).

In conjunction with deinstitutionalisation and the resultant specialisation of services a sense of confusion has arisen regarding the roles of various persons who are caring for persons with dual diagnosis. Despite the changes in philosophy and resultant changes in services over the centuries there remains one constant; there will always be times when persons with an intellectual disability and a mental illness may require acute professional inpatient care (Longo & Scior, 2004; Raghavan, 2004). The majority of health professionals that currently work with this group in New Zealand continue to be nurses.

Nurses who work in this area now have mainly entered from either of the two previous discussed scopes. Whilst there was specific training for these two scopes and nurses had broad knowledge to inform their work this may not be so evident in dual diagnosis. Nurses in this area are expected to be cognisant of the influences in both psychiatric and intellectual disability nursing. With the cessation of the discipline specific training and the introduction of comprehensive education in New Zealand, nurses are now required to work in complex areas with a generic knowledge only. Nurses working in dual diagnosis are presented with all the position requirements of the aforementioned scopes as well as those required by the specifics of the field.

The legislative, sociological, biological and theoretical influences that impact on psychiatric and intellectual disability healthcare are numerous and those that have been discussed are only a few of an exhaustive list. What is imperative to

know is that there have been substantial changes to the treatment and understanding of people in this area of healthcare. Knowledge and awareness of these changes are critical in how nursing occurs for the recipients of this healthcare. This is doubly significant for nurses who work in the area of dual diagnosis who are required to be cognisant of both areas.

Persons with a dual diagnosis have been identified as a "unique group with individual nursing care needs" (Hochberger, 1996, p. 308) and intellectual disability nursing itself has even been deemed an "early and important sub specialty in psychiatric nursing" (Devine, 1983, p. 21). Given the strength of these explanations, it is not unforeseen that international nursing literature is calling for further role development and a renewed engagement of mental health nurses in the care of the intellectually disabled (Doyle, 2000, p. 69). The current evidence for the provision of mental health services for persons with intellectual disability is unconvincing and erratic (Bouras & Holt, 2004), relying on retrospective or anecdotal reports and uncontrolled studies with small numbers of participants (Chaplin, 2004).

Nursing care in the distinct areas of intellectual disability and mental illness has been developed over the years and is now incorporated into the comprehensive nursing system. The area of dual diagnosis nursing whilst dispersed, small, less well defined and with a poor research infrastructure, is still required to respond to all of the contemporary policy documents related to both intellectual disability and psychiatry. All of these requirements indicate an increasingly complex and diverse nursing response, yet there remains a major deficit in the literature describing the role and responsibilities of nurses working within dual diagnosis inpatient services. This study therefore was undertaken to gain an understanding and description of the role of the nurse in this area.

The Aims of the Study

The aim of this study is to describe contemporary nursing practice in a dual diagnosis inpatient service. The specific objectives were:

1. To identify and describe current nursing practice within an inpatient dual diagnosis service.
2. To identify factors that influence current nursing practice within an inpatient dual diagnosis service.
3. To identify and explore policy and procedures that are relevant to nursing practice in an inpatient dual diagnosis service

Chapter Summary

This chapter has revealed that whilst there appears to be a superfluity of knowledge related to the changes that have occurred in services for persons with dual diagnosis there remains some ambiguity regarding the role of the nurse and what comprises nursing activity with persons with a dual diagnosis. Nurses working with persons with a dual diagnosis have come from three distinct scopes; Psychiatric, Psychopaedic and Comprehensive. It is evident that whilst there has been some research in this area and some discrepancies have been identified there remains an ambiguity regarding the role of the nurse in dual diagnosis. In the subsequent chapter the study design and methodology are described and the various issues intrinsic to undertaking research into this issue are discussed.

CHAPTER THREE Planning the expedition

Yet a little ethnography quickly teaches you that assumptions, at their very best, are oversimplifications. Ethnography then, offers a social science metaphor within which the richness and variety of group life can be expressed as it is learned from the direct involvement with the group itself.

(Agar, 1996, p. 63)

With the reading that preceded this study, I attained further knowledge and understanding of both psychiatric and psychopaedic nursing to add to my own experiences in this field. Whilst the particulars related to these areas of nursing are important and relevant in providing this illustration they only go part way to providing an understanding of dual diagnosis nursing. The processes employed in order to gather and then interpret the research data are detailed and described in this chapter. The methodological issues that arose during the research process are also outlined and discussed. The awareness of a separate group of nurses working specifically in dual diagnosis substantiates the idea that this group may be a subset with its own knowledge and understanding. Such a distinction would infer dual diagnosis nursing as a separate cultural group with its own anthology of patterns, behaviours, rules, lifeways, and rituals (Chiseri- Strater & Sunstein, 1997). The task of this study is to describe that culture.

Focusing on the cultural phenomenon

The focus for this ethnographic study was within a defined area of nursing practice. The investigation was on the practice of the nurses, the factors that influenced their practice and the policies and procedures that were relevant to their practice.

The participants are a group of Registered Nurses who work within an inpatient dual diagnosis facility within a district health board psychiatric hospital.

After exploring all possible factors there was no reason to exclude any of the Registered Nurses from the study, consequently there is no exclusion criteria. The service is one of only a few in the country, therefore to ensure anonymity as much as possible for the participants the names of the district health board, the unit and its documents will not be used.

It is fundamental that in seeking a contemporary portrayal of nursing in a defined area, those who live the experience are involved in describing it. I therefore sought a methodological approach to enable this. Ethnography; a study of culture, is a research process of "learning about people by learning from them" (Roper, 2000, p. 1) and therefore provided the optimum opportunity to respond to the research aims.

With the intent of this study to describe nursing practice in a dual diagnosis inpatient unit, I embarked on a focused ethnography. Focused ethnography is well suited to understanding particular areas of nursing and understanding nursing practice as a "cultural phenomenon" (Roper, 2000, p. 7). In undertaking this methodology I was able to view the defined area of nursing as a subculture with its own set of beliefs and practices, allowing focused observation within the customary setting.

The term 'ethnography' has evolved from the field of cultural anthropology, where it was focused mostly within small scale groups in society; the work of describing a culture (Morse, 1994; Spradley, 1979). Ethnography portrays not only key events in people's lives but also everyday events (Van Maanen, 1988). Of manifest import is the explicit need for the researcher to 'do ethnography' in the context of the culture being researched. Only in that environment can one acquire some understanding of the social phenomena, customs and rules of the culture being studied (Germain, 1993). Those who describe the culture of a group should

be those members of the group themselves with the ethnographer or researcher acting as a "catalyst or facilitator" (Wolcott, 1999 p. 144). However, it is not always as simple as this, as those who are immersed in the culture most often do not 'see' the culture and therefore may have difficulty describing it. The role of the researcher therefore is also paramount.

Whilst the ever changing opinion of ethnography will most likely continue as understanding of culture and interpretation continues in the modern world, there seems to be general consensus that an ethnographic text is:

> axiomatically an ethnography if it is put forward by its author as a non fiction work intended to represent, interpret, or (perhaps best) translate a culture or selected aspects of a culture for readers who are often but not always unfamiliar with that culture
> (Van Maanen, 1995 pp. 13 -14).

Contemporary ethnography has evolved to the extent that it may be a suitable method for either large scale studies taken part over years of study in a field or they may look at distinct concepts within a stated context; a focused ethnography (Roper, 2000).

Mapping the territory

Holloway and Wheeler (1996), discuss the importance of working in the natural setting of the informants so they get used to the researcher and behave naturally rather than putting on a performance. The approach was to enter this location over a period of time, to gain knowledge and insight into the culture within.

The site was a 15 bed inpatient ward. The patients become part of the cultural scene as soon as they are admitted to the unit. The age range of the patients is 19 to 65, and there were more male than female patients in the unit at

the time of the study. Unlike some of their counterparts in general medical and surgical type hospitals, the patients were not always clearly identifiable as they are most often dressed during the day and do not tend to stay close to their bedsides. To become a patient one must have been categorised at some stage as having an 'intellectual disability' and either diagnosed with a mental illness or being assessed at that time for one. All patients will have been screened by a member of the medical team as fitting these criteria. The patients each have a bedroom and share the toilets, bathrooms and social areas. There are times when persons who live in the community attend as 'day patients'. The inpatient unit was part of a larger intellectual disability service within a psychiatric service.

The clinical/treatment/maintenance members of the unit include the unit manager, two psychiatrists, a psychiatric registrar, a psychologist, a clinical nurse coordinator, the registered nurses, a social worker, the occupational therapist, enrolled nurses, a psychiatric assistant and two auxiliary staff – villa assistant and the cleaner. The Unit Manager, District Nurses, Social Worker, Behaviour Therapists, Psychiatrists and Psychologists have their offices in the unit next door or in a building near by, as they are also part of an outpatient service; they visit the unit as required.

The nursing cover in the unit includes nine nursing staff over a 24 hour period. Staffing is comprised of three nurses and a Clinical Coordinator on day shift, three nurses on the afternoon shift and two nurses on night shift. The nursing staff EFTs (Equivalent full time) consists of 10 Registered Nurses, 7.5 Enrolled nurses, and a psychiatric assistant (see table 3.1). Whilst the psychiatric assistant holds no nursing qualification this person is included on the nursing roster. The Registered nurses are from various scopes.

Table 3.1: Nursing Staff EFT's & Relative Scopes

Discipline	Number of EFT's	Scopes of Practice
Registered Nurses	10	RPdN = 1 RP = 5 RCpN = 4
Enrolled Nurses	7.5	EN = 7.5
Psychiatric Assistant	1	N/A

Whereas there is no stated requirement regarding the number of EN's that are on duty there must be at least one RN. The nurses told me this has not always been possible due to a shortage of registered nursing staff especially on night shift. It has been considered that as long as there is an RN in the building (including the unit next door) it is acceptable, but only on night shift. During the day the Psychiatric Assistant looks after the housekeeping (for example: ensuring the linen cupboard is full, doing the unit stores ordering, monitoring the patient's money) and assists the nursing staff where appropriate. The Occupational Therapist is in the unit at most times during the weekdays. A Villa Service Assistant who is responsible for the catering and cleaning tasks is also in the unit during the day and over the evening meal time. This is the only staff member who wears a uniform. All the other staff wear 'civies' [everyday clothing] and are identifiable only if they are wearing a name tag as per Hospital Board policy (Reference withheld). I saw very few staff with name tags. Whilst this informality in dress presents an absence of status symbol, the absence of the name tag makes it difficult at times for visitors to identify nurses if they needed to talk to them.

Gaining access to the field

Entry to the field and access to participants is never straightforward (Schneider, Elliot, LoBiondo – Wood & Haber, 2003) and there were various levels of entry negotiated. Firstly were the gatekeepers; persons who have the power to withhold access to areas or situations, access to people, and/or access to any documents necessary for the purpose of the research (Burgess, 1984). Gatekeepers are concerned with not only the way the study is conducted but also in ensuring the organisation and its colleagues are presented in a positive manner (Roper, 2000; Tham, 2003). Initial entry to the staff in the field necessitated negotiation with and approval from the General Manager of the District Health Board, Mental Health Division; this involved several phone calls to set up a meeting with this person. A copy of the research proposal was provided and the General Manager signed off the Ethics application. Access to the inpatient unit was obtained after this through meetings and consultation with management and senior clinicians of both the service and the nursing group.

Approval was sought from the relevant Maori Mental Health Service. This was important to ensure appropriate considerations and procedures were in place to support Tangata Whenua [people of the land] who may have been involved in or impacted on by the research (Health Research Council of New Zealand, 2002). As there were no nurses who identified as Maori employed by the unit at that specific time no further procedures needed to be put in place. It was agreed if this changed the nurse would be advised to consult with the Maori Mental Health service staff. Any patient who identified as Maori was protected by the procedures that were put in place for patients as they were not direct participants. There were also none in the unit at that time.

A Consumer Advisor is employed by the District Health Board, a required advisory role to the Mental Health Division (Health and Disability Commission, 1996). However, this person was also willing to serve as my mentor regarding all issues or questions regarding protecting patients' rights. The Consumer Advisor was consulted to ensure ethical considerations put in place for the patient group were acceptable.

I attended staff communication meetings in the unit to explain the research. Posters (Appendix 1) were put up in the staff areas of the service explaining the study and inviting nurses to attend information sessions. Nurses were invited to contact me if they were interested in taking part in individual interviews. An information sheet (Appendix II) for nurse participants in the interviews was available. This sheet outlined the study, the interview process and provided my contact details. Those who contacted me to indicate their interest in taking part in the interviews were invited to meet to discuss the study further and then sign the consent form (Appendix III) if they wished to proceed. Most of those interviewed declined this offer and chose to sign consent at the beginning of the interview.

I attended an 'inpatient meeting' in the unit to explain my planned presence on the ward. These meetings occurred once a week with all interested patients to share information regarding the running of the unit and patients were able to talk about any issues that concerned them. I hoped to use this forum to explain my role to as many of the patient group as possible. The Consumer Advisor was also to be present at those meetings; however at the prearranged time he was not able to be there. A nurse consequently stayed in the meetings to be available to the patients if they had any queries I could not respond to, (this had been agreed to by the Consumer Advisor). I arranged to meet individually with patients who had been unavailable at these times; there were two who requested this. A poster (Appendix IV) introducing me and my role was put up in various areas of the unit where

patients could see it, visitors to the unit could also read this. I wore a name badge with my full name and role.

Other unit staff were informed of my role at the staff meetings. Their choice regarding my presence during any event or interaction between them and a nurse was explained and it was anticipated that the nurse would speak with the patient and/or other staff member at the time of the observation to ascertain consent and then duly inform me if the other person did not want me there. I also relied on my own experience and professional judgment as a nurse to assess and respond appropriately if I felt my presence was not wanted.

My status as a nurse supported the possibility for me to enter the setting with hopefully some degree of acceptance and understanding from both the patient group and the nurse informants. Having worked with persons with intellectual disability in the past and having an awareness of this nursing culture I consider, enabled a smoother transition into the environment.

Gathering all parts of the story: Data collection

Data is collected from a variety of sources in ethnographic research and the process of method triangulation is useful in an attempt to maximise the range of data and to contribute to a more complete understanding of the topic being researched (Knafl & Breitmayer, 1991). This variety of data collection techniques includes observations, conversations, interviews, written documentation and interpretations with each drawing on and presenting a different dimension of the issue being studied (Agar, 1996).

Taking part or just observing

Traditionally ethnographic fieldworkers spent long periods in the field living in the field, living the life of the 'native' (Van Maanen, 1988). However, this is not always possible and in a focused ethnography the researcher may move back and forth between the field and their normal environment. My own work commitments and the amount of time available within the limits of a Masters thesis meant the fieldwork was undertaken part-time over a period of three months with between four and eight visits a month. I spent 46 hours in 17 visits in the field over this time. The fieldwork visits, usually of two to three hours duration, were undertaken at various hours of the day. Most of the visits were during the morning and afternoon shifts (between 0700 and 2300) and on one occasion I was there after midnight. Again these hours were limited firstly due to my own daytime commitments but also in recognition of the reality that whilst events and activity occurs at any time over a 24 hour period most would probably occur during the hours of 0700 – 2100. The analysis is cognisant of this limitation.

The basic activity and central method of data collection in ethnographic fieldwork is the presence of the researcher 'doing' participant observation. During this time I was able to systematically observe and to some degree participate in the activities of the community. This allowed me to experience the patterns and flow of the life of the community (Roper, 2000). Three particular approaches for observation described by Spradley (1980) were undertaken at appropriate times. Descriptive observation occurred in the initial exploratory stage, enabling me to gain an overview of the setting. In undertaking this I moved around the unit gaining a feel for what was going on and noted broad events and images to gain the "holistic view of the entire program" described by Patton (1990, cited by de Laine, 1997, p. 146). For example I gained a sense of what was happening at various times of the day and whether these events occurred at the same times each day. Focused observations occur next where one is able to contemplate particular

aspects of the field and events and respond to questions that have arisen during the descriptive phase (Streubert, 1995). I had by this stage become more familiar with the environment and had begun identifying possible emerging themes or points of importance or interest. Selective observations occurred later when I had identified very clear activities or attributes to focus on. An example of this was a question that arose regarding the use of seclusion. I was able to direct both my observations and my discourse with the nurses around this theme.

There are four well recognised levels of observation; 'participant', 'participant as observer', 'observer as participant', and 'observer', in participant observation research (Roper, 2000). Most ethnographers spend time in all or most of these various roles at different times, swinging back and forth between them as necessary (Burgess, 1984). As I was in the unit as researcher only I did not have a 'participant only' role. I moved between 'observer as participant' and 'observer' taking part in the daily activities only as appropriate or necessary. I found these roles were not always as simplistic as I initially understood and there were times I elected to stay away from an interaction or event. Several issues were evident for me from the beginning and I was very quickly aware of my own discomfort in following nurses around the ward. I recall one particular day when a group of nurses were taking a patient to a room to give him an enema.

> They walked him down to his room and all the staff went in and shut the door. I waited outside then wandered back down to the main lobby. The other patients were talking to me. I felt left out but I couldn't observe as the patient needed privacy and there were already many staff in there (Journal).

Planning to undertake the role of 'observer as participant' mostly and 'observer' only when necessary, my naïveté soon showed and I quickly realised that I was often in the way or that events were occurring that were beyond my level of capacity as a non staff member. I felt especially early on that I wanted to be

part of the environment mainly to avoid my impact as much as possible, but in the end I learned to respect the boundaries. At times I was able to move alongside the nurses, working with them, helping to make beds and assist in the dining room, at other times I just observed. Sometimes, due to my past acquaintance with the area and some of the staff, I was taken into their confidence. I had to be careful here as at times the information was personal and outside the scope of this research. On one occasion a nurse was talking with another about the difficulties related to staffing numbers and mix. The nurse alluded to the fact that it wasn't much better than when I had been there and began pulling me into the conversation inviting me to comment regarding how I had experienced these issues. I sensed the hope that my presence and this study would fix this issue. I did not want to get involved in this discussion:

> I had certainly observed enough to understand what s/he was saying. I have to be careful not to get involved in the emotion of this. I can feel for this nurse, I can feel the frustration. I have been here. [Journal]

A stranger in their midst

There was recognition that my presence within the environment may also impact on the ability of the nurses to perform their daily tasks or on the natural routine of the unit (and/or nursing) culture. I remained mindful of this to avoid being too disruptive. Another consideration regarding my impact was related to a phenomenon referred to as the Hawthorne effect (Ballantyne, 2000). Ballantyne relates to the perceived tendency under situations of observation for employee productivity to steadily increase, inferring that people who are singled out for a study of any kind may improve their performance or behavior not because of any specific condition being tested, but simply because of all the attention they receive. An example of the possibility of this effect occurred one day when we were all sitting in the staff room and the morning shift were giving verbal handover. Two of the three nurses coming on the next shift had obtained a sheet of paper and were writing, this was the first time I had observed this. Another nurse arrived in the

room and laughingly commented about the 'note taking'. This nurse then turned to me and said "They are obviously trying to set a good example for you" (Fieldnotes/day 13).

Documenting the tale

In conjunction with observations is the documentation of fieldnotes and other data gathered whilst observing. Spradley (1979) describes four different types of field notes in ethnography. Firstly the condensed account, when short descriptions are made in the field during data collection. Secondly, the expanded account extends the descriptions and fills in the detail. This needs to happen as soon as possible after observation. Next is the fieldwork journal, where the ethnographer notes their own biases, reactions and problems. Finally, analysis and interpretations are written.

It was important that I noted as much as possible early on in my data collection as at that stage I had no clear focus for my observations. "As preludes to full written notes, jottings capture bits of talk and action from which the fieldworker can begin to sketch social scenes..." (Emerson, Fretz & Shaw, 1995, p. 31). I had planned to write my notes and jottings contemporaneously however it was impossible to note all that I observed and unrealistic to be writing all the time. I also did not want to miss out on all the other activities, therefore I soon learnt to rely on my memory and make mental notes to recall later. Whilst I became quite adept at doing this I enhanced this even more by keeping a small jotter in my pocket in which to write key words for later recollection. However, I knew there would always be some data missed. Even the process of noting one event means I potentially missed another. At other times I had to write open jottings noting immediately what I had observed. There were times where I was able to retreat to private places such as bathrooms and linen rooms, to write. Complete and more comprehensive fieldnotes were written as soon as possible after each fieldwork

visit. Informal discussion also occurred in the field; as we went about the tasks of the day the nurses often talked about issues that were of importance to them. I never wrote notes as those discussions occurred, therefore data obtained from this was reliant on my recall of the conversations.

Listening to the stories

Observed patterns of behaviour or events may be discussed or discovered in interviews with individuals from the community (Roper, 2000). Whilst interviews may be formal or informal I elected to undertake semi structured informal interviews as a way to "identify the range and consensus of beliefs about a specific event" (Fetterman, 1989, cited by Roper 2000, p. 74). Whilst informal semi structured interviews are not actually prearranged but intend to follow the here and now (Agar, 1986), it was important to focus the interviewees on the topic. Hence each of the interviews began with a "Grand Tour question" as suggested by Spradley (1979, p. 62). This question 'Tell me about your work as a dual diagnosis nurse' was descriptive, helping to set the scene and allowing the nurses to talk about their work and describe the meaning of behaviours and/or events. A further purpose of the interviews was they provided opportunity to discuss and clarify questions that were arising out of early analysis and reading of the fieldnotes. Semi structured interviews were undertaken in the field with five nurses lasting mostly about one hour with two going nearer to 90 minutes. The nurses seemed eager to talk about their work in the area and once we got over any initial discomfort this generally flowed well. The interviews were taped and transcribed verbatim.

Other cultural data

Further data sources include written records and reports, historical accounts and clinical files (Roper, 2000). The policy and procedure manuals were accessed at various times in response to identified themes or events. Clinical notes were only

accessed with patient consent (Appendices V & VI). The consumer advisor was involved whenever written consent was being obtained from a patient for access to their files. The consumer advisors' role was to ensure that the information explained to the patient was understandable and accurate and that consent was understood and informed. The consultant psychiatrist was to decide which patients had capacity to give informed consent. I had initially organised a time to meet with the psychiatrist, consumer advisor and some of the patients, but the psychiatrist was no longer available and delegated this responsibility to the clinical coordinator. As some patients did not have capacity to give consent and others clearly did not wish to, this meant a limitation on the amount of data accessed from files. These documents were read only with the purpose of attaining a picture of how nurses described their actions in relation to working with the patients. Any information about patients was limited to descriptive terminology only; no patient identifying information was taken.

An introspective glance: Reflexivity

A researcher's awareness of self within ethnography is crucial (Lipson, 1989) and the mode of describing the culture is the necessity to 'tell it like it is'. This refers to the researchers' awareness of self in relation to reality for the participants, more commonly referred to now as emic/etic differentiation (Roper, 2000). Whilst I was seeking the insiders, 'native' view of their world any analysis needed to take into account my etic perspective, how I brought my own outsiders framework into this. My position as the instrument of interpretation was important and I was concerned with the significant role I played in identifying, interpreting and analysing the nurses' culture. Whilst I was aware I was not just an observer but had to some extent become part of the culture it was important I remained continuously cognisant of this. The essence therefore was an etic view or the view of self as an outsider with interpretation. I realised very quickly that as an outsider I could not really assume or anticipate anything despite my own previous

experiences in the area. My role was not as an impartial onlooker, the "ethnographic voyeur" described by Denzin (1997, p. 35) but to be aware that my interpretations of the observations were produced in cultural, historical and personal contexts and shaped by my own values. A key consideration was reflexivity, regarding my own feelings and understandings that eventuated throughout the observations and interviewing. A fieldwork journal for analytic notes was kept as it was important I was able to document my personal reflections and prompt my questioning and understanding of various events.

Entering the field as a stranger is usual especially in typical ethnography as it limits partiality and also allows for a measure of culture shock (Germain, 1993). Culture shock in this context refers to the "sudden immersion in the lifeways of a group different to yourself" (Agar, 1986, p. 100). This culture shock is not necessarily negative as it allows one to get the feel as well as the facts of the cultural scene. Like Bland (2004), who talked about nurses entering nursing environments, I was already an insider, not a total stranger studying an unknown culture or an unfamiliar tribe. Whilst I had not been nursing in an inpatient setting for three years and there had been numerous changes in the environment I, like Allen (2000), could only play the naïve stranger to some extent.

Ethnography is comparative in that one who studies a culture is herself cultured (Roper, 2000). I could not do this study without acknowledging that I brought my own life experiences and my own identity, 'who I am'. It is of the essence to "tell the truth" (Bland, 2004, p. 60) and important therefore that I am overt about where I come from, who I am and what I have bought with me to this study. The significance in acknowledging this is to avoid the risk that I would project my own perceptions onto participant's actions and statements.

A central consideration for me was my ontological positioning as both the researcher and as one who has in the past worked as a nurse within the defined area of study. That I had worked as a coordinator in the unit prior to leaving, I supposed, may have caused some nurses to be more cautious and I remained cognisant of this. I was mindful also that I brought to the field an identity shaped by the "relationships, interactions and experiences" expressed by Coffey (1999, p. 158). Being a nurse had some advantages and perhaps some disadvantages. I was well versed in the language of nursing and did not have to contend with getting to know a new language and the participants may have possibly perceived me to at least know and understand what it was really like to be a nurse. It was important also that I did not assume my understanding of particular terminology was what was meant when used by another nurse. I asked questions often to clarify this. An example of this clarifying was when one nurse was talking about 'close obs[ervations]' (Interview / SNL). My immediate assumption regarding this was that the nurse was talking about being in the same room and maintaining sight of the patient. The nurse was talking about similar observations but was referring to the legalities of this now and how it is prescribed most often by medical staff and much more formalised and categorised than how I had known it. The nurse was referring to the issue of 'on duty' staff having to undertake this task as opposed to calling on extra staff for close observations. I would not have known the extent of this issue if I had stayed with my own assumptions.

My underpinning philosophy regarding a model of care in mental health is the holistic ideology of the 'Recovery Approach' (Mental Health Commission, 2001). As outlined in Chapter Two this approach recommends that the nurse work in partnership with the patient and is the philosophy required by the NZ Mental Health Commission's Blueprint for Mental Health Services. I was careful not to assume that others also aspired to this philosophy. There are other similar

contemporary philosophies that are equally relevant to mental health and/or intellectual disability nursing.

The philosophical assumptions underlying my research methodology stem from an interpretive conviction. This implies a subjective epistemology and the ontological belief that reality is socially constructed. This is in line with my personal and nursing philosophy particularly in relation to my work as a nurse in mental health and intellectual disability and my thinking and understandings of the social construct of mental disorder. Those who espouse the interpretive approach claim that social phenomenon must be understood in the social contexts in which they are constructed and reproduced through their activities (Holloway & Wheeler, 1996). Using an interpretive perspective enabled me to increase my understanding of the social, organisational and political issues related to nursing in the field of disability.

In view of the fact that my role as the researcher was an integral part of the research process, it was imperative the research method be congruent with my philosophy of knowledge. The ethnographic methodology is aligned with my ontological and epistemological positioning towards a holistic philosophy or seeing the whole picture. This positioning is also with regard to the fact that I had worked within the area. To minimise any potential bias as much as possible, prior to entering the field I undertook a taped interview with my supervisors which was then transcribed verbatim. In this interview I was able to talk about some of the issues I had faced when working in the unit and how I had responded to them at the time. This process raised my awareness of my prefieldwork thoughts and perceptions and prevented me to some degree from using previous feelings about specific events to cloud the here and now.

Questioning the assumptions of the familiar culture whose rules and norms have already been internalised can be problematic (Holloway & Wheeler, 1996). However, ethnographic methodology in nursing is one very constructive way of exploring behaviours and perceptions in the clinical setting. It can promote understanding of the meaning of health and illness experiences for patients and providers and can generate insights that may be useful for promoting cultural change in improving nursing practice and systems and influencing health policy.

Deconstruction to reconstruction: Data analysis

Data analysis needs to be consistent with the research design. In ethnography great quantities of data are collected and this data needs to be organised in order to make sense of it. Whilst there is no set method for data analysis in ethnography it was important that a constructive form of coding, categorising and thematic analysis was undertaken (Roper, 2000).

Methods triangulation was used to increase the validity of this study. Brink (1991, p. 172) calls this "pragmatic validity". Loosely defined, this means to check out or validate inferences that have been drawn from one set of data with other sources; the comparison of one set of data with another. Whilst this seems unambiguous it may not always be so and often the knowledge is in the realisation that there is no link.

All of the data sets were analysed separately and against each other to reveal answers to the questions asked in the research study. Roper (2000) talks about this result as a written product, also called an ethnography, pointing out that ethnography is both a "process and a product" (p. 2).

At the beginning of the examination of the fieldnotes –after the very first field visits - coding was undertaken. I found it constructive to use the following questions outlined by Emerson, et al., (1995, p. 146) as a guide:

- What are people doing? What are they trying to accomplish?
- How exactly do they do this? What specific means or strategies do they use?
- How do members talk about, characterise, and understand what is going on?
- What assumptions are they making?
- What do I see going on here? What did I learn from these notes?
- Why did I include them?

These questions were valuable in that they helped identify what was occurring rather than why. The why questions ask what is causing or producing a particular outcome and these needed to come later. Open coding in this way therefore was a constructive method for interpretation and thematic analysis rather than looking for "causal explanation" (Emerson, et al., 1995, p. 147). However this questioning, whilst serving initial guidelines, was not useful later on when I needed to start comparing and contrasting data. In response I sought a technique that would take me further into this analysis.

In ethnography, there is no rule that says that all the steps of any given analysis sequence must be followed and many researchers have used different aspects of various theorists (Roper, 2000). I elected to apply Spradley's (1979) Developmental Research Sequence to the data initially. The strategies proposed in this sequence provided steps in analysis that were systematic, overt, and thorough (Parfitt, 1996). The area of focus in analysis occurs between levels 4 and 12 in the following list. This sequence (see over) provided me with a framework to build on initial analytic coding and encouraged further questioning of data.

1. Locating an informant
2. Interviewing an informant
3. Making an ethnographic record
4. Asking questions
5. Analysing interviews
6. Domain analysis
7. Asking structural questions
8. Taxonomic analysis
9. Asking contrast questions
10. Componential analysis
11. Discovering the cultural themes
12. Writing the ethnography
(Spradley, 1979, p. 135)

Prior to the commencement of this phase of the analysis all data were read separately then combined. Using Spradley's sequence I was able to work through a systematic examination of the whole to determine the parts. The relationships of the parts to each other and then the relationships of the parts to the whole were then examined. Steps one through three had occurred naturally as part of the study's preparation and implementation. Spradley (1979) recommends that steps four on are employed as one moves through a series of interviews with the findings from one set of analysis informing the next interview. I was not able to do this as I had not encountered this sequence before the interviews were completed. Nonetheless, I was able to use the technique to compare and contrast data as I moved between observation fieldnotes, reflexive notes, interview transcripts and documents, in accordance with data triangulation.

Spradley's (1979) step six 'making a domain analysis involves realising that every culture has folk terms or 'cover terms', searching for cultural categories that are related to an 'included term'. The included terms represent cultural symbols which are organised through semantic relationships. To elucidate on this an example from one of my worksheets is the semantic relationship 'a reason for' or rationale for the cover term 'seclusion' (see Figure 3.2 over).

Figure 3.2: Working example of the analysis process

Included term	Semantic relationship	Cover term
Getting into other peoples faces	*is a reason for*	*seclusion*

In doing this I was able to gain some understanding of the meaning behind the cover terms to those who used them. I then would ask of my data "what other reasons are there for seclusion?" An idea of what seclusion was or meant in this situation eventually appeared. Taking this example analysis a step further identified that a 'de-escalation area' [included term] is a place for doing [semantic relationship – location for action] 'seclusion'. This process whilst allowing me to explore data for other similarities or related terms assisted me to unearth some of the tacit knowledge that is often evident and limited any immediate assumptions I may have made.

From this process structural questions emerged which lead to further exploration and analysis and cultural categories were identified. Contrasting and comparing continued with numerous themes evident until eventually this was narrowed down to only a few key themes that interrelated with each other.

Ensuring ethical integrity

As this study involved the participation of human subjects, it was vital that ethical issues were considered and attended to prior to and during the time of the study (Roper, 2000). Ethical integrity was realised in a number of ways.

Ethical Approval

Ethical approval was sought and gained foremost from the local area [reference withheld] Ethics Committee (Appendix VIII). Approval was also sought from the Christchurch Polytechnic Institute of Technology Research Committee.

Informed Consent

Each interview participant gave informed consent prior to the interview (Appendix III). It had been agreed that the nurses who worked in the unit or who were on duty did not need to give individual consent to being observed but that they would not be identified in any way. The General Manager and other senior staff agreed that individual nurses would not need to give consent to my presence. It was necessary to have this inclusion as it would have been too problematic to only observe some of the nurses. The staff numbers are very small and often all the registered nurses that were on at any particular time may have been working together. What was important to ensure was that individual staff would not be identified in any data findings or discussions. It was, however, agreed that nurses who were to take part in any interviews were to give informed written consent. Participants who undertook interviews were given the name/ details of relevant others to contact if they were concerned about any aspects of the research (Appendix II).

The Consumer Advisor was to be involved initially at the patient meetings when the study was explained. The Advisor was also involved whenever informed written consent was being obtained from a patient for access to their files.

Confidentiality and anonymity

Confidentiality and anonymity was sustained in several ways: Anonymity was ensured by using codes for all participants and pseudonyms for any other person referred to. These codes and pseudonyms were used on all data analysis notes and

transcripts. The transcriber signed a declaration of confidentiality (Appendix VII). Audio tapes, transcripts and field notes are kept in a locked filing cabinet. Participants in the interview stage were informed of their right to withdraw their interview at any time up until the amalgamation of the data (see Appendix II).

Protection of the patient group

It was crucial that the patient group whilst being secondary to the research process was still appropriately protected from harm. It was most importantly acknowledged that the patients within the area have an intellectual disability and possibly also a mental illness and therefore may not understand or may interpret my presence differently. The processes discussed previously were put in place to ensure patients could ask that I not be present during any event that involved them.

For the period of my time in the field I was very aware and often concerned about the conflict between my responsibilities as a nurse towards the patients and my ongoing role as a researcher. This was particularly important should an event arise where I observed nursing practice that was detrimental to the welfare of the patient (Gerrish, 1995). I, like Bland (2004, p. 62) had "legal and professional responsibilities as a registered nurse to exercise a duty of care". Prior to entering the field I established crucial links for reporting any concerns and these processes were clearly outlined to staff prior to beginning the study. The chain of reporting and supporting included the consumer advisor who agreed to be contacted if any incident occurred that directly impacted on a patient, the clinical coordinator who was available at most times through the week for me to discuss queries or concerns and the 'nurse practice consultant', who would be available for me to hand over any nursing practice issues that may have been of concern. My supervisors were also very important to me and held an imperative role in regard to one key issue that arose for me. This issue will be discussed in the next chapter in regard to

'locking the doors'. One of my supervisors was contactable out of normal hours. These processes were also outlined to staff and patients prior to the study commencing.

Establishing rigour

Constancy and processes to obtain rigor are essential in qualitative research (Morse, 1991).   A technique that adds to rigor is credibility. One of the easiest ways to ensure credibility is by member checking. This activity allows those who have provided the data to validate it (Lincoln & Guba, 1985). The study as part of a master's thesis with the confines placed on time prevented the possibility of interview data being returned to the participants for member checking. Whilst this was not possible it was agreed with all participants that they could come back and talk about anything they were concerned about or wanted to talk about more. They were offered copies of their audio tapes. They were also able to ask that their interview be deleted up until the time of analysis. Methods triangulation as discussed previously also provided a measure of credibility. My experience as a mental health nurse, I believe, like Farrow (2000, p. 54) also "affords a degree of researcher credibility".

Confirmability is another process principle and refers to the importance of leaving an audit trail (Streubert, 1995). The audit trail requires a record of activities that can be followed by another individual. There is some dissension regarding whether another researcher may or may not agree with the conclusions the original researcher has developed (Morse, 1989). Nevertheless as part of undertaking the processes of this research I have formulated an audit trail. The processes associated with an ethnographic methodology results in a vast amount of data which would not be manageable without a system to categorise it. This systematic control ensures easy audit when required.

A further criterion that may be considered in ensuring rigor is transferability. Transferability refers to whether the findings have meaning to others in similar settings. This potential for generalisability is discussed later in the limitations however, according to Streubert, (1995) it is not the researcher that determines this but the user of the findings.

The theoretical anchor

Despite the rhetoric endorsing cultural awareness in working with culturally diverse client groups the concept of culture has been greatly excluded from research methodology in mental health services research (Gui, 2001). The notion of culture seems complicated at times as it cannot actually be observed directly, it must be inferred from the things people say and do as well as those things they create that are functional in their environments (Beals, Hoijer & Beals, 1977). Culture is not strictly tangible or measurable (Bate, 1994; Pacanowsky & O'Donnell-Trujillo, 1982); it cannot be treated as a variable that can be manipulated (Meek, 1988). Given the perspective that every aspect of a culture is important and cannot be viewed separately, it is important that a cultural research methodology is utilised that can attempt to comprehend particular cultural worlds and the complex social phenomena within. Through this a worldview from the point of view of those involved is provided. The emphasis also in researching a culture is on the importance of understanding events in context substantiating the need for an holistic research methodology. Past studies on cultures have their roots in anthropology and sociology (Manley, 2000), and ethnography as used in this study is a research methodology that asks 'what are the cultural practices in a defined situation?' providing a result that describes richly and in detail features of the culture.

It is not automatic that any group has a culture, and according to Schein (1985) to have a culture the group will have developed shared assumptions. The

group should have been together long enough to have shared significant problems, had opportunities to resolve the problems and have taken in new members. Although the professional sector of health systems is comprised of a number of different professional groups each group constructs its own culture and once constructed actively preserves its own boundaries, guidelines and sanctions. It has been suggested that nurses working in dual diagnosis whilst part of a nursing culture may have formed their own subset or cultural subgroup.

The notion of culture in this study is in reference to the actions and products of the defined group which are socially constructed and conveyed as well as the knowledge the group members are thought to share. "Knowledge of the sort that is said to inform, embed, shape and account for the routine and not so routine activities of the members of the culture" (Van Maanen, 1988, p. 3), and each section of society that identifies a cultural system has common patterns. Schein (1985, p. 9) defines culture as:

> A pattern of basic assumptions – invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration – that has worked well enough to be considered valid and therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems.

This definition identifies culture in relation to groups of people who together build a picture of the group, what it is about and how it undertakes its purpose. This definition is useful in understanding the context of dual diagnosis nursing in relation to the external and internal impacts that have informed it and how nurses in the field have adapted to these impacts.

Schein (1999) developed a framework for understanding what he called organisational culture, which identifies three levels of culture; artifacts, values and basic assumptions (see figure 3.3). Schein describes these cultural components on a continuum from tangible and observable to being subtle and undetectable.

Figure 3.3: Schein's Levels of Culture (1999, p. 16 adapted from Schein, 1985)

Artifacts and Creations **Technology** **Art** **Visible and audible behaviour patterns**	Visible but often not decipherable
⇩ ⇧	↑
Values **Testable in the physical environment** **Testable only by social consensus**	Greater level of awareness
⇩ ⇧	↑
Basic Assumptions **Relationship to environment** **Nature of reality, time and space** **Nature of human nature** **Nature of human activity**	Taken for granted Invisible Preconscious

Schein's cultural theory specifies three layers; cultural artifacts, espoused values and basic assumptions. Artifacts is the outermost layer and most visible expression of the culture. It includes, for example, dress code or communication systems. The second layer; espoused values refers to the principles and standards valued by the members, the foundations as to what is acceptable and what is not acceptable. At the core lie assumptions; the unspoken, non visible and often unconscious beliefs and expectations shared by individuals. For example when a

solution to a problem works continuously it is then used unconsciously and becomes the way things are done.

This way of understanding a culture is comparable to my understanding of methods in this ethnography. Through utilising various data collection techniques the purpose is to not only to gather a description of what is visible but also to become aware of what underlies how the nurses practice, what informs their practice; what is not always clearly visible even to those cultural members. Therefore Schein's (1999) 'Levels of Culture and their interaction' will serve as a theoretical anchor for this study.

Chapter summary

Agar (1986, p. 53) contends that ethnography is an "ambiguous term" emphasising that it is not only a method but also a result. The ethnographer observes the culture, interviews members, reviews supplementary information and with recognition of his/her own impact on these activities and interpretation on the findings then sets out to analyse and write ethnography. In this chapter I have described my participation in the study. The methods of collecting and analysing data in focused ethnography have been clearly set out to allow the reader to gain an understanding of the processes used. This clarity and openness regarding methods is fundamental to ensuring the credibility of the results generated.

The following chapter presents the results of the research. In accord with an ethnographical approach, the perceptions, viewpoints and actions of the nurses during fieldwork, are described. Sections of the data are presented as direct narrative from the nurses interviews. Analysis of interviews, observations and discussion, documentation and reflexive notes revealed three key themes that will be explored in relation to Schein's cultural typology.

CHAPTER FOUR The culture unfolds

Culture should be viewed as a property of an independently defined stable social unit. That is, if one can demonstrate that a given set of people have shared a significant number of important experiences in the process of solving external and internal problems, one can assume that such common experiences have led them, over time to a shared view of the world around them and their place in it.

(Schein, 1985, p. 7).

Data analysis using Spradley's (1979) Developmental Research Sequence has revealed various themes worthy of further investigation. This chapter re-presents three distinct themes 'the nurse as a linchpin' which relates to the nurses communicating as part of the team. The second theme was 'teasing out the facets' a term used in discussing assessment and 'keeping all persons safe' the third key theme was referred to often when the nurses talked about maintaining a safe environment. These themes are captured and discussed in the categories of 'communication'; 'assessment' and 'the safe unit' respectively. Schein's (1999) cultural typology which has been used to gain further understanding in relation to these themes is further elucidated to commence this discussion.

Understanding artifacts, values and assumption

Level one of Schein's (1999) cultural typology relates to artifacts; often the most visible and tangible expressions of the culture. Artifacts include the materials that communicate information about the culture's technology, values and assumptions. This level also includes the visible behaviour of group members in relation to how this behaviour is made routine. Less observable than artifacts and very complex is Schein's second level of culture; a groups 'values'. Schein suggests "all cultural learning ultimately reflects someone's original value, their sense of what 'ought' to be, as distinct from what is" (1985, p. 15). Values are those which are developed within a group when decisions are initially made by the group and then found to

succeed. In other words, if a solution is deemed reliable the group may accept it and where initially it was conjecture it becomes accepted as reality and is transformed into a value that is no longer questioned. As values become assumed they gradually become beliefs and then assumptions and eventually drop out of consciousness. Schein cautions however that this is not always so, stressing there are values in some groups that remain conscious and overtly expressed. The third level of Schein's typology is 'basic underlying assumptions'; the deepest level of culture. Basic assumptions may be so implicit, unconscious and 'taken for granted' that surfacing them can require intensive observation and dialogue. "Yet when we do surface them, the cultural pattern suddenly clarifies and we begin to feel that we really understand what is going on and why" (Schein, 1985, p. 21). Using the different sources of data the themes will now be identified to explain the role of the nurse in dual diagnosis.

Communication

Patterns of communication existed between the nurses and others as part of the daily ritual and included both oral and written forms.

Oral dialogue

Oral dialogue was an artifact intrinsic to the nurses' role in communication. Dialogue occurred at all times of the day and was a basic source for information sharing between nurses, the multi disciplinary team, with patients and significant others. Interaction between the nurses and patients occurred regularly and the nurses presented diverse ways of communicating with patients. Some of the patients have limited verbal communication skills yet the nurses appeared at times to find ways to overcome this in order to understand or get a message across. I often observed two particular nurses sitting close to patients talking quietly with them (Fieldnotes). Encouraging statements such as *well done* for example, were

used by one nurse often. Other times some nurses spoke very loudly to the patients, were directive; sounding almost bossy. At times these 'bossy' interactions resulted in arguments between nurses and patients. There were other occasions when an interaction occurred where no verbal language was spoken as the following excerpt shows.

> Mark came rushing into the office; the door had been left open. Two nurses immediately rushed out and taking a hold of an arm each, walked him to the de-escalation area. Mark was struggling. The door to the de-escalation area was then locked with him in there. Nobody said anything. I asked about this later to try to understand how the nurses had made the decision without communicating with Mark or with each other. One of the nurses responded that the patient tries to steal the coke that is kept in there for other patients (Fieldnotes / Day 9).

Various meetings occurred as part of the communication rituals. The meetings that included patients were the three monthly review meeting (Policy Documents). However I was not present during any of these three monthly meetings and therefore cannot present any further data related to these.

Staff - only meetings occurred daily, the first of these the shift handover. The nurses met together three times every 24 hours to verbalise a 'patient handover' (Fieldnotes/ Days 1, 3, 4, 5, 7, 14). In this meeting the nurses commencing duty hear a report about each of the patients in the unit. These meetings most often began and ended with some social 'chat' between the nurses. The report included any aspect of the patients' day that each nurse decided to share. Examples of these reports from the fieldnotes included information about PRN [Pro Re Nata – As Required] medication, outings and activity, visitors and periods of seclusion or behaviour, as well as the statements *ok today*, *remains the same* or *had a good day*. The accounts heard most often were related to unacceptable behaviour, PRN medication and seclusion requirements. With this focus on seclusion and medication, an absence of any reference to a patient's intellectual

disability, their strengths and abilities, their needs or even future planning, was quickly evident. As a nurse listening to these reports and not knowing the patients, I was quickly aware that the patient was presented as a 'behaviour'. I was not hearing about what was unique about the person, what their intellectual disability or their strengths might be, or even what mental illness symptomatology they might be experiencing to help me contextualise the behaviour. The nurses just listened and notes were rarely recorded.

Oral communication was enhanced often by gestures such as facial expressions. For example I observed one occasion when one nurse was stating a change in treatment ordered by the psychiatrist; another doctor was in the room at this particular time writing a note. One of the nurses listening began to question this decision. A rolling of the eyes by the speaker appeared to stop the questioning and the challenging stopped (Fieldnotes / Day 8). Questioning or discussion was rare in these handovers and the information appeared to be accepted as stated.

Oral reporting between the nurses revealed a comfort they had with each other and a value placed in each nurses' knowledge to accurately report on the patients. There appeared no discernable structure to this oral report time; some nurses presented a great deal of information where others gave a very brief he or she has *had a good day,* for example (Fieldnotes). I was unable to find any guidelines related to requirements for patients handovers. The nurses' comfort in sharing information in this informal way and the absence of questioning suggests a significant assumption that the information given is adequate and correct. This assumption also infers that the nurse giving the report and the nurse receiving the report have a similar knowledge and understanding of the patient being reported on.

Daily reports, the next form of staff meeting occurred at 0830 every morning Monday to Friday and also took place in the staff room. Fieldnotes reveal this meeting as more formal, involving all nurses on duty, the clinical coordinator and other allied health professionals. The nurses spoke more officially, reading clinical notes verbatim from the files. There was little questioning or discussion and the purpose of this meeting appeared to be to provide information about the patients to other health professionals, particularly the occupational therapist who would then plan the daily programme for the patients. The nurses would ascertain what activities they may be involved in from the programme. The occupational therapist stated the programme for the day and who would be attending. It was at this time the nurses responded to state whether or not a patient should attend an activity. It was not always clear how these decisions were made but most often they were accepted and not challenged.

A further gathering of staff to discuss patients was the once weekly clinical review meeting. This involved the clinical coordinator, the psychiatrist, the behaviour support person, the social worker, and the occupational therapist. The nurses attended separately to discuss those patients they were working with that day. I was present at three of these meetings and the following description is from the fieldnotes I wrote after the meetings.

> At this meeting, each nurse read a weekly report of the patients they were responsible for. This report, a summary of the events for each patient that had occurred over the week, had been written by the night shift nurses the previous night. Some of these reports were long and comprehensive, some brief and to the point. After the nurse read the report the other members of the team would comment at times. Discussion occurred on occasion and less often the nurse was asked for more information or clarity. The psychiatrist would most often make a final summary statement and they would move on to discuss the next patient. Generally the other team members had more to say than nurses although there was one meeting where one nurse very quietly interrupted the discussion to add in knowledge or correct misunderstandings. The nurse apologised when doing this. Most

times however, the clinical coordinator was the one nurse who spoke for the nursing team, providing an overview of all the patients and events in the unit.

The functioning of any of these staff meetings was not alluded to by the nurses during interviews but in response to my questioning, the importance of the role and complexities of the nurse within the multidisciplinary team was described passionately. One nurse declared that the nurse was central within the multidisciplinary team (MDT), being the key person who interacted between all the various team members. *Linchpin* and *hub* were terms used to describe the nurses' role.

> *You need to be the linchpin in the multi disciplinary team really. You need to know what the social worker is doing, what the psychologist is doing ...//...* (SNS / Interview).

> *...working in a team is really satisfying, definitely a nursing team. It can be quite satisfying being in the middle and knowing what the social worker is doing and what the consultant is doing and the house surgeons and just having that central knowledge that no one else actually shares and it's quite satisfying* (SNQ / Interview).

However in contrast this nurse later stated

> *... It's frustrating being the hub sometimes ...//... it's difficult to try to share all the information that you've got. And it's difficult at times to be listened to within the MDT because everyone's got their own cart to push you know... You have an expert opinion and you've got to try and integrate all those assessments and also retain your own analysis of the situation* (SNQ / Interview).

This last transcript supports the values and assumptions related to nurses' comfort with each others knowledge identified earlier. However, the observations described of the latter two meetings present a different picture than the *expert opinion* and *hub* previously described. Whereas in the nurse only meetings there had been an apparent confidence in their valued knowledge and an assertion in their communication with each other, the presence of other health professionals

appeared to alter this confidence and the assumptions previously identified were no longer evident. I wondered then if the assumption was that other health professionals would know more (Journal) and whether this was because there appeared to be an absence of knowledge related to the impact of an intellectual disability or mental illness for the patient.

This disparity between what the nurses were saying and how they presented their role in nurse only meetings and within team communication was important. I pondered again on my previous observations regarding the absence of questioning (Journal). To understand this dichotomy further I needed to explore what information the nurses considered essential information to report and how they gathered the information.

Documenting knowledge

Written communication was a regular requirement of the nurses role with the artifact most representative of this the computer. Nurses are responsible for several categories of written communication; the most regular the end of shift report. Each nurse will sit at the computer sometime before the end of the shift and write a report about each of the patients they had been responsible for that day. This report is written into a standard template (Text Module) on the data system. The nurses often accessed the computers early in the shift to prepare the notes. In doing this they assigned themselves to the patients they had for the day, pulled up the template and prepared it for later additions as the shift progressed (Fieldwork memo/ Day 5).

The headings in the templates were:
- Clinical Observation
- Speech
- Affect and Mood
- Relationships
- Health/Nursing
- Activities completed

- Issues/Progress discussed with client
- General information
- Level of risk
- Plan

The nurses are able to make comment in all or any of the headings. These notes were referred to at the commencement of each shift and the aforementioned meetings. This format is only used for the morning and afternoon shift duties, the night shift staff do not tend to use the template and note only the sleeping pattern of each individual or any other relevant overnight event. Of particular note is this template presents a primary psychiatric assessment tool. Nowhere was there a requirement that attention be paid to an intellectual disability and what this meant for the person. This is critical knowledge in order to focus on a person's abilities and strengths.

Treatment plans are another category of written documentation nurses are accountable for. These are also written into a text module framework, and to be reviewed as necessary. This use of a computer text module whilst providing structure may also impose some limitations The headings were listed as Current issues/problems and included (Fieldwork Memo/ Day 16):

- Mental health (including education)
- Physical health (including diet)
- Living skills
- Social supports (e.g. mobility, employment, interpersonal relationships, spiritually [sic])
- Leisure and recreational supports (e.g. community participation)
- Personal finances
- Discharge planning
- Other
- Aims/Goals; Treatment/Intervention; By Whom/When and Evaluation is then to be documented for each identified issue or problem.

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The treatment plan is part of the discussion that occurs at the weekly clinical meeting and amendments arising out of this discussion are made to the plan. The nurses work in teams and it is the responsibility of a team nurse who has been on duty to note any changes in the treatment plan or information that may have arisen from a review. If there is no team nurse on duty at the time then the nurse who has looked after that patient has the responsibility to inform one nurse from the team.

Discharge planning and a patient profile are further documents the nurses are responsible for, as well as other documents required by other members of the team. These include physical observations that may have been requested from the medical officers, psychiatric consultants or registrars and behaviour assessments that have been developed by the psychologist.

Perusal of the files to gain both an awareness of what was required under each heading in the text modules and an understanding of how the nurses describe their assessments was important to understand the nurses' work. There were vast disparities in the information recorded under each heading (Fieldwork Memo/ Day 16). For example under 'clinical observations' factors such as where the patient spent most of their day or evening was documented - *Spending time out of room tonight* is a case in point which whilst it may be significant especially if the patient is normally within their room, was not clear in the absence of further comment. Other comments included *elevated*; *untidy*, as single words. The 'Health/Nursing' heading was where the most documentation occurred. Included under this heading was: *PRN medication*; often only a statement of what was given rather than why or what the response was; *seclusion* [person is placed in a room in isolation]; *bathing; food and fluid intake; referrals to medical staff; blood test occurrence*

[not result]; *patient vomiting.* These comments indirectly infer nursing tasks. Further examples are the statements *Unable to be reasoned with* or *difficult to distract*, where it was obvious that the nurse had been attempting some interaction however further descriptive documentation could have helped the reader understand how this has occurred. *Nursed in seclusion* was also included in this section most often; yet there was often no mention of the length of time the patient had been in seclusion. There was no description of what 'nursing in seclusion' entailed. At times there was nothing written.

This type of documentation continued throughout; some headings contained no data for sequential days. Understanding how nurses were assessing and planning interventions was difficult to ascertain. When only three or four of the sections were responded to, the common explanation was that there were often few daily changes when some patients were in for long periods (Fieldnotes). Meaning was often mystifying when data was put in so many categories. The heading of health/nursing as separate from the others was interesting in itself and I wondered how nurses decided what should be in this category.

The aforementioned examples were the rule rather than the exception for the files perused. An assumption arises in reading these files and is related to the previous value of nurses' knowledge and understanding. This assumption is that all of the nurses know what should be written under each heading in the text module. This was plainly inferred one day when I and three other nurses were in the nursing office. We were talking about the headings in the text modules; the nurses were typing their reports. I asked how they knew where to put various data (Fieldnotes / Day 2)

SNW	*I put PRN and bathing in the nursing notes and then seclusion on the general notes*
SNY	*Yes I do the same*
CT	How do you decide why or when an event is or is not a nursing role or task?

The nurses looked surprised by this question and after pondering on it for a while SNW responded with

SNW	*Mmm, I just know it. Maybe I should think about this, maybe the Nurse Practice Consultant should come and teach us.*

It had been assumed by the nurses that what they had been writing was clear to everyone else. No one had ever questioned it. There seemed to be an expectation that the nurses would have this tacit knowledge and therefore understand. A further assumption appears where the headings are believed to be adequate and appropriate to write about all persons equally.

Of the three treatment plans accessed one had not been altered for several weeks and the other for four months. The third file belonged to a newly admitted patient and appeared minimal in content. There was an absence of data in many categories with a scarce reflection of patients' needs or wants. It offered a minimal view of the care provided and/or plans for future care. Where symptomatology or mental health issues were described, psychiatric or medical jargon was privileged over descriptive nursing data. Examples of this included use of terms such as *euthymic* or *elevated*. Without further description or evidence of how this had been assessed this terminology presents little advice for a nurse reading and attempting to plan care. Conversely use of these terms may direct a nurse whose practice is deeply embedded within a traditional

psychiatric ethos to interpret the need to provide a custodial or low stimulus response in the absence of any other information.

As previously stated, nowhere was it noted how an intellectual disability impacted on the person, what their strengths and needs were in relation to this. Significant also was a lack of information related to developmental stage, description of what was normal behaviour for this person or any physical issues that may be affecting the person. These are crucial areas to consider in order to contextualise behaviour that may be a secondary response to another health or emotional issue.

I took no more from these plans as the structure enabled only an objective illness statement without any clear description of how the nurse had worked with the patient which was the intention of my access to the files. There was also no evidence in any of the notes that the patient had been consulted regarding what they may want and this being documented. These findings present some incongruence with nurses' articulations regarding the importance of their role in communication but go some way to explaining the fieldwork observations regarding nurses' communication and reporting.

Assessment

Assessment was privileged in all the interviews and casual conversation, as the most important aspect of the role of the nurse in dual diagnosis. Oral communication and documentation were the overt artifactual symbols of assessment. The difficulty in assessing what behaviour was attributable to the intellectual disability or mental illness and what was considered inappropriate behaviour with unclear attributable cause featured regularly in the data. *Knowing the client, being experienced, being intuitive* and *knowing psychosis* or *knowing manic behaviour* were terms used to *tease out all the facets* in assessment. The nurses talked often about how complex this was:

….it's about eliciting what are their mental health issues and taking this knowledge …//… and applying it to our people and then working out what's going on (SNB / Interview).

Well dual diagnostics is a very complex kind of nursing because you're faced with people with obviously dual diagnosis and [you are] trying to work out what's operating with them. Whether it's an intellectual disability or a manifestation of their psychiatric illness or maybe something else? (SNQ / Interview).

Whilst the nurses identified this complexity it was not always clear what they were referring to when they talked about assessing, with numerous terms used to describe dual diagnosis. For example *mental illness*, *special needs*, *intellectual disability*, *behaviour*, *mental disabilities*, *manic behaviour* were some of the terminology to describe the key issues. These terms were often used interchangeably often with no clear distinction of meaning. Nevertheless, despite this variation in descriptive terminology *having the knowledge and understanding* (Interview/SNB) to *tease out all the facets* (Interview/SNS) was inferred to be a basic value. One nurse explained that this important aspect was not always recognised

I think [the] *nurses generally aren't always that good just acknowledging just how valuable we are and how much we do and how much we know and …//… what an incredibly complex job we do* (SNB/Interview).

Nurses were able to identify issues that impacted on the quality of their assessments or their ability to undertake assessments. Whilst nurses' knowledge and understanding was the key underpinning value one of the nurses often talked about their frustration when others did not *take the time* or *have the forbearance* necessary. Nurses expressed this was possibly an issue for some as they *don't really understand their role or responsibilities* (Fieldnotes/ Day 16). Another nurse also alluded to the importance of taking time to assess.

> *I think it is about being able to take the time to merely be open to what the person is trying to tell you, so it takes time, it takes energy, and it does take patience* (SNB/Interview).

These timeframes and how they did not have time, were referred to often. *Limited time to undertake tasks* was mentioned as a cause of frustration in three of the interviews and often in casual conversation. *Doing the tasks of nursing* was described as another frustration and also considered time consuming.

> *The thing that frustrates me the most is that we don't have time to do things individually with them. You know you are really rushing from one task to another without actually having time to sit and talk with them, listen to them or take them out even for a coffee....//...we have to actually do hands on or assist or encourage a lot of physical things, you know. Like showering and stuff* (SNS / Interview).

With the assessments identified as the aspect of the role most valued the protest was that other tasks were a hindrance to this. These *other tasks* referred to most often were *bathing or showering patients*, *giving out medication* and *participating in groups*. However fieldwork observations presented a very different view of this. There were busy times through the day when nurses were undertaking these 'tasks'. Some of the nurses rushed through these which then enabled long periods to sit in the nursing station. Often many of these tasks occurred with minimal verbal interaction (Fieldwork Notes). I reflected on this often and wondered if opportunities for asking about how patients were feeling that day were being missed and how assessment data was actually being obtained (Journal). Also evident in these verbalised frustrations with tasks is an absence of attention to or awareness of the specific requirements of some persons with intellectual disability. Often persons with intellectual disability require assistance and/or guidance with attending to their daily activities and hygiene needs (ADL's), because of their stage of development.

Tasks or assessments?

While there was a value placed in the importance of assessment, an assumption appeared that if assessment information was not available it was acceptable because they had been too busy undertaking the tasks, a contrast to previous observations and ponderings. One of the many examples of this occurred one evening when I arrived in the unit later than had been expected (Fieldnotes / Day 10).

> I arrived one evening in the unit at 2100 hours. I had arranged to be there at this time but there was obviously some confusion as the staff said they had been expecting me at 1900. They were sitting in the staff room having their supper break. All three staff were there. They talked about how busy their night had been, having to do all the baths. They discussed between themselves, what was left to be done and then left the staff room soon after. I wandered out to the ward area as well. It felt alive. It was after 2100 hours and nearly everyone was up. They were mostly all dressed in clean pyjamas with their hair nicely combed. The nurses had been busy with their tasks. I wondered if this had occurred in expectation of my presence to emphasise how busy they could be. This was certainly a contrast to previous visits in the evening.

Whereas the nurses complained these tasks took up all their time, these tasks and the need for an ordered unit were privileged over any other action or assessment. The fieldwork data reveals few overt examples of nurses undertaking assessment. As stated previously, there were two nurses who regularly spent a lot of time sitting with patients and talking to them. I sat with these nurses as they conversed with the patients in a very informal conversational manner, gathering assessment data. Information important and relevant to the particular patient was easily elicited within this informal chatting, and the nurses were then able to share this with others [staff] and document in the assessment and clinical notes. However this activity appeared to be the exception. Most of the nurses'

conversations with the patients were limited to 'instructions' regarding such occurrences as medication, meals, bath time and similar.

Assessment tools

A crucial issue in dual diagnosis is the difficulty some individuals have in explaining their needs, any potential for subjectivity becomes lost and vital issues are missed. It is therefore important that an individual is given many opportunities and time to communicate their needs and feelings. Psychiatric assessment and diagnosis in the general mental health population relies heavily on communication to gain a patient's subjective understanding and description not only of symptoms experienced but also emotions and cognitive functioning. For persons with decreased communication and/or linguistic abilities the impact is greater in regard to how needs are understood and resultant care and intervention is planned and delivered.

None of the nurses identified or used an assessment tool related to nursing in dual diagnosis. One nurse showed me a tool they had tried to modify from another rehabilitation unit within generic mental health services. The nurse explained that it was not useful in that it relied too much on subjective information from the patient, highlighting again this difficulty when persons have limited ability to verbally communicate. Nevertheless, in light of the difficulties with this tool no other assessment instrument particularly suitable to dual diagnosis had been developed and the descriptions of patient care, needs, issues and the nursing response was limited to the headings of their text module clinical notes.

Another important assumption; that because a nurse works in the area s/he has the knowledge and understanding to effectively undertake and document an assessment, was revealed in the data. That the nurses come from various scopes of practice seems important in regard to this and it appears assumed that regardless

of this all will have the same knowledge base. One nurse was able to recognise a difficulty with this assumption.

You know it is difficult here sometimes, I feel frustrated when the notes don't actually reveal all the issues [for the patient] there are some [nurses] that still don't really understand what their job is (Fieldnotes / Day 17).

This exchange demonstrated a common concern for this nurse and a couple of others and supported my observations also in regard to the documented clinical notes and some of the verbal communication I heard. I recall one day, all the nurses were in the nursing office, some were typing their shift reports and others were sitting together. One senior nurse was sitting with a pen and paper (Fieldnotes/Day 11).

The nurse (SNU) was asking questions and writing responses prompting the others to think and respond often. SNU stopped and explained to me

SNU *We are trying to write information about Margaret so we can give good information to her new caregivers when she gets discharged.*
SNU then carries on asking questions under certain headings
SNU *What are her food and fluid preferences, what kind of clothing does she prefer?*
Two other nurses respond and SNU writes.

This nurse (SNU) approached me later to discuss another issue and took the opportunity to express frustration at having to do the previously mentioned task. SNU suggested that if *leadership had not been taken then the patient would be disadvantaged as the records would not be comprehensive enough for the caregivers*. The need for a nurse specialist in the unit who could be involved in guiding the staff in improving their documentation was suggested by this nurse.

In the interviews the nurses described the importance of knowledge of mental health and linking this knowledge with their experience.

> *It's about eliciting what are their mental health issues and that's the challenge...then taking this knowledge and applying it to our people and then working out what's going on* (SNB/Interview).

> *The biggest challenge is the separation of the behaviours...the longer you know them the better your chances are in saying, I **think** that is part of the psychiatric disorder or I **think** that is a behavioural component ...knowing your patient is important and experience is important and you only get that after you have been here a long time* (SNL/Interview)

Whilst the nurses were able to articulate this importance of knowledge and experience the fieldwork and document data has revealed the knowledge and experience to be strongly correlated to a traditional psychiatric behavioural focus with little evidence of understanding of the impact of the intellectual disability.

Assessment does not just occur in conversation and it is acknowledged that nurses may utilise other skills such as observation to gain an understanding of what is occurring at any given time. This was not clearly evident in the documentation. Complete assessment however it is undertaken, takes time and nurses must manage all other issues whilst this is occurring. A primary consideration at the outset of assessment most especially with persons who are acutely unwell is risk management. This leads on to the next theme related to nurses and safety.

The safe unit

'Keeping all persons safe' was a fundamental value inferred often by the nurses. The nurses described and presented ways they believed they were achieving this. Some nurses regularly spent time with the patients talking to them, sometimes just sitting with them whilst in the television lounges; there were few incidents observed when the nurses were in these areas.

If the unit was quiet the nurses regularly sat together in the nursing station. They would be talking with each other or accessing various websites on the computers. At times they were discussing unit issues but often this discussion and computer work was not work related. The nurses did not re-enter the ward unless a task such as medication was due to be completed or a loud noise alerted them. There were times I was also in the nursing station with them. It was a strange feeling to be sitting in there at times, especially when there was paper sellotaped over the window to prevent patients looking in. I worried about not knowing what was happening outside. There were other times that the nurses sat together in a lounge; sometimes there were also patients in the lounge, other times there were not.

Artifacts overtly significant to the role of the nurse in 'keeping all persons safe' included physical domains such as seclusion, medication and locked doors. Seclusion encompasses an area at one end of the unit situated behind the nursing station. A small window in the nursing station is covered by a venetian blind which can be lifted to provide a limited view of the area. The first room entered in this area is the de-escalation room; it contains two large lounge chairs, a dining room chair, has built in cupboards and a table. Prior to the research my understanding of the purpose of the de-escalation room was that it was an unlocked area that provided a quiet, low stimulus space where a patient could go

if wanting a quiet space or an area where a nurse could sit with a patient to provide a low stimulus and/or safe milieu. Both of these situations were to prevent as much as possible any escalation of behaviour or a situation that may result in seclusion. At times during the fieldwork the de-escalation room was locked when a patient was in there alone.

Two seclusion rooms lead off the de-escalation room; each of these has an ensuite with a separate door that can be locked to keep the door either open or shut. The purpose of a seclusion room is to provide a safe, low stimulus environment for patients who were assessed as requiring this. These rooms are usually locked when a patient is in there and policy exists in relation to the correct use and management of   seclusion. The doors have double locks that require a specific turn of the key. If a patient is isolated in one of these rooms the nurses are legally required to attend the area at stated times to check the patient to attend to their wellbeing, assess their mental state and respond to their needs (Policy documents).

Creative ways to manage

Nurses appeared to focus on maintaining a quiet environment and any loud noise was responded to promptly. On several occasions I observed this prompt response; there would be a loud noise such as a shout or raised voice and nurses would stop immediately what they were doing and run to the scene. A regular response also was that one nurse (often the clinic nurse) would quickly observe who was involved and retreat to the clinic to fetch medication. Administration of PRN [as required] medication was a regular early response to any incident as the following excerpt shows.

> We [one nurse and I] were in the office, I heard a yell. We went out to
> the lounge. There were two nurses walking with one patient. They

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were walking each side of him holding his arms gently. I heard quiet encouragement

SNB   *C'mon, Matthew, we will just go to your room*

As another nurse approached the patient tried to kick out. The nurse jumped back

SNM   *Whew that was close.*

We arrive in the bedroom. The nurses sat beside the patient, still holding his arms.

SNM   *We need some PRN.*

The other nurse had already gone to get some and arrives back with it. Offers them to Matthew and he does not respond.

SNC   *Please take these.*

He pushed them away and kept his mouth tightly closed. The situation continued with some encouraging and cajoling from one nurse. Matthew again tried to kick out and the nurses put their legs over his while they were sitting to prevent any injury. After the encouraging had failed one nurse asks him...

SNC   *Do you want to make a phone call?*

He nods.

SNC   *Then take your meds and we will get the phone for you.*

Matthew took the medication and the nurse got the phone and rang the number.

SNC   *There is no answer. We will try again later.*

They tuck the patient into bed. It is 0830 in the morning (Fieldnotes / Day 4).

One nurse said that it was important to look at *creative ways of managing safety* such as:

> *I'm sure there are many options that are tried...//... just spending time with them, keeping them and others safe is most important* (Interview/ SNB)

However this 'creative way of managing safety' also revealed an assumption that was inferred often, particularly when discussing the use of the de-escalation area as a seclusion area. This assumption is that people are 'better off on their own for low stimulus; better off away from both peers and nurses'.

As one nurse stated *It's about people having space and separation* (Interview/SNB) and

And then we run into a practical situation where if we put a nurse in with him [it] *doesn't give him the degree of low stimulation environment* (Interview/ SNL).

Protecting the patients and others was spoken of frequently and one of the most regular responses to any actual or potential risk event was that a person was removed to a locked area. The use of the usually unlocked de-escalation space as a locked area, much like a seclusion area, was a particular risk management measure prevalent in the unit at the time. This action presented some polarisation between various nurses' beliefs in the benefits or appropriateness of this action. Some of the nurses felt it was not really appropriate or right for the patients but was the best they could do in the circumstances. One nurse assumed it was best practice and referred to the ritual as *creating or providing sanctuary* (Interview/ SNL).

Locking the doors

De-escalation as a locked area presented a complex situation for me. There was no policy related to the use of this area as a locked area. Most often if there was a patient in the de-escalation room and the door was locked less attention was being paid to them and the nurses visited mostly only to provide food or medication. I would often observe a face looking out at me from the locked de-escalation area and either one or both of these areas were utilised each time I visited the field at sometime during my visit. The following excerpt from the fieldnotes illustrates my first discovery of this practice.

I arrived in the unit and observed a patient standing at the window of the de-escalation area, calling out. The door was locked. I stood for a minute and looked at the patient. He began smiling at me. I had seen patients in there at earlier visits also but had not realised that the door may have been locked. I continued to observe this area throughout my three hours there. After the first hour, two enrolled nurses unlocked the door and took some food and medication in to the patient then left again, locking the door behind them. I was perplexed.

I asked about this.

> **SNK** *Not sure if there is a policy for that just that we have the ok to use it as a seclusion area.*
> CT Are usual seclusion observations required?
> **SNK** *No, theyre not done – usually someone in the office next door. You can see if someone is in de-escalation* (Fieldnotes/ Day 7).

Given my current knowledge and understanding regarding both seclusion and the expected use of a de-escalation area, in particular the requirements set by both divisional Policy and the Mental Health (Compulsory Assessment and Treatment) Act (Ministry of Health, 2000), I experienced some concern. This was in particular regard to the ethics and the legality of this practice, both for the patients and the nursing staff who were using it. I consulted my supervisor before choosing to pursue the issue further; I needed to understand this complex observation. On one occasion I was in the nursing station and a nurse was tallying up the monthly seclusion record. I asked if a seclusion record was done for the de-escalation area when it was locked. I was told it wasn't required and that it had been okayed by the psychiatrists. The nurse told me *We have a piece of paper that says this but no one can find it. We just know that it is ok* (Fieldnotes /Day 8). Another nurse interrupted and pulled down a folder presenting me with a document. The document related to using the Mental Health Act when one is not deemed to be mentally disordered; it was stamped DRAFT and did not mention the use of seclusion or de-escalation.

This questioning instigated a great deal of dialogue and debate regarding managing risk and the issues for the nurses. A further complicated issue was one day-patient who often spent part of his day within the locked de-escalation area. The nurses' talked about this being best for him and for the other clients; they *needed to keep the others safe* (Fieldnotes/ Day 7).

...he's been a bit moody...//... possibly not happy about being here and almost out of the blue has hit out. He gets into other peoples faces...//... because we can't be on his bottom lip all the time because that aggravates the situation for him it would be better for him during the day to be separate from the others (SNL / Interview).

Significant issues in regard to this patient and seclusion were evident. Over the several times he attended the ward when I was there, spending time in the area was only part of his day. There were times when he was working alone with the occupational therapist. I asked about this inconsistency and the nurses countered that when the patient *was not otherwise occupied he becomes mischievous and teases the other patients* (Fieldnotes). The nurses stated they were too busy to keep him occupied all the time. One nurse told me emphatically *I am not here to keep the patients entertained* (Fieldnotes/ Day 6).

The nurses were also not concerned that despite a patient being locked in the de-escalation area they were not undertaking usual seclusion observations. The justifications included explanations such as *the area is next door to the office*, *there is a window in the office that looks through to the area and there is usually a nurse in there*, *the environment is safe* and *the* [window] *glass is unbreakable*, and *this patient won't harm himself anyway* (Fieldnotes). One senior clinician who was not a nurse, also referred to the secretary who was in the office next door and who could hear if anyone yelled. This way of thinking fits the nurses value of 'keeping everyone safe' with an assumption therefore that 'limiting the rights of one person' was alright to maintain this safety notwithstanding whether this response was legally or ethically acceptable or not.

Following initial questioning regarding the use of this area and the lack of clear legal guidelines I asked the nurses how they perceived their role in this practice. The nurses had an assumption there was a mandate for this. When they found out that whilst this had been agreed in kind by the doctors but never

actually finalised into a clear documented directive, some were initially disconcerted. Despite this they continued with the practice as they viewed it as the best option in the absence of any other. It was left to the Senior Clinicians and the Management Team to sort the legalities and paperwork around it. The nurses were not concerned whether their role in this practice was illegal or unethical; if medical staff had sanctioned it, it was assumed acceptable. It continued to be seen as a way of minimising the use of 'seclusion' (Fieldnotes/ Day 9).

Managing the risks

Risk management was stated as a crucial aspect of their role. However what they considered actual risk or who was at risk was not always clear. A further example from the fieldnotes helps to elucidate this:

> Peter was wandering in and out of his room. SNG had told me that Peter's mood was elevating and he will need low stimulus. Peter was told several times to return to his room. He returned each time but only for a short period. Later on [we were in the nursing station] SNG spoke to SND stating "*oh I have put Peter in seclusion, he couldn't stay in bed*". Peter's primary nurse for the shift said "*What do you want me to write in the notes?*". "*Just write, placed in seclusion for low stimulus to aid settling*".

This example is different in that the response seems indicative of preventing potential future risk. The patient was well known to the service and the nurses told me it was crucial to act early as the patient becomes aggressive when his mood is elevated. I was not there to witness this at all and cannot comment further in response to this explanation. However, a further risk issue arises out of this scenario; the nurse is undertaking a practice that is contrary to policy in regard to seclusion practices thereby placing his/her own position in a risk situation. Seclusion policy states clearly that a minimum of three staff will be present to place a patient in seclusion at all times (Reference withheld). The incident was also not questioned by the patient's key nurse that day.

With 'keeping all persons safe' valued as an important aspect of the role of the nurse in dual diagnosis, using seclusion was assumed to be accepted practice. There was no evidence in any of the notes accessed that 'all else' has been attempted when persons were placed in seclusion (Fieldnotes). Sometimes PRN drugs may have been given, but often seclusion occurred first and then the PRN medication. Often when persons have been inpatients for long periods and nurses know that seclusion is a regular end point this occurs earlier than usual. This last exemplar where the patient was walked down to seclusion is an obvious example of this.

From the latter example further assumptions are also evident. These arise out of the value nurses state of the need to have staff on duty that 'know the patients well' at all times.

> *... this is basic ...knowing your patient is even more important in this area and you only get that after you've been dealing with them for a considerable length of time* (SNL/Interview)

> *You have go to know your patients because for some people it doesn't pay to get too close...//...once you get to know your patients you minimise the risks to yourself* (SNL/Interview).

By knowing the patient well it is assumed the patients receive better care, an assumption evident earlier also in relation to communication in staff meetings and in relation to documentation. Knowledge of patients should be useful to enable nurses to respond in a way that the patient may have already indicated and therefore help nurses to avoid responses that have never worked in the past. However, at times this knowledge of the patient is historical and caution must be taken to re-contextualize this regularly. It appears also this comfort with knowing the patient may cause nurses to take legal and ethical risks in regard to following seclusion protocols.

Knowing the patients presented several examples of nurses placing themselves at risk because 'they knew the patient'. One day I was standing in the kitchen area involved in a conversation with the caterer and one patient. Everyone else had left the dining room. Another patient came running into the area; he was not allowed in there without a nurse escort I was told later. A nurse ran in after him. The nurse grabbed the patient by the arm, the patient wrestled to get free. Another nurse approached before I could respond and together they walked out with the patient. This patient was taken to the de-escalation area and the door was locked (Fieldnotes/ Day 9). We talked about this later and the nurse told me s/he *knows the patient well* and therefore *I know how far I can go*. Again this incident presents several issues, the first is regarding the patient having to go into a locked area because he tried to get more food; secondly the patient is being held against his will by the nurse [a legal issue]; and finally the personal risk the nurse had placed her/himself under as s/he 'knew the patient'.

Whilst loud behaviour often resulted in an immediate response the notion of risk behaviour and how it was understood and what response it should generate was difficult to decipher or understand. Any discussion regarding risk was related most often to physical risk to others and at no time was risk to a person's personal emotional or mental state referred to. The following exemplar explains this revelation further; we [nurses and I] were in the nursing station, the unit was quiet, many patients were already in bed, the nurses on duty were typing their computerised shift reports.

> I could hear a patient crying nearby and mentioned this. A nurse responded with "*oh yes, she's labile*" and hurriedly went back to writing the notes. I felt concern as the crying quietly continued. The patient was sitting in a lounge nearby. I sat beside her. She told me that another patient had been hitting himself and she was scared. She stopped crying. I wondered why the notes were most important (Fieldnotes/Day 10).

This patient had been admitted with a possible bipolar disorder diagnosis [meaning that there was some observed alteration in mood] and was presenting with hypomania [elevation in mood]. Being 'labile' is sometimes evident in persons who are experiencing hypomania. In the described event the crying was seen as a natural part of the illness, presented no physical risk and therefore required no response. The behaviour was labeled according to psychiatric symptomatology and the person's emotional state was not considered. This incident was also one of the many occasions where I struggled with my responsibilities as a researcher and my duties as a nurse.

Nurses as protectors

Many of the previous events described and numerous others highlighted an aspect of the role the nurses valued highly and was aligned with the value of keeping all persons safe; that of 'protector' of those assumed not able to fend for themselves. Several times this was cited as important especially in regard to the need to use seclusion and as a supporting factor in having to use the de-escalation room as a locked area. A situation frequently referred to was one patient who was often in either the de-escalation area or the seclusion area for this very reason.

> *We have a particular patient here who is often the victim of assaults because he gets very, very noisy, gets in peoples faces, doesn't understand the concept of personal space and that results in assaults...* (SNL / Interview).

The nurses felt they had no other option than to seclude this patient for his own protection. We discussed this situation often but those I talked with could think of no other solution (Fieldnotes). A further example of this value the nurses placed in their role as protectors is the need for nurses to undertake medical interventions against a patient's will.

> We had just sat down in the staff room to wait for the afternoon report. One nurse came to the door. "*We have to give Trevor an enema*".

The nurses all arose immediately and followed the nurse out; I followed. Trevor was on the toilet. One nurse encouraged him to stand up. He had no trousers on. Two nurses walked him down the corridor to his room. The rest of the nurses followed. They all entered the room and shut the door. I stayed outside. There were seven nurses in there with the patient. I heard nothing. They all left the room about 5 minutes later (Fieldnotes / Day 8).

This exemplar supports to some degree the importance at times of the 'nurse as protector'. The patient concerned had many times been admitted to hospital very ill when an enema had not been administered in time. The nurses were carrying out a procedure that was necessary to sustain the life of the patient. However, whether there needed to be seven nurses at the scene is arguable. Unnecessary also was the need to walk the patient down the corridor with his bottom half, naked. Whilst this benevolent and depersonalised response may have been initially necessary there were other similar occasions where practices such as this also could come at the end when all other attempts to provide choice and autonomy for the patient have been exhausted.

With the regular use of seclusion and de-escalation as locked areas the alleged risk minimisation arising from this seemed an easy solution. However some nurses were able to identify a disparity between what they perceived as practical risk management and the legal issues associated with the use of this area. The difficulties with low staff numbers in the afternoon and night shifts were identified as impacting on the increased use of this area. *There are nurses in the unit next door* [in the same building] *who can be called on to help, but this takes time and is not always easiest solution* (Interview/ SNL).

Another reason accentuated in instigating the use of this procedure was related to the lack of other areas in the ward and the ward was not big enough. Observations during fieldwork do not totally support this issue. The nurses spent

vast periods of time in the nursing station and there were many times where all nurses were in there together. Outside the nursing station there is a reception desk which offers a degree of visibility into one main lounge area and down two sides of a corridor. The nurses never used this area. Two doors provided access to the unit from the nursing station; these doors had small glass windows to provide some view of the world outside the nursing station. Most times paper was sellotaped over these windows prohibiting any visibility of the unit outside the nursing station. The explanation for this was that one patient kept looking in the windows and would not go away (Fieldnotes). For those patients wanting to talk to a nurse, they had to stand and knock at the door and wait for someone to respond, they never knew if there was someone in there at that time. There were occasions where the patients who were waiting at the door actually became agitated. This need for patients to stand and wait without knowing if a nurse would respond presents an issue of power and controlling practices.

The findings revealed within this theme indicate an ethic of maintaining a degree of safety and order above all else. The idea of maintaining safety is related to keeping persons quiet and limiting any extreme emotional responses. If medication did not provide this then seclusion was used, responses seeped in a custodial ethos of care.

Seclusion practices identified in this study presented ethical issues not only for some of the nurses but also myself as a researcher. I had a Duty of Care; this is fundamental to all nursing practice. The Duty of Care must be exercised regardless of unit or service policy. I was aware that my questioning in response to my 'duty of care' impacted on future responses from some of the staff and my fieldwork journal reveals numerous reflections on this.

Chapter Summary

The visible evidence of a cultural group has been presented in this chapter with the artifacts apparent in the domains, rituals and communication patterns of the cultural members presented. Judgments and conclusion about nursing practice can be made on superficial levels of observation. However, to truly understand the nursing practice probing beneath these surface levels has been necessary. Schein (1985) has provided a valuable theoretical framework for understanding some of the deeper levels of nursing practice. This chapter whilst considering some of the basic artifacts, values and assumptions informing and directing nursing care in the unit has exposed several areas of concern. These will be summarised and discussed in the next chapter.

CHAPTER FIVE Dual diagnosis nursing - A unique subculture?

Power/knowledge can demonstrate the ways in which the oral basis of nursing culture causes nurses to continue to be oppressed because they are unable to move from individualism to collaboration, they are unable to document their clinical knowledge and practice for reflection and critique, and they are unable to challenge the power base of the medical and administrative cultures articulated and perpetuated through means of written communication.

(Street, 1992, p. 267)

It is comprehensible within the contemporary notions of normalisation, the social constructs of disability and the concepts of recovery that most persons with an intellectual disability will not require nursing care. However there will always be a percentage of this group, as with the non disabled sections of the community that will require nursing input in assisting them to manage their mental illness. If nurses are to respond to these needs they need the knowledge to understand the complexities of their own role. This study has explored contemporary dual diagnosis nursing practice and the impacts and influences upon it, in one inpatient unit. This chapter presents an examination of the findings in relation to relevant literature thereby setting the scene for future enquiry.

Communication and contemporary nursing

Street (1992) describes communication as not only intrinsic to the role of the nurse but also a fundamental aspect of the routines and structures that surround nursing practice. Artifactual evidence of communication in this study is provided through the team meetings and computerised documents generated by the nurses. The nurses implied a value they had in each others ability to report to each other with the underlying assumption that the reports, whether oral or written, would be accurate and that all nurses had an equal understanding of the messages being conveyed.

The data has identified various instances of nurses communicating. Nurses were involved in regular meetings which gave them the opportunity to share knowledge about the patients. Naturally communication with others took place but it was the team communication that occurred most often during the observations. Whereas in the nursing only meetings, the nurses revealed a comfort with their reporting and communication skills, their silence in larger team meetings presented some perplexing data initially. The nurses had talked about how critical they considered their role was to the functioning of the team yet provided little evidence of this during the observations. Whilst Cleary (2003, p. 217) in her ethnographic study of mental health nursing in an acute inpatient unit found that nurses believed less successful case reviews were "those which are medically oriented, [and] have little input from nurses; " the absence of the nurses voices in the multi disciplinary team meetings is similar to the finding by Street (1992) who suggests that even nurses who believe they are equal to medical staff continue to struggle in their autonomy due to the traditions and unconscious habits personified within them.

The findings revealed knowledge and understanding deficits regarding the text modules in which the nurses documented their observations and communications. This may be due to the attempts to fit generic mental health text module headings to a non generic area. Similar issues are identified by Gilbert, et al., (1998) who express their concern that the theoretical base for understanding mental health issues in persons with intellectual disabilities "relies upon the traditional theories of mental illness being extended to cover people with learning disabilities" (p. 1152) and highlight how problematic this can be. There was no clear model of understanding the complexities of dual diagnosis and how nurses can work with this evident in this study.

A treatment plan is developed for each patient by the nurses. The findings showed plans that were not only directed toward an illness focus but also concentrated on behaviour and medication. The terminologies used to describe patients were psychiatric medical terms and provided little information to guide nurses in care planning. This terminology however, serves the needs of the doctors and other clinicians. In doing this it also shifts the power from the patient. Crowe (2000b, pp. 584 - 585) outlines how nurses collude with the medical clinicians when they "provide data and descriptions of observations to enable a diagnosis [and] integrate the nomenclature of diagnosis into the language of mental health nursing practice". O'Malley (2001, p.168) suggests that "mental health nursing practice is inextricably linked to the process of medical diagnosis and treatment" and that the scientific explanations of mental illness have been integrated into nursing practice. In the absence of a clear model of assessment related to the needs of persons with dual diagnosis it is critical that if nurses are going to use this psychiatric jargon they need to be aware of, and understand the impact of the constructs of what is normal and what is abnormal for each individual. The brevity and at times absence of descriptive data in the notes written by some of the nurses does not demonstrate this awareness or understanding.

Street (1992, p. 173) illustrates a finding where the notes rarely reflected the "patients view of the world with a carefully articulated picture of the clinical care that had been provided and the plans for future care". The point here is that despite the nurses feeling satisfied with their documentation the evidence shows that not only is the patient as a person invisible, and presented as a list of behaviours and emotions, but the clinical care being provided by the nurses is also invisible.

The nurses readily talked about their clinical knowledge and the factors that affected their practice; however this knowledge was most often presented with

unexamined reasoning. The nurses were articulate in discussing what they felt was real about their role but this also was not reflected in their written documentation or their communication. Neither their written nor oral communication seemed to be used as a foundation for their own critique. Whilst it was evident at times that nurses are therapeutically involved with the patients the absence of this in the documentation detracts from the acknowledgement of it. This is a common problem also described by Street (1992) who suggests, by not capturing a full picture of the patient and any interactions they have had with the patient it is difficult not only for other staff to either learn what works and continue with it but also for the nurse him/herself to critique and theorise their own practice. Tunmore and Thomas (2000) suggest that the care plan for the patient is useful as a therapeutic tool when developed in conjunction with the patients and relative others. O'Malley (2001) presents a similar finding where the plans of care for the patients were not always complete, consistent or updated and the "frameworks for assessment were not explicit" (p. 94). She highlights that there was variable evidence of involvement of the patients and or family in care planning and the clinical notes written by the nurses did not always reflect the care plan or provide information about nursing care delivery.

Assessment and contemporary nursing

Assessing the mental health needs of persons with intellectual disabilities is fraught with complications and draws on the expertise of skilled professionals. Persons who are receiving support and care from health services are partially reliant on staff to recognise the impacts and changes in their mental health state. For example "one of the skills required is to be able to draw out the issues in a person's life that can lead to a comprehensive assessment of mental health" (Priest & Gibbs, 2004, p. 11). The outcomes of these assessments are then communicated to relevant others either verbally or in written form.

It is well documented that the prevalence of mental illness for persons with intellectual disability is much higher than the general population and care of persons with a dual disability presents various intrinsic complexities (Borthwick – Duffy, 1994; Haut & Hull, 2000; Jacobsen, 1999). The primary difficulty is the attempt to make a diagnosis (Gabriel, 1994). Bernal and Hollis (1995 cited by Halstead, 1997, p.210) accentuate numerous issues in endeavouring this such as:

> Communication difficulties may make the diagnosis obscure. More emphasis therefore has to be placed on changes in biological functioning and adaptive behaviour in detecting episodic mental disorder. Mental illness may be missed and chronic symptoms can be mistaken for the person's normal personality. Accumulation of adverse life events may lead to adjustment reactions and depression. Similarly untreated physical disorders (or under-treated) disorders such as epilepsy) may lead to the presentation of psychiatric symptoms.

How the nurses undertook assessment in cognisance of the nature of any of these complexities was unclear despite my investigation. With the ability to distinguish between a psychiatric disorder and a behaviour problem of some persons with an intellectual disability being very dependant upon the skill of the person undertaking the assessment; there were no obvious general guidelines available for the nurses.

The complex issues described previously by Halstead (1997) relate also to a common concern in dual diagnosis; 'diagnostic overshadowing'. This phrase was first coined by Reiss, et al. (1982) and refers to a phenomenon where "some debilitating emotional problems appear less important than they actually are, when viewed in the context of the debilitating effects of mental retardation" (Cooper, Melville & Einfeld, 2003, p. 5). Most commonly what occurs is behaviours that may be indicative of mental illness are erroneously attributed to the intellectual disability and the issue of the mental illness gets disregarded. This also

indicates the importance of having an assessment tool that appropriately guides nurses in understanding the issues for the patient with a dual diagnosis.

A consideration also in dual diagnosis that continues to undergo much research is the notion of 'behavioural phenotypes' (Holland, 1999). Advances and understanding in molecular genetics has presented the possibility that there may be links between various genetic syndromes that cause intellectual disability and certain behaviours that are directly linked to specific syndromes. The absence of attention to a person's intellectual disability and their lived reality in psychiatric focused text modules inhibits individual care planning which should eventuate as a result of assessment. Effective assessment will also consider any recent alterations in behaviour, for example self injurious behaviours, changes to sleeping and/or eating patterns and any new behaviours as well as changes in self esteem (Ailey, 2003). Attention to this will alter how the nurses work with the patients and possibly change some of the safety issues that have also been identified in this study. Assessment and diagnosis in the general mental health population relies heavily on communication to gain a patient's subjective understanding and description not only of symptoms experienced but also emotions and cognitive functioning. For persons with decreased communication and/or linguistic abilities the impact is greater in regard to how needs are understood and resultant care and intervention is planned and delivered.

Undertaking assessment in order to communicate about the patient was a role responsibility privileged in all the interviews when nurses talked about their practice. Oral communication and documentation provided artifactual evidence of this. The nurses identified a value in each others knowledge and understanding with a corresponding assumption that if a nurse works in the unit then they had the skills to undertake assessments and eventually report on them. The data around assessment revealed many issues worthy of future consideration.

With the evidence in this study of nursing knowledge related to assessment appearing minimal and inconsistent, the dearth of effective nursing assessment tools specific to dual diagnosis provides a possible explanation to this. The findings reveal the text module the nurses used to guide their reporting was closely aligned to a conventional psychiatric assessment model. The absence of a requirement to pay attention to the patients' needs and strengths related to their disability and corresponding abilities indicates an area also for further contemplation.

A further assumption that arose regarding assessment was where the nurses stated they were too busy at times to complete effective assessment and reporting. The tasks of the role took up this time. This type of issue is also evident in the literature in relation to both assessment and documentation. Bray (1999) suggests that nurses seem more concerned with attending to the daily business of running the ward rather than interacting with the patients in a therapeutic manner. Porter (1993) identified that nurses tended to avoid therapeutic interaction in order to respond to their desire to sustain environmental order. O'Malley (2001) describes the argument put forward by nurses in her study who insisted that they are too busy to attend to the care plans. The nurses stated that writing a care plan is not a priority and that "direct care and attending to the routines of ward life place[d] higher demands on their time" (p. 132). O'Malley warns that this dearth of care planning means that care possibly becomes "reactive and inconsistent and has the potential to lead to conflict, insecurity and unsafe situations" (pp. 132 -133).

The safe unit and contemporary nursing

Early identification of the artifacts related to maintaining a safe unit as 'seclusion', 'medication' and 'locked doors' suggest a patient management philosophy seeped in institutional tradition. The underlying assumptions in this study related to maintaining a safe unit – 'people are better off on their own'; 'its ok to limit the rights of one for safety of others'; 'if the doctors say it is ok then it is ok' - have revealed some serious and highly concerning practices. With the value base of the nurses role as 'protector' to 'keep all persons safe', and the conviction that nurses who have been around long enough to 'know the patients' are best suited to undertake this role the underlying assumptions are explicable. Bishop and Ford – Bruins (2003) express a concern that whilst the importance of maintaining safe environments supports the role of the nurse in assessing safety and risk, nurses tend to determine clients unpredictability in relation to the safety of staff and others in establishing what is acceptable and what is unacceptable. Higgins (2004) insists assessment of potential risks to patients and others should be responded to quickly to decide the reactive and contingency procedures that may need to be put in place.

It has been shown that there was not always clarity in the nurses understanding of the difference between intellectual disability and mental illness and often behaviour itself was pathologised as a single issue regardless of any other health issue. Nurses often reacted to a behavioural episode with the response directly related to a behaviour that was perceived to be outside the norm, rather than what may have actually been occurring for the patient or why.

The use of the de-escalation area as a seclusion area presented many issues worthy of further investigation. Some of the nurses talked about how the use of the de-escalation area did not really sit comfortably with them but as it was inferred

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'ok' by the majority in the absence of any other clear options they resigned themselves to it. However, this feeling of discomfort is a clue that something may be wrong. Lakeman (1999 cited in Barker 1999, p. 214) states that "nurses share a common adaptive trait with the rest of humanity; that of feeling uncomfortable about being uncomfortable". This discomfort usually indicates that something is wrong and that one needs to change their behaviour in order to minimise whatever it is.

The regular use of seclusion as an early response to any behaviour considered unacceptable, also presents concern. Wynaden, et al. (2002, p. 260) highlight that seclusion as a management strategy "remains controversial and the source of ongoing debate". These "controlling practices contribute to the stress of mental illness and provoke the very behaviours they are designed to contain" (Watson, 1991, cited by Lakeman, 1997. p. 12).

The local District Health Board document identifies seclusion as a "specific clinical intervention requiring valid, objective clinical reason for its use" (Reference withheld). There are clear parameters stated for the use of seclusion in accordance with the New Zealand Restraint Minimisation and Safe Practice Standard, (Standards New Zealand, 2001) and the Mental Health (Compulsory Assessment and Treatment) Act, 1992 (Ministry of Health, 2000). The District Health Board document lists the following situations where seclusion may be appropriate.

> a. The control of violent behaviour occurring during the course of a psychiatric illness which cannot be adequately controlled with psychosocial techniques and/ or medication.
> b. Disturbance of behaviour as the result of marked agitation, thought disorder, severe confusion, hyperactivity or grossly impaired judgment.
> c. To reduce the disruptive effects of external stimuli in a person who is highly aroused due to their illness.

The reporting and documentation around the need for a person to be secluded was sparse and offered little understanding of the decision making involved.

The nurses in describing the use of de-escalation and seclusion as places of safety, assumed their role as protectors of those possibly not able to fend for themselves.   The principle of limiting the rights of one patient in order to protect others is often incorrectly or mistakenly thought appropriate. Nevertheless, within institutions, norms and expectations develop that make the exercise of power accepted and expected (Kearins, 1996). O'Brien and Golding (2003) write of similar issues, also inferring that often staff incorrectly determine they are acting paternalistically in protecting some of the group by limiting the rights of another. In an area where patients are perceived to have little self determination or autonomy nurses can often become over protective in their desire to minimise risk and keep all patients safe.   Tolerance towards the use of seclusion may be seen as a way that nurses exercise a power that enables them to control individuals and/or maintain an orderly unit (Gastaldo & Holmes, 1999). O'Malley (2001) identifies power issues in mental health services in regard to a close alignment with medicine and the ability through legislation to treat people against their will. She draws attention to the issue that in an environment where control is a major factor, issues of power are magnified.

"The use of a seclusion room is an (extreme) example of the application of discipline and control in the field of psychiatric behaviour modification" (Gastaldo & Holmes, 1999, p. 237). Alongside this and the medical discourses on impairments lie notions of power. Munford and Sullivan (1997, p. 22) assert that "power operates insidiously and unconsciously as a particular view represented as 'truth' and beyond question" They elaborate on this stating that when the medical model is the dominant discourse persons with disabilities may be classified as less

than whole and therefore deficient. This in turn leads to these groups of people becoming oppressed. These understandings have also greatly impacted on the concepts of nursing in this area, where nurses have been trained to provide total care for those 'cared for' within a medical paradigm. The connotation of the title 'nurse' infers a sick or disabled role for those under care in an institution in the absence of any other relative theoretical understandings. The inferences here indicate a traditional psychopaedic nursing ethos where nurses 'maintained control' of the patients in their [the patients] best interests.

Also crucial in the findings was the assumption that a document had been developed by the doctors to enable use of a usually unlocked area to become an area of seclusion. The nurses' acquiescence in accepting a document or decree that was not clearly or adequately mandated is not unusual. Gilbert (1995, p. 870) encapsulates this type of issue well where he states

> For nursing practice to be empowering the nurse needs to be able to identify the discursive practices through which they as nurses are formed…the awareness of this process is essential if they are to identify similar discursive practices which work to produce the individuals who are to be the subject and object of their practice.

Other issues impacting on this regular response to what was considered unsafe behaviour were related to the environment. The nurses felt that seclusion and use of the de-escalation area would be lessened by some strategic changes. Firstly increasing nursing numbers was seen as a priority. This is not examined or discussed as it is beyond the scope of this thesis to make a judgment or comment on the adequacy or not of staffing equivalents. The nurses also complained that they did not have the visibility to see around all areas of the ward and felt that changing the architecture of the unit to afford full visibility would at least minimise any potential risks. The type of environment suggested is comparable to

those evident in some penal institutions and forensic areas such as the 'panoptican' described by Foucault (1980) that allows guards to see into each cell. The thought behind the panoptican was that prisoners would never know whether they were being observed or not and thus would adjust their behaviour in case they were being observed.

Similar environmental issues to those identified by the nurses have been acknowledged by the Mental Health Commission (2004) report on seclusion practices in New Zealand. Low staffing numbers have been cited as compromising care and adding to the demands nurses face in order to manage the ward. Poor ward design was also alluded to identifying issues such as the lack of quiet rooms and personal space. The unit however had been redesigned several years ago in response to these very issues. The previous unit had been modeled on the earlier institutional blueprints with shared dormitory type bedrooms and large 'dayrooms' where everyone collected. In response to the idea that these large spaces afforded little privacy and added to issues of agitation, a new design was developed. The current unit provides individual bedrooms and several lounges where patients can go. There are also outdoor areas, although these are now limited as the unit is continuously locked. The predicament now however is that the increase in spaces for patients to go demands more interaction from staff in order to maintain an essential level of observation (Mental Health Commission, 2004). This study has revealed this to be a key issue as nurses are spending a great amount of their time in the office, unavailable to the patients.

The seclusion policy for the DHB (Reference withheld) outlines very clearly the procedures for initiating seclusion. These procedures are clearly not only to protect the patient but also any staff who are involved in the seclusion process. Two critical points in regard to this are Point 6 where dialogue and calming throughout the process are encouraged and Point 8; the requirement of at least two

staff entering the room at all times. Pertaining to Point 6, the data reveals a situation where the nurses collected a patient from the office and placed him in seclusion in silence with no attempt to negotiate an alternative course of action. Point 8 is significant in relation to the situation where one nurse felt comfortable to seclude a patient on his/her own. These are two of many similar examples.

It is rarely possible to eliminate risk completely however it is expected that nurses have the skills to reduce it to an acceptable level. Whilst there will always be conflicts between the nurse's professional accountability and the patients' autonomy, the calculation of the risk is based on the knowledge and skills of the nurse. Mental illness is constructed within psychiatry as a disorder caused by some internal biochemical fault (Crowe, 2000a). If nurses working within mental health sanction this notion then it becomes certain that their nursing response will consist of controlling behaviour by the use of medication and helping the patient maintain a dependant illness focus on self. The nurses nonetheless perceived their risk management to be effective even in times when they may have been placing others or even themselves at risk.

Final thoughts

This study has described the roles and responsibilities that are important to nurses in one dual diagnosis inpatient unit. In concluding this discussion a further and most critical finding is evident. Whilst the enquiry has identified the roles and responsibilities undertaken by nurses in the unit there is little evidence of practice in response to the contemporary philosophies of nursing and health care for persons with dual diagnosis. The institutional nursing activity in both psychiatric and psychopaedic nursing environments of the 19th and early 20th century, for example custodial care (Matheney & Topalis, 1974), oppressive seclusion practices (Fennell, 1981) and deficit focused care (Hunt, 2000) described earlier in this thesis,

were apparent also during the study. It is apparent that the role of the nurse in this dual diagnosis inpatient unit has not changed markedly from the traditionally bound nursing practice of the institutional treatment approaches of the past. This finding makes sense of the artifacts that describe the routines of practice, the values that are accepted without question and the underlying assumptions that have been identified in this 'taken for granted' traditional ethos of care. This study, adds to a current knowledge base of contemporary dual diagnosis nursing practice in that it has identified that regardless of policy changes and societal shifts, the status quo has been maintained and the practices of the nurses reflect the very issues that lead to the contemporary philosophies of recovery, normalisation, and deinstitutionalisation.

Chapter Summary

The findings have been revealed and present implications for nurses and consumers in the future. Chapter six concludes the discussion, identifies the limitations and considers recommendations for further consideration.

CHAPTER SIX: **Journeys end**

Many of us who have worked in mental health for many years are ready for the new, not something that will completely jettison what we have learned, but rather that which will reject certitude, constraints on freedom, complacency, and uncritical acceptance of what is, always was and because "we've always done it that way". Between the "no longer' and the "not yet" lie possibilities of change that might be impossible under traditional modes of thinking.

(Mohr, 1995, p. 90).

Discussion

This study grew out of an ambiguity in understanding the role of nurses working within dual diagnosis. The actions and activities of the nurses, the factors that influence their practice and the policies and procedures that inform and impact on practice have been identified and discussed. A number of social processes have been realised that whilst describing a nursing practice in the unit have suggested an absence of dual diagnosis specific practice. The following concludes this study, considers the limitations and suggests actions which may be taken in response to the findings of this research.

What is clearly evident in this study is that nurses in dual diagnosis need to have not only a clear understanding of intellectual disability and mental illness but also to know and understand how each of these effects the other and what this means for the patient. Therapeutic nursing of persons with an intellectual disability requires a particular array of skills. It is a "level of nursing practice that requires practitioners to develop a uniquely client centered view without necessarily having access to either thoughts or language" (Gilbert, et al., 1998, p. 1153). These authors describe the necessity to unite the skills of intellectual disability nursing with the knowledge and skills one may develop in generic mental health services. These skills then link this knowledge to the objectives of

normalisation theories, applied behavioural theories and the knowledge of mental health treatment and intellectual disability.

These findings suggest that it may be unrealistic to expect nurses who have not received education in relation to their changing roles to be able to perform them adequately. However, whilst this absence of education and corresponding knowledge deficit may be apparent all registered nurses regardless of their scope of practice are required to maintain a level of competence and professionalism to retain their practicing certification (Nursing Council of New Zealand, 2005a). What seems more evident in regard to the knowledge deficits identified is the lack of self awareness the nurses may have in regard to this. The levels of competence put forward by Te Ao Maramatanga: The New Zealand College of Mental Health Nurses (2005) and outlined in chapter two present a reasonable level of care and responsibility that could be expected from any of the nurses in the unit. All the nurses had been in practice longer than the two years indicated in these standards.

The findings of this study are analogous with international trends. Literature shows that mental health professionals feel ill equipped to provide services to persons with intellectual disabilities (Gilbert, et al., 1998; Longo & Scior, 2004; Mohr, et al., 2002). Conversely staff in intellectual disability services also feel inadequate in responding to mental health needs (Gilbert, et al., 1998; Mohr, et al., 2002). The debate continues also whether mental health care for persons should be delivered within generic or specialist psychiatric services (Chaplin, 2004; Doyle, 2000; Longo & Scior, 2004). There is consensus that staff training needs to be increased and staff need to be supported in ensuring a comprehensive specialist response (Mohr, et al., 2002). Nursing in dual diagnosis will need to develop an approach that goes beyond administration of medicines (Simpson, 2002). They require advanced skills in communication techniques (Chatterton, 1999; Williamson, 2004), greater knowledge and understanding of comorbidity (Fuller &

Sabatino, 1998) advanced observation skills (Haut & Hull, 2000) and an understanding of behaviour and all that encompasses (Gilbert, et al., 1998).

Given the findings in this study a further plausible supposition may be that nurses struggle to understand and define their role in an environment that is itself not clearly defined. Several external factors were identified that impact on nursing practice. The health care environment response to current theories of normalisation and deinstitutionalisation has meant a change in who is admitted to hospitals and in what circumstances. The impact of this has altered the patient group to more acute admissions with resultant care complexities. The findings have identified this in relation to nurses trying to understand dual diagnosis and manage the more complex assessment and treatment requirements. More interaction between nurses and family could identify key information to guide nursing care. Nursing assessment tools specific to dual diagnosis could assist nurses in undertaking effective assessment.

Other influences are related to the design of the environment. The literature identifies that environmental and design features of an inpatient unit must provide privacy, comfort and security whilst maintaining a therapeutic milieu (Dix & Williams, 1996; Gray & Thomas, 1998; Yonge, 1989). The nurses indicated a perceived lack of adequate spaces to provide de-escalation or low stimulus to prevent situations where they could be therapeutically effective. Conversely, the findings revealed adequate space indicating the issue may be more related to effective use of the space and the need to increase the visibility of the nurses. O'Malley (2001) talks of geography and boundaries between nurses and consumers. She identified consumers [patients] concerns that the nursing office "engendered emotional responses that conveyed to the consumers the feeling they were a nuisance" (p. 145).

The limited or at times silence of the nursing voice in meetings with other health professionals although not an uncommon finding in the literature and therefore not unique only to this study, presents an issue in need of further consideration. O'Malley (2001) identified a paradox where when nurses described their role in the presence of other health professionals, they referred to the 'medical' aspects of their work including such things as medication and diagnosis. Conversely when they talked in nurse only groups they described their nursing work as holistic, wellness and recovery focused. The nurses reporting in the presence of other health professionals in this study also focussed it seems on the information they thought the doctors and others wanted to hear. Street (1992) describes nursing from the past where nurses acted as handmaidens to the doctors and suggests that even nurses who respect themselves as equal to the doctors still find it difficult at times to "act in ways that are emancipatory because of their traditions, because of their embodiment in habits which they respond to on an unconscious level" (p. 200).

Keeping the unit as stress free as possible was privileged over enabling persons to express emotion. There was a lot of seclusion and medication used, often to suppress behaviour that was assumed outside the 'norm'. Individualism and free will for the patients was at most times difficult. Priority was given to ensuring patients were bathed and fed which whilst certainly important and appropriate most times, sometimes eventuated only as a result of extra medication or containment. Balancing freedom and restriction for the patients appeared to be an ongoing challenge for some nurses particularly in the ethos of containment that prevailed. Often any positive steps to change how persons were nursed reverted back as soon as one negative outcome occurred and the risks to try something new were minimal. The most common treatment was medication. "In the work of mental health nursing, caring and controlling are enmeshed and any attempt to

change practice requires recognition of the tensions in this mix" (O'Malley, 2001, p. 227).

Limitations

The study was undertaken in one dual diagnosis unit and therefore the findings are influenced by any philosophies of care that govern the unit. The small sample number for interviews also meant that saturation of data was not obtained.

The small number of registered nurses working within the unit places limitations on generalisability. There are also Enrolled Nurses within the unit and some data that included these nurses was not able to be used. A key issue in this study is related to the limited number of interview participants (5), the limited time in the field and the common requirement in ethnographic methodology to obtain data saturation. This refers to when the information discovered and collected has begun to be repeated and therefore no more needs to be collected (Streubert, 1995).

An important limitation is in regard to whether the findings can be generalised to other similar units. This is not an issue as no claim has been made that the findings are representative of any other environment. However it is worthy to note that generalisability in qualitative research is not about the extent to which the findings can be applied to the broader population more about providing the opportunity for readers to identify with some of the content and relate it to their own situation (Morse, 1991).

The limited number of patients who were willing or had capacity to give consent placed some constraint on the number of clinical files accessed for data collection.

Methodological limitation

A major limitation of this study is that it was confined to one unit at a particular point in time. The ethnographic methodology provides one interpretation of the practice of the nurses and therefore the findings are context bound. However the research process has been clearly acknowledged and reflexive processes which are consistent with the ethnographic tradition were utilised throughout the study.

Theoretical limitation

Denison (2000) warns that researchers must remain aware when utilising Schein's (1999) levels of culture framework to avoid 'dividing' a culture into three distinct levels. He emphasises the importance of maintaining a link between the three levels to avoid also the mistake of focusing on a cognitive assumption thereby de emphasising the more visible levels of the culture. A further caution is stressed in regard to the notion of unconscious assumptions. He asks "to whom are these basic assumptions unconscious? Insiders? Outsiders? "(p. 5). Also significant is the importance of the researcher to remain thoughtful regarding what happens when cultural members become conscious of these underlying assumptions.

Recommendations

These findings from this small study proffer insights into the world of nursing practice in a dual diagnosis inpatient unit. The potential usefulness of these findings is that they provide a basis for further research into the area. The data has also provided valuable information that can be used to create recommendations for the direction and measurement of change in relation to some of the identified issues.

The findings of this study have implications for nursing practice. Further research is needed to develop clinical practice guidelines for this area of nursing, identify how nurses manage some of the complexities of their role in dual diagnosis and how they may develop new solutions.

There is an understanding that very strong cultures are often resistant to change and novel influences, often growing more conservative over time (Flint, 2000). Paradoxically, weak and negative cultures also resist change. This resistance in weaker cultures is understandable if one considers the function of a culture as a place where persons are comfortable and know what is required of them; thereby reducing anxiety. Flint purports that members of the culture then rarely question the basic assumptions and even if the culture is dysfunctional they will hold fast to whatever makes them feel secure. Action is recommended for the service to further examine the factors that are working to maintain the status quo that has been identified. Nurses need to be supported to understand change and the possible impacts of change upon them.

Urgent action is also required to respond to the safety issues and responses identified in the unit. It is not denied that there are situations that may arise in which seclusion is the only viable option. However, its therapeutic value identified in this study is questionable. Service development needs to ensure nurses are working in an environment which encourages best practice. Effective systems of care delivery develop when good clinical leadership is in place to encourage and support positive practice.

The findings indicate a need to provide nurses with support in gaining further understanding and knowledge regarding dual disability and what this means for the patient and their resultant care. Support for nurses in advancing these areas impacts on support for the patients. Research and/or consultation

could be undertaken with patients and family groups to determine their expectations of the nursing service. Research could include questions formulated by consumers and their families that incorporate their concepts of positive practice and outcome rather than those developed only by health professionals.

Meeting the healthcare needs of person with dual diagnosis requires highly specialised skills. Further research is recommended to discover the baseline knowledge of nurses working in dual diagnosis and ascertain any knowledge deficits they may identify. Haut and Hull (2000) undertook a study in the United Kingdom examining the psychiatric knowledge of intellectual disability nurses. They carried out a survey both pre and post a series of tutorials about psychiatric topics and found these tutorials to be effective in improving knowledge. An Australian study (Mohr et al, 2002) was also undertaken to trial an education program for staff working with persons with dual diagnosis. This study suggested positive outcomes for the patients following staff training. Similar studies and approaches could be used as foundation to developing education programmes for nurses working with persons with dual diagnosis in New Zealand.

Journey's end or just the beginning?

> In the grey light at the dawn of the 21st century the mental health nursing profession should take care to examine carefully its 'given' role ... to ensure that it is practising in the spirit of [it's] own philosophy of care.
>
> (Crowe & Carlyle, 2003, p. 26).

Implications for nurses

Nurses need to be attentive to the caring aspect of their role in ensuring this is paramount in meeting the needs of those they care for (Sullivan, 1998). Nursing practice in dual diagnosis occupies a distinctive niche at the juncture of two parallel nursing cultures; psychiatric and psychopaedic nursing scopes. Whilst

nursing in dual diagnosis shares a focus with each of these scopes one would assume the culture of dual diagnosis nursing to differ in their practices, beliefs and social structures. This study has shown that whilst nurses in the unit negotiate a labyrinth of roles, responsibilities and expectations they have no clear contemporary model of dual diagnosis nursing to guide them. Within the limitations of this study, further exploration of this absence of clear role definition was not possible; however this study does provide direction for future research and possible areas for change that may assist nurses to perform their roles according to contemporary evidence.

Implications for patients

Under the legislative frameworks and modern theories of mental health care, nursing practice in psychiatry treads a fine line between benefiting and harming the human rights of those within its care. The basic principles of human rights set boundaries on the "degree of social authority and social isolation" which can be imposed on individuals (Gosden, 1999, p. 144). The complexity in psychiatry is the requirement at times to go beyond those boundaries in managing potential or actual risk situations with a resultant antithesis between human rights and psychiatric practice. Risk in this sense referring to the "danger of some bad outcome arising" (Halstead, 1997, p. 218) and the attempt to counter a potential risk necessitating the process of 'risk management'. Lakeman (1997, p. 13) maintains "health professionals face the dilemma of balancing a societal mandate to control those with mental illness and a mandate to care for them". He insists those persons who work with persons with mental illnesses regardless of the setting "must ensure that caring takes precedence".

Consumers of mental health services are entitled to a high standard of care as part of the "contemporary ideology of service" described by O'Malley (2001, p. 209) and underpinned by the Code of Health and Disability Services Consumers'

Rights (Health and Disability Commission, 1996). If inpatient treatment continues to be an indispensable component of care for some persons with a dual diagnosis, a nursing care and service provision philosophy underpinned by current knowledge, effective communication and contemporary safe care practices is a basic right of those receiving the service.

In conclusion, this study goes some way to recognising areas for further examination regarding the knowledge base and the role of the nurse in dual diagnosis in response to current treatment provision trends and to move beyond the containment and control ethos of the past. The last day I was in the field I was talking to one nurse about data analysis and how the process helps one to identify themes. The nurse stated "I know what my theme is; "*bring dual diagnosis nursing in* (unit name withheld) *out of the dark ages*" (Fieldnotes/ Day 17).

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LIST OF APPENDICES

Attention: all registered nurses who are currently working in [Name withheld]

You are invited to attend an information session about a proposed research study looking at nursing practice in the area of dual diagnosis.

The research is called

⇩

Contemporary nursing practice in a dual diagnosis (intellectual disability and mental illness) inpatient service: A micro-ethnography.

Primary researcher:
Chris Taua RCpN, BN, PGCertHlthSc (Mental Health)

Two information sessions will be given.

Date: Date:

Time: Time:

Place: Place:

Come along and find out what is involved.

Project Title Contemporary nursing practice in a dual diagnosis (intellectual disability and mental illness) inpatient service: A micro-ethnography.

This is an ethnographic study that will be undertaken with registered nurses who work in the area of dual diagnosis (intellectual disability and mental illness). The researcher will enter the field of study (**xxxxx** inpatient unit) to observe nursing practice. Field notes will be taken of the observations, communications and events that occur. Semi structured interviews will be undertaken with nurses who choose to take part in them and some written documentation such as clinical files or policy manuals may be accessed if necessary. The researcher will keep a diary documenting her own thoughts and reflections regarding the observations and events. The data that is collected will be analysed into themes. The final findings will presented as a descriptive account of the observed culture – nursing practice in dual diagnosis.

What is the purpose of the study?
The purpose of the study is to describe current nursing practice within the area of dual diagnosis. It is anticipated that the factors that influence practice will be identified.

What happens in the study?
You will notice Chris Taua on the unit. She will be observing the nursing activity in the unit, reading written records and policy manuals and interviewing other nursing staff. She will be writing field notes related to her observations, discussions and interviews during the study. Once this is completed the results will be analysed and written up as part of her Masters study. The results may be published in journals and at conferences. Neither you nor the inpatient unit will be identified anywhere in the publications or presentations.

What are the discomforts and risks?
There should be no risks to you from this study. However, you may feel uncomfortable or uncertain in regards to feeling that your practice is being questioned by the research process. Chris will endeavour to minimise this by clear explanations of the purpose and process of the research, along with information regarding confidentiality for the participants and the unit. It is possible that there are particular events in your work that you would not feel comfortable discussing and you are free to identify these. You may stop the interviews at any time.

There may also be psychological risks to consumers of the services in having a stranger in their environment. This will be minimised by the researcher describing her role and purpose for being in the area. Opportunity will be given for consumers to elect not to have her present during any interaction or activity with the nurse.

What are the benefits?
The benefits of taking part in this study for you could include opportunities to discuss, identify and articulate your own practice within the current healthcare environment. It is hoped that your participation, along with the participation of others, will provide a description, knowledge and understanding of current nursing practice in dual diagnosis. It is envisaged that the study will advance knowledge and awareness related to inpatient nursing care for persons with a dual diagnosis and provide a foundation for future research.

How is my privacy protected?
The information you give will be amalgamated with information from others for analysis by the researcher. Your name will not be recorded or given to any other persons and pseudonyms will be used where necessary. Neither the name nor location of the unit will be stated in any publications or presentations.

Invitation
If you are a Registered Nurse working within the unit you are invited to take a further part in this study. This will involve you being interviewed by Chris Taua, the lead investigator in this project. One interview will be held with the option of having one more interview if required. The interview will be held at a time and place of your choice.

The focus of the interview will be around your nursing work in the unit and will probably last between half an hour to one hour. The interviews will be tape-recorded. You can choose not to answer any specific question(s) or ask for the tape recorder to be turned off.

You are very welcome to have a support person with you during the interview(s).

Costs of Participating
There will not be any cost to you

How was a person chosen to be part of the study?
Anyone who is a registered nurse and works in the unit is offered the opportunity to join.

How can I join the study?
You just need to advise Chris Taua of this, either in person, by phoning 03 9408613, or by email tauac@cpit.ac.nz. You will be given a consent form to read and complete if you decide to be interviewed.

Opportunity to consider invitation
You will need to inform Chris Taua within the next four weeks if you decide to participate in the study. You can phone her on the number given above, or her project supervisor, Paul Watson, phone 9408707.

You can withdraw your information any time up until the information is amalgamated in the study. This is likely to be up to one month after the interview/s is/are completed.

While your participation in the research would be welcomed, you are under no obligation to take part. If you decide not to take part in the interviews, you do not need to do anything further.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional organisation.

Informed Consent:
Written consent has been obtained from the appropriate division of the District Health Board to enter the field of study. Written informed consent will be obtained from you prior to an interview.

Statement of Approval:
This study has received ethical approval from the _____Ethics Committee.
The General Manager, (Name withheld) of the (XXXXX) District Health Board, Mental Health
Division has given his permission for this study to be carried out.

Please feel free to contact the researcher of you have any questions about this study.

Thank you for taking the time to consider participation in this study.

Contemporary nursing practice in a dual diagnosis (intellectual disability and mental illness) inpatient service: A micro-ethnography.

INVESTIGATOR: Chris Taua
PRINCIPAL SUPERVISOR: Paul Watson

STATEMENT BY THE PARTICIPANT:

- I have read and I understand the information sheet dated_____ for volunteers taking part in this research project. I have had the opportunity to discuss this study and I am satisfied with the answers I have been given.
- I understand that taking part in the study is voluntary (my choice) and that I may withdraw from the study at any time and this will no way affect my employment.
- I understand that my participation this study is confidential and that no material that could identify me will be used in any reports on this study.
- I have had time to consider whether to take part.
- I know who to contact if I have any questions about the study.   YES NO
- I consent to my interview and any other discussion related to the study being audio taped.   YES NO
- I wish to receive a copy of my audio taped interview.   YES NO
- I would like the researcher to discuss the outcomes of the study with me.   YES NO

I _____ (full name) hereby consent to take part in this study.

Project explained by:

Project role:

Signature (Participant) _____ Date_____

Signature (Researcher) _____ Date_____

Introducing
Chris Taua

*Insert
photo
here*

You will see Chris often in the ward over the next few months.

Chris is doing research

She visits at different times of the day to observe the nurses in their daily work.

You can talk to Chris if you want to.

If you are talking to your nurse and you do not want Chris to be there then you can tell Chris, your nurse or another staff member and Chris will leave that place.

Contemporary nursing practice in a dual diagnosis (intellectual disability and mental illness) inpatient service: A micro-ethnography.

Hello,
My name is Chris Taua and I am a nurse and a nursing lecturer. I am also a postgraduate student at the polytechnic. Part of what I have to learn is about how nurses care for people.

I am here in your ward to see how nurses do their work.

At the end of my time in your ward I will write about the nursing care in this ward. When I am looking at or trying to understand what the nurses are doing it may be helpful for me to read what they write about their care in your notes (file).

I will not read anything in your file if you don't want me to and the only information I will take from it will be about the nurse and not about you or what you are doing. I will only read your file if you give me permission to and then I will sign the form over the page.

You can say I can read your file and then change your mind. You won't get in trouble for this. You also won't get in any trouble or your care won't change if you decide that you don't want me to read your file. You can ask me any questions about this at any time.

Have you got any questions for me now?

You can ring me at 9408613 or my supervisor Paul Watson at 9408707 if you have any questions at any time about this study.

Have you decided whether I can read your file?
If you agree to me reading your file you can sign the consent form.

Appendix VI: Consumer consent form.

Contemporary nursing practice in a dual diagnosis (intellectual disability and mental illness) inpatient service: A micro-ethnography.

I.. have read/ or .... has read the information to me about why Chris is visiting this ward.

My questions about the study have been answered.

I know that Chris may read my file.

I know that Chris won't take any information about me from the file and that the information is about how the nurses work.

I know I can ask more questions if I want.

I know that it is ok for me to change my mind at any time.

I .... agree to let Chris read my file.

Signed (Patient): .... Date: ....

Signed (Consumer Advisor): ....Date: ....

Signed (Researcher): .... Date: ....

Appendix VII: Transcriber Confidentiality agreement

Contemporary nursing practice in a dual diagnosis (intellectual disability and mental illness) inpatient service: A micro-ethnography.

I (print transcribers name) .... shall not utilise or disclose confidential information available to me in the course of transcribing interviews for the ethnographic study regarding nursing practice in a dual diagnosis inpatient setting. I will ensure data is maintained and stored according to the protocol outlined for the study

Signed (transcriber): _____Date:_____

26 April 2004

Ms Chris Taua
School of Nursing
P O Box 540
CHRISTCHURCH 8032

Dear Chris Taua,

Contemporary nursing practice in a dual diagnosis (intellectual disability and mental illness) inpatient service: A micro-ethnography
Investigators: C Taua, P Watson (Supervisor)
Ethics ref: CTB/04/04/042

Thank you for your response to the Committee's suggestions. The above study has now been given ethical approval.

Approved Documents
Information Sheet for Nurse Participants version 1 dated 16 April 2004 (Appendix 2)
Information session flyer (Appendix 1)
Nurse Participant Consent Form (Appendix 3)
Introduction poster (Appendix 4)
Information Sheet for Consumers (Appendix 5)
Consumer Consent Form (Appendix 6)
Transcribers Confidentiality Agreement (Appendix 7)

Certification
The Committee is satisfied that this study is not being conducted principally for the benefit of the manufacturer or distributor of the medicine or item in respect of which the trial is being carried out.

Accreditation
This Committee is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, March 2002.

Progress Reports
The study is approved until 31 December 2004. A final report is also required at the conclusion of the study. A form for this is available from the Administrator.

Amendments
All amendments to the study must be advised to the Committee prior to their implementation, except in the case where immediate implementation is required for reasons of safety. In such cases the Committee must be notified as soon as possible of the change.

It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants. Please quote the above ethics committee reference number in all correspondence.

General

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

We wish you well with your study.

Yours sincerely,

Alieke Dierckx
Ethics Committee B Administrator
alieke_dierckx@moh.govt.nz
tel. 372 3037