PARTICIPATORY ACTION RESEARCH IN A PSYCHIATRIC UNIT:

STRIVING TOWARDS OPTIMAL PRACTICES

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STUDENT DECLARATION

I, Robyn Mills, declare that the thesis entitled *Participatory action research in a psychiatric unit: Striving towards optimal practices,* is no more than 100,000 words in length, exclusive of tables, figures, appendices and references. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

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ABSTRACT

The experiences of working in an acute psychiatric unit were investigated in this research using multiple qualitative methodologies, particularly Reflective Topical Autobiography and Participatory Action Research. The Participatory Action Research was undertaken in an acute psychiatric unit of a major public hospital in Melbourne. The collaborative design focused on bringing staff and consumers of psychiatric services together with an aim to develop new work practices for mental health practitioners. Four consumer consultants including a Koori representative participated in this study. Consumer consultants and staff, working in collaboration with the researcher, informed the fluid and iterative research process. Data included thirty eight interviews with psychiatric health professionals (2 psychiatrists, 2 managers, 6 psychiatric registrars and 28 nurses, including two charge nurses). Horizontal violence, and its impact on the capacity for reflexive work practices, became a strong emergent theme. Other emergent and important themes included workplace hierarchy, values, power, and the impact of critical incidents and supervision. Ego-state theory was utilised to better understand the psychology of staff members, and Organisational Ego-state theory was presented as an original concept to explore the psychiatric unit as an organism having its own personality characteristics. It was concluded that for there to be permanent and iterative change to the organisation that engrained automatic responses of the organisation need to be identified and new responses developed. The research resulted in a number of new work practice recommendations, including the establishment of non-discriminatory review processes where work practices that are viewed as inappropriate by staff and consumers can be assessed with consideration to the importance of all stakeholders. Specific insights and conclusions have been suggested in relation to the treatment of aboriginal (Koori) people in the psychiatric unit. A central conclusion from this study was that psychiatric staff and consumers need more inclusion in the design and review of work practices.

FORWARD

This thesis is about the culture and the work practices of a psychiatric unit and the experiences of the mental health clinicians, consumer consultants (ex-patients employed as advisers) who work within the unit and my personal experiences and reflections whilst working as psychiatric nurse in this psychiatric unit.

In chapter one, I begin this thesis by placing the research into the context from which it is derived, the community's stance on mental illness and associated policies. This is followed by the organisational context, individual context and my personal perspective at the time of the research.

With the scene of the research set, in chapter two the literature review explores previous knowledge in relation to society, culture, organisation, hierarchy and status as dimensions that shape the culture in which the psychiatric unit is situated. This also incorporates a brief review regarding the history of psychiatry; it is some of these factors that led to the current status quo in regard to the provision of acute care in psychiatric services. This chapter completes the understanding of the context and the confines in which this research is placed and also focuses on my optimal vision for work practices within a psychiatric unit. This leads to the rationale, objectives and aims of this study.

Chapter three incorporates the methodology that discusses the research paradigm that I have selected as most appropriate for the research: that is Reflective Topical Autobiography and Participatory Action Research. This is followed by the recruitment of participants and the many dilemmas associated with the chosen methodology and recruitment.

In Chapters four, five and six, the results and discussion sections are combined. Each of these chapters has four layers to it; my lived experiences of issues relating to the three themes (power, horizontal violence and values), followed by a literature review and the staff members' experiences in regard to the theme at hand. The fourth layer is a summary table of challenges to optimal work practices and associated facilitative or inhibiting factors.

Chapter seven, explains the action phase of this research, when staff and consumers meet together in weekly groups to discuss work practices and to develop suggestions for change.

Chapter eight, extends theory in relation to values, horizontal violence and power by discussing them in relation to ego-state theory. The psyche of the individual will be explored in reference to ego-state theory. The usefulness of this theory to understand the culture and the organisation will be examined. Chapter nine draws together the conclusions from this thesis and recommendations for future research.

I believe that it is necessary to unveil who I am in my role as the researcher. I am a 51 year old, Anglo-Saxon woman. I began life in a working class area of town, sharing with my twin brother the position of youngest in a family of six children. I began my career in the health field as a nurse in 1973, psychiatric nursing in 1976, naturopath in the 1980's, and as a Psychologist in the 1990's.

This thesis captures a snapshot of my experiences working in an acute psychiatric unit in a major public hospital in Melbourne, Australia. In part, it highlights my own personal journey of the struggles between my own values, power and interests, and those held by the culture of the unit. I illuminate my passage from entering this workplace as an empowered, self-aware woman, through to the depths of perceived

victimisation and victim mentality as a staff member of the unit, and back to empowerment again at the end of my time working at the hospital. At times in this thesis these phases of gaining self-awareness are evident. I particularly draw your attention to the findings and discussion section, where I talk about my personal experiences; the writing quite obviously reflects victim-thinking. This is intentional; as it reflects my thinking at the time I was working in the unit. Writing and reading it back now from a place of a distanced self-awareness and reflection, I can see more clearly the role I played in the culture. It is important to show you, the reader, what I was thinking at that time and how I perceived the environment. This self-disclosure is not a cathartic release for me, but rather, a great learning about how the dynamics of a culture can affect individuals. I believe that there is value to be learned from this type of presentation, and I hope it will facilitate future changes for people who work in 'the system'.

DEDICATION

To my Mother

I dedicate this thesis to my mother who had her own moments of mental torment and was a victim of her own thinking and that of her time and culture. She taught me about the different parts in people.

To my Children

I also dedicate this thesis to my own family, my three beautiful daughters, Kellie, Jacqueline and Nicole. There were many times when this thesis took me away from precious moments with them. They teach me about unconditional love.

To my Husband

To David, my serviceman, my computer expert and my solid rock, thank you.

To my Best Friend

I also dedicate this thesis to my best friend Dianne Lee. When I began at Royal Park Psychiatric hospital in 1976 I met Dianne Lee. She has been an incredible friend and mentor, together we have spent thousands of hours talking over life's issues. Her unending support has been wonderful; I call her debriefing Dianne, as she is always at the end of the telephone able to add positive energy to any situation.

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I am lucky enough to have people spiritual people in my life who support me in being the best that I can be: **Dianne Lee, Kathy Miceli, Annie Cvetkovic, Dr. Bobby Cvetkovic, Suzanne Fitzmaurice, Julie Madden, Jan and Rebecca Reynolds and Susan Summers.**

My academic friends who travelled this journey with me have also been invaluable **Evelyn Morrison, Tony Pirotta, Raelene Bartram, Jane Saunders and Dr Kerrie Kershaw. Julie Morsillo.**

The **consumers** of mental health services taught me about the diversity in people and taught me about myself and I appreciate the mutual trust that we share.

I thank all the staff of the hospital who participated in this research. Finally, I would like to thank the hospital management for allowing me to complete this research in their establishment.

TABLE OF CONTENTS

TABLE OF FIGURES

TABLE OF TABLES

CHAPTER 1

INTRODUCTION

The community has become more aware and more interested in the treatment of people with psychiatric disorders in recent decades. This is evidenced by the introduction of the new Mental Health Act in 1986. Prior to this Act, people with psychiatric disorders could be said to be “out of sight, out of mind” (1994, p.64). Since de-institutionalisation in 1986, individuals with mental illness are more likely to reside within their community, rather than be placed out of sight in a psychiatric institution (Commonwealth Department of Health, 1992; Victorian Health & Community Services, 1994). Further to this, through the National Mental Health Strategy, Mainstreaming Policy (Australian Health Ministers, 1992), the government sought to close the old psychiatric institutions and build new mental health units within general hospitals in local communities (Commonwealth Department of Health and Family Services, 1996). The aim of this government initiative was to de-stigmatise mental illness (Commonwealth Department of Health, 1992). The government stated that people with mental illness should be able to go to a general hospital just as would anyone else with any other disorder, and be afforded appropriate treatment for their mental illness in hospitals that are closer to family, community and cultural networks (Commonwealth Department of Health, 1992; Commonwealth of Australia, 1992). These initiatives were meant to change the face of psychiatry and, with it, the nomenclature changed from psychiatric institutions to Mental Health Services.

Although the aforementioned government policies heralded momentous and positive changes for the treatment of people with psychiatric disorders, they also brought with them difficulties associated with change. For example, staff members who

were familiar with institutional care were transferred to work in either the community or the new mental health units within general hospitals.

One such new mental health unit within a major public hospital is the subject of investigation in this research. This unit combined staff already working in a small psychiatric unit within the hospital (16 beds), with staff who had been working in a particular ward (25 beds) at the old psychiatric institution (approximately 200 beds). There were many adjustments that had to be made by the combined staff of the new unit (henceforth the inpatient unit). Prior to their transfer to the inpatient unit, those staff previously working in the Psychiatric Institution had belonged to a larger group of like-minded people. They had worked within a culture developed over 100 years, one that was based on society's low threshold for difference, particularly of individuals with psychiatric disabilities. In this culture, controlling difference was a key factor in the safety and security of staff and other patients. Patients in this culture were often certified under the Mental Hygiene Act (Government, 1952) and were kept hospitalised for long periods of time (Petroulias, 1994). Cultural norms included secluding people who were suicidal or aggressive to others.

In contrast, those who worked in the old psychiatric unit in the general hospital usually worked with patients who were not certified, who were voluntary patients and were often given the label of 'the worried well'. There were no seclusion rooms and it was illegal to seclude someone without being certified under Section 12 of the Mental Health Act. Certified patients were not allowed by law to be kept at a general hospital inpatient unit. Patients who surpassed the tolerable threshold for potential aggression or suicidality within the unit were not kept in the hospital, but certified and transferred to the psychiatric institution. The two cultures' thresholds for coping with people with

mental illness were quite different, as were their populations of patients. These two distinct cultures were joined to become the inpatient unit staff, forming a new culture. There were also one or two other staff members who were employed throughout the coming year, who were not aligned with either group and came from another major psychiatric institution.

The staff members were not the only people needing to adjust to the new environment. The patients from both cultures were brought together for the first time on the first day the unit opened. Patients from the old psychiatric unit, who were considered at the healthier end of the mental health continuum, were placed alongside the patients from the psychiatric institution who could be said to be at the highly disturbed end of the continuum. It would be fair to say that the old psychiatric unit patients were frightened of the psychiatric institution patients. This culminated in the psychiatric unit patients getting permission to lock their bedroom doors from the inside (never heard of before in psychiatry) to feel safe. This unsettled the nursing staff who were used to being the ones who decided if doors were locked or not.

Many of the nursing staff from the old psychiatric unit were feeling nervous about working with certified patients, and also wanted to protect their patients from the highly disturbed patients. The institutional staff members were saying that the old psychiatric unit psychiatric unit patients were ‘not sick enough to be in hospital and were just taking up valuable beds’. The organisational culture then was one of bringing two groups of staff members and two different patient groups together to create a new culture.

Personal Context

I began working in this inpatient psychiatric unit on the first of July 1996, the day it opened. At the time, I was completing my Honors year in psychology. My motivation for returning to psychiatric nursing after a long break was purely financial; I had been overseas and needed a quick way to replenish my finances. My intention was for short term, casual employment only. Not having belonged to either of the two major subcultures, my investment in the culture was much less than that of other stakeholders.

I was a general and psychiatric nurse, who had become a naturopath and worked in private practice, and was now in the process of becoming a psychologist. My experience in the health field spanned 25 years. I began my general nurse training in 1973 and on completion of this began my training in psychiatry in a major psychiatric institution (Royal Park Psychiatric Hospital) in 1976. I had also worked in the old inpatient unit in question, from 1978-82. Thus, I had previously worked in similar environments to both cultures. However, in this new inpatient psychiatric unit culture, I was appointed by the charge nurse who was a personal acquaintance and had invited me to work there. I was therefore aligned to her and indirectly seen as aligned to management. At the same time, I was on the lower end of the hierarchical power structure, being a casual employee and not a permanent staff member, and not being aligned to either subculture.

Of particular interest to this research is the impact that Mainstreaming (Commonwealth Department of Health, 1992) changes have on the work practices of the health professionals within the culture of the inpatient psychiatric unit. Of particular interest is the bringing together of these subcultures to a new inpatient psychiatric unit. Staff from the psychiatric institution were also very nervous about leaving their existing

culture and moving into a general hospital culture. Their previous culture had structures that had held them in good stead over many decades, and they did not believe the new culture could offer them the safety and protection they needed. They voiced their concerns for this through the union on an almost daily basis in the first few months.

In the context of these extraordinary pressures, the work practices that I observed varied from excellent to totally unacceptable. Unacceptable practices included secluding people for punishment, taking away their rights and possessions and medicating people against their will, in general, practices that are against basic human rights.

I was surprised and dismayed that the unacceptable work practices I had observed 20 years before while working at Royal Park Psychiatric Hospital, were still occurring to varying degrees. It led me to ponder the factors that influence work practices, and in particular, those facets of the interactions between the organisation and the individual psyche that are most influential.

In light of this, I have looked toward theorists in relation to culture and organisations. Organisational psychologists shed light on the effects that organisational culture has on work practices (Argyris, 1990, 1993; Argyris & Schon, 1984; Boud & Garrick, 1999; Tosi, 1990). They suggest that the culture within the organisation can have a significant effect on work practices. This has been further delineated by (Schein, 1992) and (Argyris, 1999) who have suggested that the organisation is a learning entity. Values are also important factors in investigating the culture of the organisation (Bilanich, 2000, 2004; Gibson, Ivancevich, & Donnelly, 1997; Scott, Jaffe, & Tobe, 1993). In discussing the effects of values within the organisation, Prilleltensky (1999) distinguished among the values of diverse stakeholder groups. He stated that there are

often conflicts among consumers, workers and management in relation to work place values and that the optimal circumstance is the alignment of values across these three stakeholder groups. The nursing literature also reveals individual and organisational values as pertinent to the quality of work practices of health professionals (McNally, 1990; Short, Sharman, & Speedy, 1998).

I observed and experienced many conflicts between the staff members throughout the initial year. These conflicts related to staff relationships with the consumers of mental health services, other staff in the hierarchy and with each other. These conflicts appeared to influence work practices within the unit. One way to try to understand and explain this behaviour is by looking at the work of previous authors in relation to oppressed group behaviour (Fanon, 1963; Friere, 1985; Roberts, 1983). Although both Fanon (1963) and Freire (1972) studied oppressed group behaviour in third world countries, their extensive knowledge can and has been applied to groups of people throughout the world. Their findings can be related to entire populations of people or to oppressed groups such as ethnic minorities and even smaller groups affected by hierarchical structures in the workplace such as nurses (Duffy, 1995; McCall, 1996; Roberts, 1983; Serghis, 1998; Waitere, 1998). Many authors have regarded as an oppressed group within the hierarchy and as a function of their oppression, nurses lash out at each other with horizontal violence (Duffy, 1995; Giles, 1998; Lybecker, 1998; McCall, 1996; Serghis, 1998). This practice is more commonly known as work place bullying.

Purpose of the Study

I was a victim of practices of horizontal violence in the year that I worked in the inpatient unit. Similarly, when I had worked at Royal Park Psychiatric Hospital in 1978,

I had raised questions about the quality of care, which was extremely poor at that time. I had been walked to the car by two large men who threatened me, saying that if I caused any further trouble, they would physically harm me. I chose to leave the hospital, feeling that I did not have the courage to see it through. However, this time I saw a chance to make a difference in another way; to investigate, explore and understand the factors that inhibit or facilitate good work practice. I wondered what it would take to bring about cultural change to support optimal work practices as a cultural norm. With the changes to the Mental Health Act (1986) and subsequent amendments to the Act (1995) and changes to society's view on people with mental illness, the time was ripe for change.

In light of this, my research began by using a qualitative methodology, Reflective Topical Autobiography, to explore through narratives the experiences I had during this crucial time period. These experiences then became a pivotal point from which this Participatory Action Research project was initiated a year later.

A purpose of this study is to understand the nuances of power in regard to the work practices within this psychiatric unit. Power will be investigated from multiple perspectives including the experiences of the different stakeholders (patients, nurses, doctors, management) and through the extensive literature available regarding power as a construct.

There are four pertinent layers to this thesis. The first part of this thesis is a reflection of my experiences within the mental health unit over the initial year of its existence. Here I give examples of work practices that I either experienced or observed, and the personal experience of the effect of horizontal violence on work practices.

The second part incorporates thirty eight interviews with Management, Psychiatrists, Psychiatric Registrars, Nurses and Consumer Consultants reflections of the staff's experiences regarding their work practices within the unit. The staff members were specifically asked to give an example of an optimal work practice and a less-than-optimal work practice.

The third part of this research comprises group meetings with consumer consultants and staff members who were brought together for the express purpose of developing consumer-responsive work practices. This consisted of six group meetings that I facilitated.

Fourthly, continuing in the Action Research Paradigm, the dissemination of the results to inform practice remains part of this thesis. It incorporates the development of a CD as an education tool to facilitate discussion and raise discrepancies regarding complex practices. This final layer discusses the use of the CD to inform consumers, carers, student nurses, staff and government representatives in an effort to inform policy through social and political agendas.

Studying the work practices of psychiatric health professionals is important at this time. One indicator of this is the Mental Health Act 1986 and its subsequent and recent amendments in 1986;1995;1998; 2003; 2005 (The Health Legislation Miscellaneous Amendments Act, 2005)(Australian Health Ministers, 1992; Commonwealth Department of Health and Family Services, 1996) more recently to Government Mental Health Policies of 2001; 2002; 2005 ("The Health Legislation (Miscellaneous Amendments) Act," 2005). Such changes reflect the desires of the community in regard to improving services for people with mental illness. Society demands that individuals with mental illness be afforded respect and dignity (Australian

Health Ministers, 1992; Commonwealth Department of Health and Family Services, 1996; Public Affairs Commonwealth Department of Health Housing and Community Services, 1992) and be maintained in the least restrictive environment (Health, 1986). In 1996 the United Nations developed a code of best practices for the treatment of people with mental illness (Zifcak, 1996). The major shift in the attitude to psychiatric patients can be seen world-wide through the World Health Organisation (World Health Organisation, 1973, 1978, 1991, 1993, 2005), which has stated on numerous occasions in the last decade that the care for psychiatric patients must be improved dramatically and immediately.

In light of the opening of this new psychiatric unit in 1996 and the subsequent experiences of the researcher within this new culture in its inaugural year, it seemed timely to investigate the work practices and culture of this acute psychiatric unit. Although the geographical position and buildings that housed people with mental illness changed, there seemed to be less focus on changing the individuals and the culture that perpetuates work practices. This research attempts to address this gap. That is, it aims to understand the factors that may influence the work practices and the culture of an acute psychiatric inpatient unit. Further to this, it seeks to develop new work practices that are consumer responsive and that uphold both the mandate and the spirit of the National Mental Health Standards and the Government's Strategies for Change, 2001.

> *"If you want to understand science you should not look in the first instance at its theories or its findings and certainly not at what its apologists say about it; you should look at what the practitioners of it do"* (Geertz, 1973, p.5).

This research investigates what the practitioners who work in a psychiatric unit ***do***, that is, to investigate and explore their work-practices. In particular, it wishes to

examine the thesis that practitioners' capacity to honour the minimal intentions of recent mental health legislation, much less to surpass it, will rest on their ability to operate from reflective practice.

CHAPTER 2

LITERATURE REVIEW

History of Asylums

The incarceration of people with madness (sic) began in 1377 in Bethlem in London (Sainsbury, 1976). Treatments were inhumane and people curious about madness went to the lunatic asylums (sic) and paid money to see the inmates plunged into icy water or flogged (McGovern, 1985; Petroulias, 1994; Sainsbury, 1976). Reforms to these lunatic asylums (sic) coincided with the French Revolution and have been attributed to Philippe Pinel. He unchained the patients after years of torture and torment, developing what were considered more nurturing and humane institutions (Petroulias, 1994; Sainsbury, 1976). In retrospect, not all philosophers were happy with this, claiming that the work of Pinel was not enough and that it led to the medicalisation of mental illness, "pathologising" people who were different (Foucault, 1967; Foucault, 1975; Garton, 1988). Foulcault (1967;1975) stated that placing people in institutions took away the richness and depth of individuals within our society, institutionalising those who were different from the bourgeois.

During the late nineteenth and early twentieth centuries, Western society again saw big institutions being built many miles from major cities (Garton, 1988; Geller, 2000; McGovern, 1985; Sainsbury, 1976). These institutions were built for humane and moral purposes, intent on caring for and curing the insane (Morissey & Goldman, 1984). Although the original intentions were from a high moral ground, institutions were characterised by long periods of neglect and indifference from the Australian public and hence devoid of adequate funding (Lewis, 1998).

The precursor to psychiatric institutions in Victoria was the separation of 'unfortunates afflicted with insanity' from normal jails to a lunacy ward attached to a jail (Petroulias, 1994, p.24). In this vein, the first psychiatric institution in Victoria, the Merri Creek Asylum, was built in 1848. Admission could be directly from jail or by private referral (Petroulias, 1994). The private referral could be made by a friend, including two medical certificates by general practitioners and sanctioned by a judge of the Supreme Court. Friends were required to pay an ongoing fee to keep their insane friend incarcerated (Petroulias, 1994). Even though the property was on a site of 600 acres, there was nothing for the inmates to do (Dax, 1961; Petroulias, 1994). Institutions were run like prisons and this only increased the stigma associated with insanity during the late 1800's to 1900's (Dax, 1961; Garton, 1988; Kosky, 1986; Talbott, 1985).

It was as early as the 1950's that urgent reform was called for and most of the 600 inmates were given the task of clearing the land and growing vegetables and fruit trees (Garton, 1988; lewis, 1988; Petroulias, 1994). Regular inspections by Official Visitors were made to ensure that the 'treatment of the poor unfortunates was humane' (Dax, 1961). The Lunacy Act was made in 1867 (Petroulias, 1994) and people with mental illness were taken to asylums until 1903, they consisted of rows of bunk beds without privacy (Garton, 1988; lewis, 1988). On the 31st December 1884, 3228 people were housed in 5 asylums with 387 staff. They were the subject of the 1888 Zox Royal Commission to investigate mental hygiene practices in Victorian institutions (Brothers, 1962). This led to the separation of inmates into three different groups for the first time; a ward for women was built at Sunbury; children were housed separately and the criminally insane placed in a jail of their own at Ararat (Brothers, 1962; Petroulias, 1994).

Many amendments to the Lunacy Act were made throughout the decades until the 1950's. Then a decline in the care of the mentally ill ushered in a major investigation that became known as the Kennedy Report (1950) (Garton, 1988; Petroulias, 1994). As a response, the government set up the Mental Hygiene Authority in 1952 (Petroulias, 1994; Sainsbury, 1976). By 1955, fences to asylums were taken down and this was thought to make the care of the mentally ill more visible to the public. It was seen to be a new era in the treatment of those afflicted with mental illness and the recognition of the patient's rights and freedoms (Garton, 1988; lewis, 1988; Petroulias, 1994). Up until this time hospitals were 'run on extreme custodial lines with a strict hierarchical authoritarian structure'(Petroulias, 1994, p.8). These changes heralded new and improved conditions for patients and staff. For the first time, nursing positions were upgraded and psychiatrists were offered incentives to work in the institutions (Petroulias, 1994; Sainsbury, 1976). 'A different era for the treatment of the psychiatrically ill had begun' (Petroulias, 1994, p.25).

Of particular relevance to this study is the famous work of Erving Goffman (1961) who investigated the effects of the institution on the self. His work detailed the tenacity of the self to fight against the system to survive. He stated that the psychiatric asylum was worse than a concentration camp because it stripped away at the self leaving it with nothing (Goffman, 1961). His work underpinned much of the psychiatric reforms of this era (Goffman, 1961).

Implications of the Mental Health Act of 1959 and 1986

In 1991, Mental illness affected 3-4% of the Victorian population per year (Public Affairs Commonwealth Department of Health Housing and Community Services, 1992). In 1998, it was said that one in five adults met the criteria for a mental disorder

in the preceding 12 months (Australian Health Ministers, 1998). The environment in which these people are placed impacts profoundly on their illness, recovery and possible relapse (World Health Organisation, 2005).

In recent decades, human rights movements around the world began to target the lack of human dignity and rights that mental institutions afforded their residents ("The Health Legislation (Miscellaneous Amendments) Act," 2005; National Health Strategy, 1993). United Nations Resolution 96B on the Protection of Rights of People with Mental Illness (World Health Organisation, 1993). The General Assembly of the United Nations put forward a set of principles for the Protection of Persons with Mental Illness (Zifcak, 1996). These principles underpinned the Australian Commonwealth Government's National Mental Health Policy (Commonwealth Department of Health, 1992), which led to the first National Mental Health Standards (Zifcak, 1996). Lobbyists pressured governments for urgently needed reforms.

In Australia, changes in regard to the care of people with Mental Illness preceded the National Mental Health Policy (Commonwealth Department of Health, 1992) with sweeping changes to the Mental Hygiene Act (1959) through the new Mental Heath Act (1986). This Act demanded changes to the environment in which people diagnosed with mental illness were placed, and to the work-practices of individuals who cared for them (NMHS, 1992). The Mental Health Act (1986) mandated some of the most important law reforms for the mentally ill seen in the twentieth century (Commonwealth Department of Health, 1992). It heralded changes that opened the doors of institutions and placed expectations on health care providers to support individuals with mental illness within the community (Commonwealth Department of Health, 1992). This was in stark contrast to previous legislation (Mental Hygiene Act, 1959), which had the

effect of forcing individuals to be confined in locked wards or institutions away from the public eye and devoid of a normal social setting (Sainsbury, 1976). Under Section 42 of the Mental Hygiene Act (1959), individuals could be transported against their will to an institution and kept there until the authorised psychiatrist changed their status to Section 41, that is, a voluntary patient. Certified patients were usually placed in locked areas and visitors were kept to a minimum in both number and time spent with the patient (Sainsbury, 1976). Conversely, while Section 12 of the Mental Health Act of 1986 still gives a psychiatrist the legal right to detain persons to have treatment for mental illness against their will, it now gives two choices of where that treatment would be given. The difference is that a person who is certified in this way can stay in his/her own home and receive treatment, if this is deemed appropriate by the treatment team. This manifested in 600,000 community contacts to psychiatric services in 1991, compared to 20,000 in 1960 (Commonwealth Department of Health, 1992). In 2005 amendments were made to the Mental Health Act 1986 to further define the treatment of mental health consumers in their homes ("The Health Legislation (Miscellaneous Amendments) Act," 2005).

There are many authors who have suggested that de-institutionalisation is under-funded and that the lack of care for and social stigma associated with mental illness has worsened since the institutions closed (Ball, 1991; Garton, 1988; McCubbin, 1994). As early as 1978, Talbott was suggesting that in the USA, the problems associated with de-institutionalisation were directly related to funding, likewise McCubbin (1994) stated that funding issues *paralysed* deinstitutionalisation . Shifting people from the hospital to the community is not enough (Lamb & Bachrach, 2001). There is now ‘a new generation of un-institutionalised persons who have severe mental illness, who are

homeless or who have been criminalised' (Lamb & Bachrach, 2001, p.1039). This, in turn, has added pressure to psychiatric services within general hospitals and created greater stigma for people with mental health problems (Bachrach, 1981).

Although the Mental Health Act (1986) is a major step towards restoring human dignity for those people suffering from mental illness, it does not address the social stigma and lack of community resources for people now treated in the community. 'Mainstreaming'(Victorian Department of Health and Community Services, 1993, p.3; Whiteford, Macleod, & Leitch, 1993) was an initiative created by the Victorian government to address this stigma. It mandated mental health providers to close the larger psychiatric institutions and create smaller psychiatric units within general hospitals. The impetus for this comes from section 4.2 (a) and 4.2(b) of the 1986 Mental Health Act which states that:

> *4.2 (a) ' people with a mental disorder are given the best possible care and treatment appropriate to their needs in the least possible restrictive environment and least possible intrusive manner consistent with the effective giving of that care and treatment…*
>
> *4.2(b)…in providing for the care and treatment of people with a mental disorder and the protection of members of the public, any restriction upon the liberty of patients and other people with a mental disorder and any interference with their rights, privacy, dignity and self-respect are kept to the minimum necessary in the circumstances'*

In the spirit of the 1986 Mental Health Act, Section 5 (a) (1) states that:

> *'the objectives of the Department under the Act are to provide standards and conditions of care and treatment for people with a mental disorder which are in*

all possible respects at least equal to those provided for people suffering from other forms of illness'

The mainstreaming policy (Commonwealth Department of Health, 1992) mandated that individuals with mental illness should be treated in the same way as people with any other illness. To this end, individuals with mental illness would attend a general hospital and be admitted to a ward of that hospital, in the same way that someone with a broken leg would be admitted to an orthopaedic ward and someone with hepatitis to a medical ward (Commonwealth Department of Health, 1992).

Further expectations for change were mandated by the Victorian Government through the 1995 amendments to the Mental Health Act of 1986. One of these changes is to:

''5 (a)(ix) encourage patients and other people with a mental disorder to participate as far as possible in the development and operation of those services'.

This legislated that mental health service providers recognise consumers of these psychiatric services as partners in their own recovery rather than the passive recipients of treatments.

In summary, it can be seen that the impetus in for change Victoria began with the Mental Health Act in 1986. This has coincided with a push for the human rights of people with mental illness by the United Nations Principles for the Protection of Persons with Mental Illness (1991) (Zifcak, 1996) and the Australian Government's response to it with the National Mental Health Policy (Commonwealth Department of Health, 1992) and ensuing National Mental Health standards. At least at the level of policy there have been major shifts in regard to mandating for the rights and protection of people with mental illness.

Society: Social Systems

Society has within it social systems and organisations that have developed their own distinctive cultures (Anderson & Carter, 1978; Geertz, 1973). These organisations contain subgroups that are made up of the smallest components of society: individuals (Malinowski, 1944). It is proposed to give an overview of each of these social systems to place the organisation of society's response to mental illness in perspective.

Within the systems model, 'a social system is a bounded set of interrelated activities that together constitute a single entity' (Olsen, 1968, p.228). Anderson and Carter (1978) state that a systems model can be applied to any social organisation. Individuals are its smallest components, who by their behaviours and roles also constitute social systems. Anderson and Carter (1978) state that to fully understand the system model, we must pay attention to both the part and the whole at the same time. This may be described as a **holon,** that is, 'each entity is simultaneously a whole and a part' (p. 11).

> Koestler said that 'like God Janus, a holon faces two directions at once - inwards towards its own parts, and outwards to the system of which it is a part by definition both part and whole'(Koestler, 1967).

What occurs in social systems may be described as an exchange of energy between the people or groups of people (Anderson & Carter, 1978). Anderson and Carter (1978, p.13) describe energy in this sense to be 'capacity for action' or 'power to effect change'. Hierarchical systems indicate the order in which the energy is distributed. Hierarchical social systems are constantly adapting and changing themselves as they head towards attainment of their purposes. The social system to be investigated in this research is the mental health/illness system. One of the goals that it

strives for, is ‘care for the mentally ill’ and it does this through the agency of a number of organisations.

Organisation

Hierarchy within the Organisation

To understand the modern organisation, it is necessary to briefly look at its origins. In 1745, Monsieur de Gournay coined the word bureaucracy to mean the *rule of officials* (Giddens, 1997; Knowles, 1990; Mitchell, Dowling, Kabanoff, & Larson, 1988). In 1914, Weber extended this theory, outlining the ideal bureaucracy and identifying many pertinent characteristics (Gibson, Ivancevich, & Donnelly, 1997; Giddens, 1997; Knowles, 1990). Of particular importance is the structure of the hierarchy, that is, clear cut lines of authority. This is often depicted as a pyramid with the most powerful decision-maker on the top and the least powerful (most likely the workers) on the broader base at the bottom (Gibson, Ivancevich, & Donnelly, 1997; Giddens, 1997; Knowles, 1990). Within an organisation the rules are generally well documented (Weber, 1964). At each level the individual attains stronger financial gain, and employees do not own the resources they manage (Gibson, Ivancevich, & Donnelly, 1997; Giddens, 1997; Knowles, 1990; Mitchell et al., 1988).

Hierarchical structure informs managers and workers at each level, who they need to answer to and who needs to answer to them (Giddens, 1997; Knowles, 1990; Mitchell et al., 1988). In a strict hierarchical organisation, each manager is directed by only one supervisor (Giddens, 1997; Knowles, 1990; Mitchell et al., 1988). The hierarchical system aids functional specialisation and task fragmentation while it minimises the discretion of employees (Thompson, Allen, & Rodrigues-Fisher, 1992).

Problems with the strict hierarchical organisational structure (classical organisational theory) are difficulties with accountability and responsibility (Snyder & Maris, 1997; Thompson & McHugh, 1995). Accountability lies strongly with the managers, whilst responsibility is more likely to be with the worker at the lower end of the pyramid (Snyder & Maris, 1997). There is a risk of '*asymmetrical information*', where subordinates have more information than their bosses (Snyder & Maris, 1997, p.3). This is further compounded by a dilemma coined *moral hazard*, when junior personnel execute their tasks below standards because they are aware that they would not be held accountable (Snyder & Maris, 1997). Hierarchical theory fails to acknowledge the inter-organisational complexities that impact within organisations. These complexities were first raised in 1938 by Chester Barnard who identified the relationship between the formal and informal organisation. Since then, many authors have expanded upon his original work (Giddens, 1997; Snyder & Maris, 1997; Thompson & McHugh, 1995). He recognised the value of the informal contacts between members of the organisation that were not set out in the formalities of the hierarchy (Giddens, 1997; Thompson & McHugh, 1995). These were the lunches, the informal conversations and the friendships that developed between workers (Snyder & Maris, 1997). This aspect becomes highly relevant to psychiatry and the context in which this research is placed. As will become evident throughout the research, the group or clique to which a staff member belongs is immensely important to their experiences working within the psychiatric unit.

Pertinent to this research, is the work of Simon, Waldo and Selznick. Using Barnard's work as a springboard, both Simon and Waldo developed theories regarding increased employee participation through a democratic organisation (Snyder & Maris,

1997). Philip Selznick (1957) also extended Barnard's work by being the first theorist to talk about 'organisational institutionalisation' (Giddens, 1997; Selznick, 1957; Snyder & Maris, 1997; Thompson & McHugh, 1995). He expanded the base theories of moral hazard and asymmetric information, proposing that organisations develop character and institutional goals, adding values beyond the mere task requirement. (Snyder & Maris, 1997) inform us that this can be positive as well as negative. In the negative, characteristics inherent to organisations can develop norms, which may not be for the highest good for all concerned. An example of this may be placing consumers in a seclusion room for self-harming behaviours. This is not a written code, yet occurs frequently in the psychiatric unit. In the positive, the culture could develop practices where consumers were *specialled* (one worker to one consumer) when experiencing thoughts of self-harming. Also within the positive, the culture may forge community solidarity and achieve goals beyond those envisioned or possible by individuals working singularly, as in compassion and equality for all individuals who are admitted to the service.

Contemporary Organizational Theory

In contemporary organisational theory, increased worker participation has been upheld as one resolution to the problems inherent in hierarchical structures(Snyder & Maris, 1997) (Giddens, 1997; Thompson & McHugh, 1995). The bringing together of the formal and informal organisations delivers more valuable communication and therefore an organisation that functions more desirably (Giddens, 1997). Within this contemporary organisational structure (also called matrix), managerial lines are less prominent and the work is focused more around independent teams (Snyder & Maris, 1997) (Thompson & McHugh, 1995). For psychiatry, this is evident in its move to

multidisciplinary teams, where the team is made up of nurses, psychiatric registrars, allied health professionals (social worker and/or psychologist) and psychiatrists. Each team is given particular geographical areas and the patients who are admitted from that area become the responsibility of the team allocated that area. Although, on paper, these teams are seen to be independent, they still have strong hallmarks of strict hierarchical controls. This is particularly evident in the psychiatrist having the 'last say' on any decisions about a particular patient.

The Role of Status Within the Culture

Hierarchy is governed by the organisational structure, whereas status is governed by the inter-organisational pathologies(Snyder & Maris, 1997). Hierarchy delineates the horizontal lines of accountability, responsibility and supervision. However, levels of pay and status provide us with vertical differentiation, that is, in what esteem we are held by our work colleagues (Gibson, Ivancevich, & Donnelly, 1997) (Giddens, 1997) (Mitchell et al., 1988) Schlesinger (Schlesinger & Kotter, 1992; Tosi, 1990). Status is determined by the group, according to a multitude of attributes a person may have, and whether or not the person is valued by the group (Giddens, 1997; Mitchell et al., 1988; Sonnenberg, 1993; Tosi, 1990). These attributes may include achievements, possessions, personality or previous position within the group, and people with the highest status will have more influence and power within the group (Schlesinger & Kotter, 1992) (Mitchell et al., 1988, p.275). It is important to note that attributes held in high esteem in one environment, for example, a Ph.D. in a university, may be held in low esteem in another, Ph.D. in a psychiatric unit. Status influences our behaviour within a group. "We defer to people with higher status because we respect them, fear them, idolize them, want favours from them or want to be like them.

Whatever the reason, status helps us structure our interactions with others" (Mitchell et al., 1988, p.275).

One way that an individual's status is projected to others is through organisational story telling (Sonnenberg, 1993). The stories that people tell give clear messages about what is acceptable, valued and rejected, and how the organisation responds to certain behaviours within it (Sonnenberg, 1993). Status is an important factor in group structure, indicating to others what behaviours are expected (Gibson, Ivancevich, & Donnelly, 1997; Mitchell et al., 1988; Sonnenberg, 1993).

Status between organisations is called *occupational prestige.* An example of this would be the high status a doctor is held at in all hospitals (Mitchell et al., 1988). In society, people are ranked this way. In Australia, judges are held in the highest status, whilst garbage collectors hold the least status (Mitchell et al., 1988). Occupational prestige is based on the label of your position, not on your ability to do it, or any other characteristics. In contrast to this, status within the organisation is called *organisational status* and personal attributes and characteristics are extremely important in evaluating this (Gibson, Ivancevich, & Donnelly, 1997). This assists in explaining the complexities that are germane to the psychiatric unit. On one hand there is a strong likelihood that doctors will be held in high esteem regardless of their abilities. On the other hand, nurses will be held at the lower end of the organisational status, but might be held in high esteem by their colleagues due to special characteristics. Those without the required characteristics may find themselves outside the dominant group.

Another dimension to organisational status is *status incongruence*, when a person may be very high in some characteristics that are highly valued by the group, but extremely low on others, causing confusion within the group about the acceptance of the

person's status (Mitchell et al., 1988) (Knowles, 1990; Sonnenberg, 1993). Nevertheless, the value and influence of key persons cannot be denied, as they bias the way information is filtered through the organisation and as they impact on the beliefs of the organisation.

Another dimension that is pertinent to this research is whether an organisation is Organic or Mechanistic (Knowles, 1990). "In Mechanistic, there is a high degree of specialisation and structures tend to be rigid. In comparison, organic forms are not so compartmentalized and people have a greater sense of common purpose. In Mechanistic organisations, responsibilities tend to be precisely defined with praise or blame attributed to a single person" (Mitchell et al., 1988, p.245). Although the hierarchical structure of hospital multidisciplinary teams has been developed, they have not been given the full law of responsibility. That is, final responsibility rests with the authorised psychiatrist. This means that although he or she may take the recommendations of the team into consideration, in the end, the team has much less power than the authorised psychiatrist, who is most likely to make a decision that protects his/her own position and legal responsibilities rather than the recommendations of the team.

Organisations are groups of people that come together to procure a particular goal (Mitchell et al., 1988). Within systems theory, it is the interactions of the parts that make the whole that constitutes the main focus of organisation. These comprise the individuals and the subgroups of social networks to that they belong. An open systems theory approach to organisations not only focuses on these interactions, but also places the organisation within the context of its own milieu (Knowles, 1990; Mitchell et al., 1988). Within the psychiatric unit these subgroups appear to be multi-layered. First, they can be according to discipline, such as nurses, doctors or administration; and

secondly, according to values and norms shared by the group. Cultures within these subgroups may be strong where the majority of people uphold the shared values; or weak, where there is little group alignment on norms and beliefs (Goodenough, 1963). This is an important factor in this research as it explores the relationships between these group members, who in turn, influence the work practices of the individuals and the groups. I believe that the power of these cliques has been underestimated in its role in influencing work practices with acute psychiatric units. I intend to address this issue throughout the research.

Understanding Culture Within our Society

To quote Ward Goodenough:

'culture is located in the hearts and minds of men (sic)…. A society's culture consists of whatever it is one has to know or believe in order to operate in a manner acceptable to its members'(Goodenough, 1963).

For the purpose of this research 'culture' will be defined by reference to a variety of definitions: (Knowles, 1990) and (Geertz, 1973). Culture is defined as the morals, beliefs, values, norms, attitudes and behaviours which lead to a knowing in the hearts and minds of the people, of what is acceptable to its members, and by that its institutions are formed.

Anderson and Carter (1978) define culture by differentiating culture from society:

'A society refers to a group of people who have learned to live and work together. Society is viewed as a holon, and within the society culture refers to the way of life followed by the group (society). The term culture is- that which binds a particular society together and includes its manners and morals, tools and techniques' (p. 35).

Knowles (1990) expressed culture as:

> *'the most pervasive of all influences upon the formation of attitudes. Perhaps the most important effect of culture is to socialise people into developing attitudes compatible with the society in which they live'* (p. 82).

Geertz (1973) described man (sic) as possessing several layers of culture, from the 'bigger picture' of belonging to the greater society and social organisation, to the inner psychological factors and the core of anatomy and physiology. This holistic concept of layers supports the notion that a person cannot be separated from his/her environment (Anderson & Carter, 1978; Castillo, 1998; Geertz, 1973; Malinowski, 1944). Culture is important to this research because health professionals bring with them their individual beliefs, morals, values, norms, attitudes and behaviours to which they have been socialised, and which are then shaped together with those of other neophyte professionals, into a collectively-held professional culture. Malinowski (1944) suggested that to describe culture, one would need to examine and describe the parts that create the whole, that is, the institutions into which the culture is organised.

The Impact of Culture on Societal Response to Mental Illness

The social system and culture to which individuals belong influence their attitudes and shapes their behaviours (Castillo, 1998). Mental illness is a marker for a society of its threshold for deviant behaviour (Castillo, 1998). Castillo, an anthropologist and psychiatrist, referred to the effects of culture in relation to 'mental illness', as the cultural significance of mental illness. That is, the meaning projected onto the mentally ill by the surrounding society that then structures the experience of suffering by the patient' (p. xiii). The influence of culture is so strong; it affects the subjective experiences of individuals with mental illness and shapes their treatment and the

possibility of recovery (Graham, 1993). For example, in Indian culture, people may believe madness to be demonic possession (Kleinman, 1988). Other primary cultures consider it to be shamanic, while Western culture believes it to be a genetically inherited and/or biopsychosocial disease.

Culture affects our beliefs in regard to mental illness in several ways. Kleinman (1988) states that culture shapes our understanding of madness by the symptomatology. The symptom is deemed by that particular culture as a symptom of madness. In another culture, the symptom may be perceived as a gift from God. Hearing the voice of God, for example, could be interpreted in different ways according to the culture in which it is experienced (Haldipur, 1984). In one culture a person could be demonised while in another held in high status as a spiritual leader.

A further way that culture shapes our understanding of mental illness can be seen in the significance that is projected onto the mentally ill by society. The type of mental illness will carry with it a cultural schema that affects individuals' experiences of mental illness and their treatment and outcome (Castillo, 1998). The interpersonal relationships experienced by the individual at home and at work influence the experience of mental illness (Szasz, 1970; Szasz, 1972). For example, the amount of behaviour tolerated by the family before they allow one of the family members to be deemed 'deviant' and hospitalised represents the family's tolerance of mental illness. This person, who has reached the family's cultural threshold for mental illness, then finds him or herself in a different culture, that of the psychiatric unit that may have different thresholds for, or definitions of 'deviant' behaviours. This becomes problematic in psychiatry when families are desperate and take their loved one to hospital only to be turned away by staff who does not feel the person is mentally ill

enough for hospital. As health professionals we need to stand up for these injustices in our community (Kloos, 2005). Further, this is another way that nurses gain power within the psychiatric unit, by labelling patients with their colloquial terms of 'they're too well to be in here' or 'they are really disturbed'. They may not have the power in the multidisciplinary team meeting, but their influence in handing over opinions of the patient's status may impact in the long run, on his or her experience of their mental illness.

The construction of mental illness has been criticised by many authors (Illich, 1976; Taylor, 1979). This can be found within the work of Foucault (Foucault, 1967; Foucault, 1975) who questioned the structure of diseases, and Illich (1976) and Thomas Szasz (1970) who claim that the medicalisation of society is fraught with iatrogenic illness (illness caused by medical treatments). Instead of categorising social misfits into psychiatric disorders, one should be searching the social and economic structure of the society for antecedents to mental illness (Foucault, 1967; Foucault, 1970; Pilgrim & Rogers, 1999).

The contribution of Foucault was to map out discourses associated with particular social periods and places (Fillingham, 1993). Michel Foucault investigated power and knowledge, particularly the construction of power and knowledge through the use of language. He studied 'normality' and 'abnormality', that is, the categorisation of people. History shows us that the definitions of normal and abnormal have changed over time, with increasing restrictions on those who were classified as abnormal by those who classified themselves as normal (Castillo, 1998).

In summary, cultural contexts have been raised as relevant to the individual's experience of mental illness, influenced by cultural schemas, (Fabrega, 1989; Peters,

1985) the culture of hospitals and the health professionals that work within them (Menzies, 1970), and the culture of psychiatry (Castillo, 1998). Thus, people diagnosed with mental illness should be placed within their social context and the many facets of their cultural identity understood (Anderson & Carter, 1978). When this person reaches the society's, social group's or family's threshold for mental illness, he or she may be admitted to a psychiatric unit.

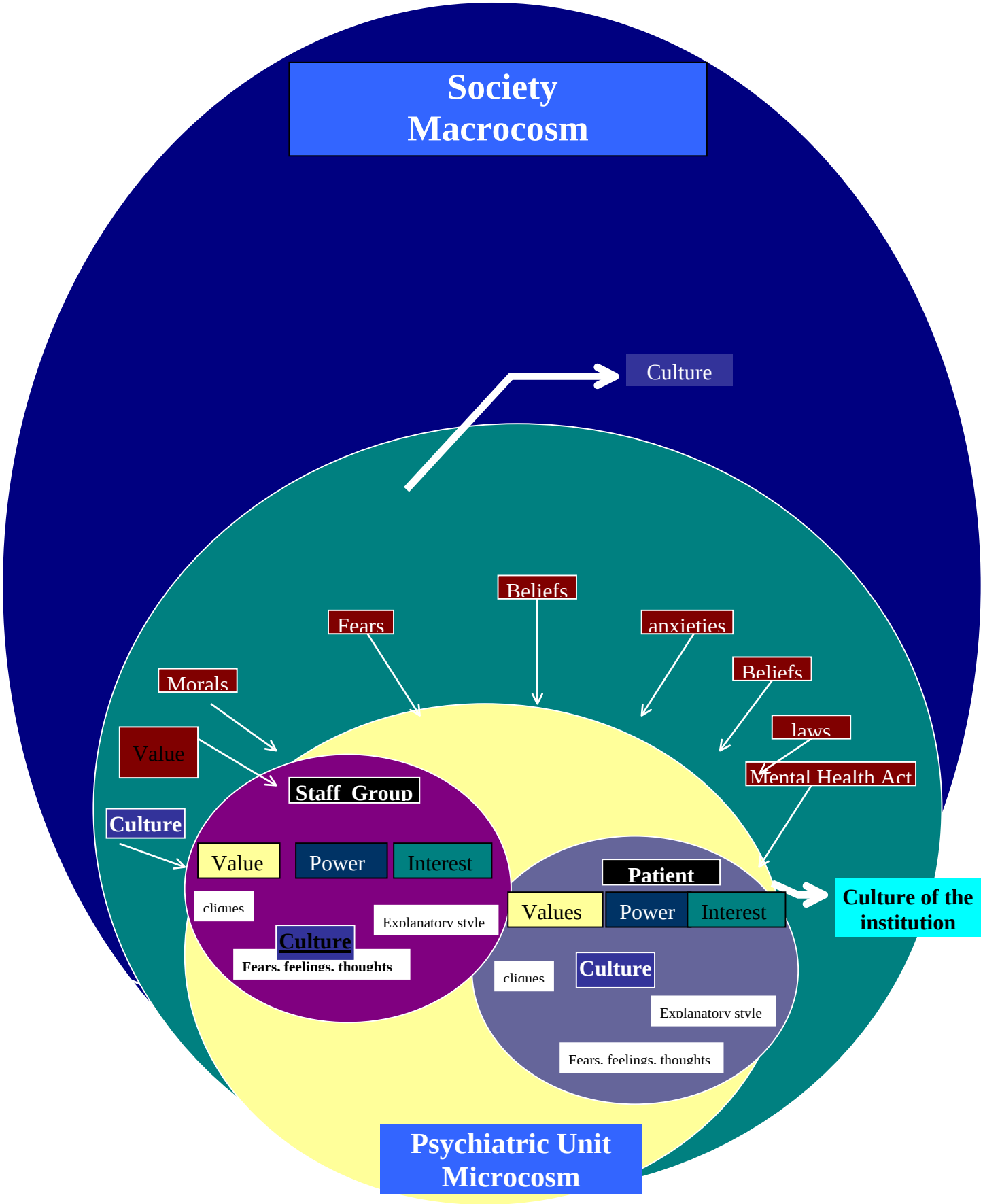
An illustration of this can be seen in Figure 1. representing the society, culture, social system, organisation, psychiatric unit and subgroup to which staff and consumers 'belong' and the influences associated with them.

The Mental Health Institution -The Acute Psychiatric Unit

The psychiatric ward is an organisation with a mandate of taking care of people with acute mental illness. As with any other organisation, it has individuals that comprise its parts and subgroups of people who have particular roles and status. Within the psychiatric ward, the two most distinctive groups are staff and patients. Each group within the psychiatric unit is made up of individuals who bring with them their own culture, and have status and/or roles according to which group they belong. For staff, this status may be associated with the subgroup they belong to, for example, doctors, nurses, cleaners, administration staff or the cliques they fit in to. The patients too, may belong to subgroups according to their diagnoses, or their nationality, or the length of time they have been known to the services, or their past history may place them into particular subgroups.

As has been previously suggested by many authors (Kleinman, 1988; Malinowski, 1944) any investigation into an organisation should attempt to view the parts and the whole simultaneously.

Figure I. Society, culture, social system, organisation, psychiatric unit and subgroup contexts for staff and consumers.



In this instance, it incorporates the individual staff members, the groups they belong to and the culture that they carry, that is the environment in which they act (psychiatric unit). Particularly, this will involve investigating the Mental Health Act and what it reflects about the culture of this society in relation to its treatment of mental illness.

Health professions' influences on themselves is great, providing formal standards and documentation as boundaries to practise (Kleinman, 1988; Nelson, Prilleltensky, & MacGillivary, 2001). Kleinman investigated how professional values influence the work of psychiatrists. He interviewed patients and their respective psychiatrists and compared the clinical notes of the psychiatrist with journals of the sessions kept by the patients. Kleinman (1988) found that not only was the institution in which the psychiatrist worked and the personal interests the psychiatrist held major influences in their treatment of patients, but also the school of thought to which the psychiatrist had aligned his practice (for example, behavioural, psychoanalytic, etc). Kleinman identified that the structure surrounding psychiatry, including its professionalisation, minimised the importance of the narrative of the patient. He stated that seeing the patients in a biomedical, rather than a more holistic paradigm, devalued the patient's individual experience and possible recovery (Kleinman, 1988). Removing people from their environment, where they have set roles and status within their family and community has been raised by several authors as inappropriate (Anderson & Carter, 1978; Goffman, 1961). Goffman (1961) named this process 'disculturation', where people lose these roles. This is compounded by a 'closing of the ranks' where the family structure alters to adapt to the loss of the person.

When I read this it reminded me of an incident at Royal Park Hospital in 1977 during my psychiatric training. I was in my early twenties and the primary nurse for a

male patient in his sixties. He came and asked me to help him organise weekend leave. He explained to me that he was the head of the family and in his Italian background this was very important to him. He said that he had to be home to make the decisions and to be who he was, the head of his family. I asked his psychiatrist to authorise weekend leave for him, but this was denied, the psychiatrist saying that the patient was too suicidal to go home. I pleaded the patient's case in much the same way as he had pleaded it with me. I explained that he measured who he was in the world by being at home and in charge and that without this he had no identity and would be more depressed. He had promised me that if he could go home he would be safe. His request was denied. I went home with an awful feeling in my stomach, that this mans needs had not been met or even fully understood.

The next morning when I arrived at work, the other nurses told me that the patient had hung himself over the balcony. The balcony was only three feet off the ground and therefore almost an impossible place to hang oneself. The conversation between the nurses was riveted to this point, with such remarks as 'he must have held his feet up off the ground'. That was not the most important point, for me it was that I was ashamed to work for a system that had let this man down. Not only had it failed to fully understand him, but had failed to keep him safe in the face of his loss of self. This example upholds Goffman's theory of disculturation. This patient may not have used a sophisticated nomenclature, but he did plead his case of being head of the family and not wanting to lose this position. Furthermore, if he was too suicidal to go home, why wasn't he observed overnight? The psychiatrist felt his view that the patient was too suicidal to go home had been upheld. I felt like an accessory to murder. This was the culture that I was part of and I felt powerless to change it.

In some respects, psychiatry often fails to address the whole family and the complexities inherent in the interactions with each other, more likely to focus on the identified patient. The following story illustrates this well. In the early 1990's, I assessed a young woman in her early twenties; her mother had reported that her daughter was mentally ill and needed treatment. The girl was living with her boyfriend, someone that the mother did not like. The mother had no hesitation at contacting people in the head office of mental health services to get her point across and have action taken for her daughter to be assessed. She rang regularly and told the psychiatrist that her daughter was at risk. She said that if something happened to her daughter she would hold the service accountable. The psychiatrist decided that there should be two workers, one to talk to the mother and another to the daughter and that neither worker should talk to the other client. Crisis assessment teams chased her daughter around Melbourne trying to assess her. I had assessed this young woman and had believed her story that a few years before she had used drugs and had some bizzare experiences, but since then had been clear thinking. She was a gentle, spiritual girl who had different belief systems and lifestyle to that of her mother. She had been prescribed medication during the only episode she had of odd thoughts, but disclosed to me that she never took any of the medication and that when she stopped using illicit drugs the symptoms resolved. She said that her mother was controlling and did not want her involved in any of her medical records. To this end she left her home and lived in special accommodations and caravan parks, to avoid the involvement of her mother and mental health services in her life. This young lady was pregnant and terrified that her mother would succeed in having the child taken away from her. A few months later, I found myself sitting on a bed, trying to console a 38 week pregnant young woman, as she lay sobbing, locked in a seclusion

room, terrified that they would not take her to the hospital if she went into labour and that her mother would take the baby away. Her mother had convinced authorities that her daughter was mentally ill, even though I had performed mental state examination on her and was the only person who had assessed her in several months and had said she was not mentally ill. Admitted by the psychiatrist for observation and diagnosis, I suggested to the inpatient staff that there was a strong possibility that she was not mentally ill and that they should be open minded about this when writing her notes. The next day I was called into the psychiatrist's office and told that I was not a team player and that he was in charge. I was immediately relieved of my involvement with her. The nurse who replaced me was a colleague and she informed me that the girl was not mentally ill and that they kept seeing her until after the baby was born and into the initial post natal period and then discharged her. It is possible that this mother, bereft of the loss of her daughter, had constructed a mental illness story to contain her in a space where she had more access. Regardless, family therapy in the initial presentation years before 1996 may have prevented this scenario from ever existing. Just as Rosenhan (1973) and Schulman (1969) have demonstrated, psychiatric labels do stick and people who are essentially mentally well, can be incarcerated by those who label them unwell. This young pregnant woman lost all her rights and her treatment when against the mandated criterion for certification under the Mental Health Act, yet it did not stop her being certified and/or prevent her seclusion. In this case the psychiatric team failed the young woman by not looking at her family as a whole, but merely focusing on her as the identified sick person.

The Psychiatric Unit as a Social System

The exploration of health professionals as a group within a social system has been extensively investigated, with (Goodenough, 1963, p.84; 1996) giving a succinct overview of the value that health professionals attain from this social group:

> *'The social group is a critical system to each person and especially so to the helping professions. As an area of social interaction, the group has the potential to provide for a range of human needs including:*
>
> 1. *a need to be validated and be accepted:*
> 2. *a need to be validated through feedback processes:*
> 3. *need to share common experiences with others: and*
> 4. *An opportunity to work with others on common tasks.*
>
> (Anderson & Carter, 1978, p.84).

The issue of *cliques* is also relevant within the institution. The staff cliques form more of an affective dimension, giving meaning and acceptance to the organisational requirements (Wolfe, 1966). Furthermore, cliques help preserve individual egos against the dominant force of the institution, and provide collective support when events deviate from those normally expected, particularly when there are hierarchical power distributions within the organisation. Cliques are important as supplementary interpersonal sets that reveal intricacies about the mechanisms of complex societies and the forces within them (Wolfe, 1966). Belonging, or not belonging, to a staff clique within the psychiatric unit may prove to be an important part of the culture of that unit. Each person has several social identities, and in specific situations one is selected as appropriate (Main, 1989). This, Goodenough (1963) terms the *selector's social persona in the interaction* (Rayner, 1989). Watkins (1997) also supports this notion of the

selection of an internal identity or personality part, which is appropriate to the social setting one finds oneself in. This is highly relevant to this research, because nursing staff work in teams and have doctors and psychiatrists allotted to those teams and may find themselves in a multiple of settings within the psychiatric unit. Furthermore, the nurses are rostered to work together in groups of five; each nurse being given a group of patients belonging to their different teams. Staff members are then forced to have some sort of relationship with the nurses they are rostered on with. This is totally separate from the cliques they *choose* to belong to by becoming friends with particular individuals or groups of people within the unit. If this statement by Goodenough holds true, perhaps depending on what clique a staff member belongs to in the unit, a 'persona' or personality part within that person may be activated. These personas may change according to the power, values and interests of the group they are interacting with at the time. Some of these personas may or may not be appropriate for staff-consumer relations. For example, one group may be focused on highest quality of care for consumers, while another more interested in socialising with their colleagues in the nurses station. This research incorporates the conflict that occurs for nurses when they are torn between their own values, power and interests and those of the group. In the words of Kanopka; *'It is within the group that the power, basic and immense, human beings have over one another occurs: the power of acceptance* ***or*** *rejection'(Konopka, 1972, p. 46).*

Therapeutic Communities

Hospitals are not only complex environments for staff members; patients are also affected by the organisation and hierarchical power relations. Tom Main (1989) raised concerns that a psychiatric hospital was constructed as a 'social retreat' that

denied patients the support of community members which would optimally be provided in a community (Koldjeski, 1984). He designed a therapeutic community to replicate the social and emotional structure one would hope to find in a supportive community. Unless the patient achieved socialisation back into society as a fully functional individual, the goal of treatment had not been achieved (Koldjeski, 1984). Main (1989) a psychiatrist, stated that to create a therapeutic environment, doctors had to be able to relinquish the power that they usually exerted over their patients and other staff members. In a letter to Radical Psychology, McCubbin, Weitz, Spindel, Cohen, Dallaire and Morin (2001) suggest that the power to run mental health services be given to the consumers of mental health services in preference to health professionals.

In the therapeutic community, patients were able to maintain their sense of personal responsibility and participate in decisions regarding their treatment. However, other hospitals failed to replicate this structure due to difficulties in changing staff and patient power relations. The organisation of a hospital is based on a bureaucratic hierarchy with psychiatrists on the top and mental health professionals ranked according to status and roles in levels below them (Main, 1989). In contrast to the model by Main, current psychiatric units are primarily concerned with managing deviant behaviour so that individuals can quickly return to ‘the community’ (Rayner, 1989). The care of the mentally ill is structured against individual participation in daily life activities and focuses more on group management. For example, in Main’s therapeutic community, the patients would be able to cook the meals and choose what food to buy. In the current hospital setting, meals arrive on a trolley from the central kitchen and patients do not participate in the serving of any meals. Main promoted a ‘health-seeking’ system that

encouraged a sense of community and the development of relationships that people could learn from (Main, 1989; Rayner, 1989). Main (1989) claimed that doctors did not 'own' patients and doctors had to give up this notion, and patients must be free to organise the activities of the hospital. Tom Main's idea was that you 'do not do things ***to*** patients, not ***for*** patients, but ***with*** patients' (Wadsworth & Epstein, 1996a, p.xx). The aim of the therapeutic environment was to have individuals participate fully in daily living within a managed supportive community and eventually re-socialisation into ordinary society (Commonwealth Department of Health, 1992, p.8).

Tom Main espoused that the distribution of duties according to a highly structured hierarchical model of care should be replaced by a model of encouraging personal efficacy, where individuals have control over their own environments. He was not however, the first person to illuminate the potential of consumer driven services. As will be seen in the following paragraphs work in this area began as early as 1935.

History of Consumer Participation

This section details the beginning of consumer participation in health care. It commences with participation via self- help groups such as Alcoholics Anonymous and GROW, a psychiatric self- help group that began in Australia. It then details the research project of Epstein and Wadsworth that heralded consumer participation in Australia. The section finishes with the employment of ex-patients as consultants regarding health care delivery in psychiatric services. This is highly pertinent to this research because Consumer Consultants were employed in this research to have an equal voice to staff in developing new work practices.

The history of consumer participation begins with self-help groups. The earliest self-help groups began with Alcoholics Anonymous (AA) in 1935 (Bufe, 1991; Le,

Ingvarson, & Page, 1995). The success of AA demonstrates quite clearly that experts were not needed for people to recover from alcohol addiction (Chamberlin, 1995; Le, Ingvarson, & Page, 1995). The history of consumer/survivors-operated services can be traced back to the 1950's in New York City when self-help organisations first evolved (Chamberlin, 1978). These became more popular in the 1960's and 70's. Although self-help groups were prominent in religious groups, bringing like minded people together to share common goals and values, it was not seen in mental health until the 1980's. Many positive benefits have been achieved by self-help groups (Chamberlin, 1995; Rappaport, 1988). Peer support provides a sympathetic ear by someone who has similar experiences. Further to this, when groups of people form, they also gain strength from the numbers of people who participate, giving a voice and creating power for otherwise powerless individuals (Finn & Bishop, 2001). This equates to synergism where the combined power is greater than the sum of its individual parts. This group power is particularly relevant in regard to advocacy to try and change systems (Zinman, Harp, & Budd, 1987).

The mental health consumer movement was driven by overwhelmingly negative experiences of patients as a protest in regard to the treatment of people with mental illness. It began with the book 'A mind that found itself' by Clifford Beers as early as 1908 (Beers, 1908) and was further cemented in 1978 by Judi Chamberlin who wrote a book called 'On Our Own' (Chamberlin, 1978).

Grow was founded in Australia in 1957 by former psychiatric patients who supported each other through sharing their lived experiences and common problems associated with mental illness (Finn & Bishop, 2001). The success of Grow has been well researched and documented (Rappaport, 1988, 1993; Rappaport & Seidman, 1986)

(GROW, 2000). The key concepts of Grow are the sharing of common problems, the mutual support and exchange of knowledge gained from the lived experience of the members (Finn & Bishop, 2001). It is also important to note that Grow did not place itself in opposition to mainstream mental health services. Rather, it was complementary to it. This could be considered an important factor in the survival of such groups.

The National Mental Health Policy (McGuiness & Wadsworth, 1991; Wadsworth & Epstein, 1996a; Wadsworth & Epstein, 1996b) provided a fertile ground for involvement of consumers and carers of mental health service users in policy development in Victoria (McGuiness & Wadsworth, 1991; Wadsworth & Epstein, 1996a; Wadsworth & Epstein, 1996b). In the wake of this legislation, the Victorian Mental Illness Awareness Council (VMIAC), a mental health consumer/survivor advocacy organisation, funded a substantive research project that investigated the lived experiences of consumers at Royal Park Psychiatric Hospital (Epstein, 1998). This ground breaking research gave the researched an equal voice in a research that was for, and about them. This heralded momentous changes for psychiatric consumers. In 1996 a Melbourne hospital employed a consumer consultant for the first time to evaluate the model for quality improvement (Epstein & Olsen, 1998; Kroschel, 1998). As a direct result of this the Victorian Department of Human Services, Mental Health Branch, funded Consumer consultants in all Area Mental Health sectors (Epstein & Olsen, 1998; Kroschel, 1998). Consumer Consultants are ex-patients who are employed as staff members to mental health services. They represent the voice of the mental health consumer, to inform policies and practices and to give peer support (Campbell & Humphreys, 1993). Consumer Consultants are now well known in their evaluation of the mental health systems (Barnes, 1997; Epstein, 1998; Kroschel, 1998) and have

impacted strongly on planning, delivery and evaluation of mental health services, legislation at national levels and research (Chamberlin, 1978, 1990, 1995; Chamberlin & Rogers, 1990; Epstein, 1998) and more recently into the General Practice arena (Bailey, 1997; Hider, 1997; lyall, 1997). Barnes and Shardlow (Barnes & Shardlow, 1997) found that service user groups played a key role in ensuring rights were protected and that service providers were accountable for their services. Others joined forces to strengthen the community by taking action on the needs of groups within the community, for example the Purple Sage Project, 1998-2000. They listened to what people had to say and then took action to implement change across for the community.

Consumers brave the elements to 'come out' in the public arena as mental health consumers, in an effort to change public attitude, stigma, policy and the treatment of patients with mental illness (Campbell, 1997; Epstein & Olsen, 1998; Kroschel, 1998). This lead Merinda Epstein to be employed at a national level to impact on policies associated with mental health. Consumers add distinctions and depth to the inquiry about the quality of service delivery (Epstein, 1998), (Campbell, 1997) and are said to be a potent force in breaking down stigma (Whittaker & Gilmour, 1997) informing community initiatives (Villeneau, 2000) and being involved in the training of mental health workers (Basset, 2000). However, they must have support networks of their own due to the pressures of having two identities in the work place, that of being consumers and mental health workers at the same time (Nelson, 2001).

In Australia, there are strong consumer groups advocating for consumer-driven services. One leader in this field is Alan Pinches (2003) a prolific writer in regard to consumer participation in mental health services, who convenes a consumer advocacy group called 'Thinking CAP". Pinches (2003) argues that the current medical model is

mechanistic and reductionist and is devoid of spirituality, advocating that services driven by consumers would be more holistic and encompass a biopsychological approach to mental health.

More recently, consumers began contemplating a return to a name that gives them less stigma and more equality in the world, that is, *citizen*(Carter, 1997; Sutton, 1997). They are citizens trying to access high quality health care for themselves and other citizens who may follow. As taxpayers, they are seeking value for their own dollars (Carter, 1997). Owen (1997) argued to the Australian Health Minister's Advisory Council that the consumer movement is so strong now that it demands autonomy regarding decisions about access and health alternatives. The level of consumer participation in service delivery models differs greatly from no participation to having control of developing the model in collaboration with the service providers (Silburn, 1999). Staff members who were often cajoled to belong to committees with consumers felt unsure of their roles and reluctant to participate fully (Bowl, 1996). Further to this, there is a belief held by some people that for consumers to have power, the other stakeholders must relinquish it (Silburn, 1999). There will need to be a shift in thinking that allows for consumers to be a valued resource that is not in a power competition with any other stakeholders before true collaboration can be experienced. Consumers' voice is minimal in relation to the behavioural health organisations and there is a strong need for organisations to be held accountable for the reasonableness of their practices (Sabin, O'Brien, & Daniels, 2001). Accountability for reasonableness requires three elements: transparency of organisational policies and decisions, deliberation that recognises the needs of both the individuals and the population served,

and opportunity for appeals and revision of limit-setting policies (Sabin, O'Brien, & Daniels, 2001).

I agree with Sabin, O'Brien and Daniels (2001), that there is a need for robust consumer voices to further impact on the lived experiences of consumers of mental health services. One area that I noted difficulty with during my employment at the major public hospital in this research project was that of the limitations placed on consumer consultants. The consumers appear to have little impact on the day to day work practices of mental health professionals. Their job descriptions required them to be on many committees, assist with writing policies and occasionally facilitated groups regarding advocacy. However, they did not have access to nursing handovers, nurses' stations and/or nursing notes and did not directly discuss observed work practices with staff. This is one gap in consumer consultant service provision that this research project attempts to address. In opening up the possibilities for consumer consultants' collaboration to directly inform work practices, the potential of transforming work practices for the highest good of all concerned is enormous.

Optimal Work Practices

'Primum non nocere': First do no harm (Hippocrates)

My vision for optimal work practices incorporates 'first doing no harm'. This comes from my personal observations over time. Often in psychiatry, there were staff members who sat in the nurses' station, chatting and socialising with staff and occasionally talking to a consumer. They appeared to make little difference to the consumers, but at least they did not do any harm to them. In contrast to this there were others who appeared to be on-guard ready to respond to changes in their environment with aggressive responses by secluding people. This was often as a first response

without attempting other options. I also observed others who appeared to deliberately irritate or humiliate consumers, often leading to seclusions and or critical incidents. I believe therefore, that it is better to do nothing at all than to induce harm to another, hence *primum non nocere*.

When one is constantly working within the system it is often difficult to see how to bring about change. Whistleblowers were treated so badly that they were forced to leave. This happened to me in the 1970's when I tried to voice the discrepancies I perceived in the work practices I was being asked to participate in and the personal values I held. My vision for optimal work practices is inspired firstly by the work in Australia of Wadsworth, Epstein and McInness (1996-1998) in facilitating consumers' voices to be heard. I gained further distinctions in exploring the theories of Prilleltensky (2001a) who places emphasis not on one particular group (consumers) but on the values, power and interests of *all* stakeholders, and more recently of Nelson, Lord and Ohocka (2001) who have illuminated the empowerment-community integration paradigm. In line with Nelson et al (2001), my vision for optimal work practices involves stakeholder participation and empowerment at all levels. New paradigms should be driven by consumers rather than imposed upon them by health professionals (Main, 1989) moving from a 'power over' to a 'power with' model (Nelson, 2001; Prilleltensky, 2000, p.22). Mental health clinicians would need to have a paradigm shift from 'expert-technician' where they know what is best, to a position of 'resource collaborator' that is focusing on what the consumer wants and is interested in, and assisting him/her in actioning it (Wadsworth & Epstein, 1996b, p.22). In this optimal vision of work practices family is highly valued, as are members of the community to which the citizen belongs. As Nelson, Lord and Ohocka. (2001) have raised, the focus will then be diverted from the

negative aspects of a patients' mental illness (symptoms) to the positive aspects of the citizen (what they value about themselves and in their community). In my vision of optimal practice individuals do not get traumatised from coming to hospital, but rather empowered and find it an illuminating experience as they travel from community to hospital and back to community again. It would be important to build these bridges filling the gap between inpatient care and community, a potential place for community psychologists to stand (Kloos, 2005). My vision entails a seamless transition that occurs without the loss of everyday supports and without the loss of self.

As a health clinician, optimal practices for me would be to be free to work within my own value systems: to be able to work 'beyond the pale' without fear of retribution; to be able to hug and to touch, when a citizen indicates that this is what is needed; to be able to have transparent notes that are written with the consumer, not as evidence against them; to be able to respond to consumers' values and needs in the moment wherever possible. This would entail human rights, dignity, cultural sensitivity and responsiveness to the needs of the individual and the families. In summary, optimal work practices for me means that my values would not have to dramatically alter because I came to work. What I hold as essential for human rights of citizens, is part of my daily living, no matter what environment I find myself in. The most important right of humans is that of choice. Optimal practice seeks and facilitates choices of citizens.

Overview of Objectives

General aims

In light of the recent changes to the MHA (1986) and its amendments (1995), and the governments mainstreaming policy (1996) that funded the building of a new psychiatric unit, it seems a highly appropriate time to explore the culture of an acute

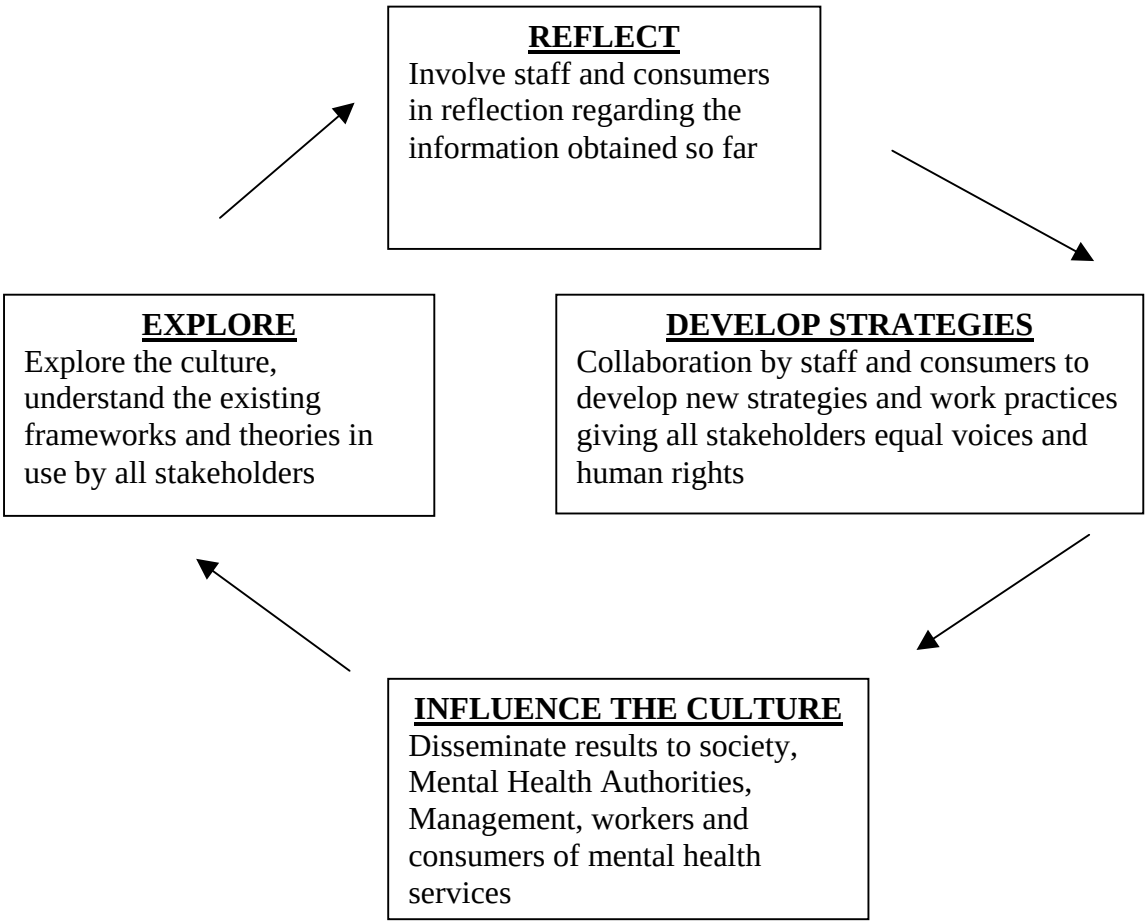
psychiatric unit and to investigate existing work practices within that culture. Staff and Consumer voices in relation to work practices will also be evaluated. In line with the literature that purports consumer responsiveness as highly important to optimal practice, this research will explore ways to enhance consumer-responsiveness. In the same vein, this research investigates the potential structures that could perpetuate acceptable feedback regarding work practices. In accord with the literature in regard to consumers being equal stakeholders in their own care, I propose to design optimal work practices in collaboration with staff and consumers.

I intend to understand how I as a worker and as a researcher impacted on the culture of the psychiatric unit by delving into my own lived experiences within the unit. I will attempt to understand the underlying theories-in-use that influence my own practices. This will be followed by an exploration of underlying theories-in-use of the 'Other' practitioners from their own voice.

Specific Aims

Specifically, I aim to understand the culture and power dynamics within a psychiatric unit and to understand mechanisms and opportunities for change in a psychiatric culture. I intend to develop new consumer-responsive work practices for psychiatric health professionals. In line with the participatory action research framework of this thesis, my final aim is to develop structures that will impact on the culture of mental illness through the dissemination of the results at the level of society through government policies, the next generation of workers being educated at university, and the current managers, workers and consumers within the psychiatric unit. The aims of the research are illustrated below within the action research framework.

Figure 2. Action research framework



Overview of the Thesis

In light of the context of policy change reflecting community values and my personal experiences within the culture of an acute psychiatric unit, I conducted the following study into the complexities surrounding the work practices of mental health professionals. In order to contextualise the findings, I embedded the data in the naturalistic context from which it was derived and also in the scholarly literature available at this time.

In Chapter 3, Methodology, it will become evident that the project veered from its original course due to participants' unwillingness to disclose their work practices in

front of other colleagues. The original research design incorporated a Participatory Action Research paradigm from the beginning: one where staff met in groups to discuss their work practices. However, I overestimated staff's willingness to talk openly in front of each other about their work practices, and therefore eventually relinquished this group discussion for individual interviews. It seemed that this was necessary to put the worst work practices on the table so that optimal work practices could be forged. Following this cathartic release, the project did eventually get back on course and became a Participatory Action Research project where staff and consumers met together in groups to discuss their work practices and develop new work practices.

In light of this, the information in this thesis has been presented in the chronological order in which it was gathered. The findings and discussion are found in Chapter six, and have been organised in a manner that reflects the story of the thesis. It has been divided into sections according to themes of power, interests and values. These themes begin with my experiences of working in the mental health unit, and then explore the literature associated with each theme. The data from the staff interviews and the consumer consultants' reflections on that data follows. It ends with a discussion of the theme at hand. A model summarising the factors that influence and inhibit the work practices of mental health professionals according to each theme completes this section.

Chapter Seven describes the action part of the research project, that is, the changes that occurred and/or were proposed by the staff and consumer group, as a result of the research. This leads into chapter eight which moves away from data driven findings and into the theoretical discussion relating to those findings. Ego-state theory is used to understand the culture of the individual, the unit and society in relation to the mental health unit. In Chapter nine, the thesis then draws together suggestions for future

research in regard to mental health services and concludes with statements that summarise the value and purpose of this study.

CHAPTER 3

METHODOLOGY

This chapter outlines the methodology as it evolved throughout a four-year period and through the difficulties relating to recruitment of participants and the eventual methods of data collection that lead to the completion of the project. It begins with an overview of qualitative methodology, Reflective Topical Autobiography and participatory action research (PAR). This is followed by the methodology used.

Qualitative Research

The Importance of Context

Qualitative research 'is multi-method in focus, involving an interpretive naturalistic approach to its subject matter' (Denzin & Lincoln, 1994, p.2). That is, it does not adhere to one method of data collection (Van Manen, 1991). Rather it draws on many sources of information to inform the research (Moustakas, 1994). It is research that moves away from the rigidity of a structured environment, preferring to explore the experiences of people in a more wholistic sense in their organic environments, intent on understanding the meanings people attribute to their experiences (Moustakas, 1990, 1994; Pratt & Loizoz, 1992). Context is critical to the qualitative inquiry (Freedman & Combs, 1996). Rather than being a reductionist/specialist who seeks to identify a controlled portion of an object (Ackoff, 1974) and who often practices what Guba and Lincoln (1994) call *context stripping* in an effort to control extraneous variables, a qualitative researcher deliberately searches for the whole picture (Denzin & Lincoln, 1994; Guba & Lincoln, 1994). The issue becomes, how do we ever search for the whole picture? The search may include a multitude of meanings and can be said to be *multi-storied storeyed* (Clandin & Connolly, 2004). This is particularly relevant when there

are multiple stakeholders involved in the area being researched, which is highly important to this current project.

A Multiple Methodological Design

The tools a qualitative researcher uses to achieve this wholistic understanding are highly varied and may incorporate interviews (Plummer, 2001) reflection (Johnstone, 1994), viewing documentation (Hodder, 1994), personal experiences (Crossley, 2000), archival, life documents (Neuman, 1994), biographical (Smith, 1994), reflective topical autobiography (Berg, 1998; Denzin & Lincoln, 1994; Johnstone, 1999b) narratives (Etter-Lewis, 1993; Polit & Hungler, 1993), observation, case study (Denzin & Lincoln, 1994), hearing the life story and journaling (Denzin & Lincoln, 1994; Levi-Strauss, 1966; Neuman, 1994). The reasons for the use of multiple methods are to add "rigor, breadth and depth to any investigation" searching for an in-depth understanding of the phenomena in question (Levi-Strauss, 1966, p.2) The researcher is often said to be a 'bricoleur' or a jack-of-all-trades', who uses 'bricolage' or multiple methodologies to solve a problem (Denzin & Lincoln, 1994, p.2). These solutions are often developed on-the-run as new dimensions arise throughout the research and emergent themes are being responded to (Strauss & Corbin, 1998). The result or bricolage (Denzin & Lincoln, 1994) brings the multiple stories together like the pieces of a jigsaw puzzle, to make up the complex, deep and meaningful story of the research as told in that moment by those involved as co-producers (Denzin & Lincoln, 1994).

Qualitative researchers draw on techniques from many perspectives: ethno-methodology (Atkinson & Hammersley, 1994; Marcus, 1994), phenomenology (Holstein & Gubrium, 1994), hermeneutics, feminism, rhizomatics, deconstructionism, grounded theory (Denzin & Lincoln, 1994), psychoanalysis, cultural studies (Fiske,

1994), constructivism (Schwandt, 1994), interpretive, postmodernism and critical theory (Denzin & Lincoln, 1994) (Kincheloe & Mclaren, 1994). It is beyond the scope of this research to explore all these dimensions of qualitative research see (Berg, 1998; Denzin & Lincoln, 1994) for a comprehensive analysis).

Qualitative research has also been through many phases over the past millennium. Denzin and Lincoln (1994) have summarised the history of qualitative research into five phases. These phases began with the traditional phase in the early 1900's with Ethnography and moved through to the Modernist phase (1940-1970s); Blurred Genre phase (1970-86); Fourth Moment (1980's), characterised by interpretive theories; through to the current Fifth Moment. This is more action orientated and places the researcher as a central figure to the research (Neuman, 1994). It is within this Fifth Moment that this research is placed. Denzin and Lincoln (1994, p.11) argue that in this current Fifth phase of qualitative research, the researcher is no longer aloof and "the personal biography of the gendered researcher who speaks from a particular class, racial, cultural, and ethnic community perspective. The gendered, multiculturally situated researcher approaches the world with a set of ideas, a framework (theory, ontology) that then is examined (methodology, analysis) in specific ways" (Polit & Hungler, 1993, p.11).

This thesis has elements of hypothesis generation particular to grounded theory, that is drawing the hypotheses from the data as they emerge (Glaser & Strauss, 1967; Glaser, 2005; Strauss & Corbin, 1998). It also upholds similar tenets to that of Simmons and Gregory (2004) who coined the phrase *grounded action* to describe the complex organizational and social changes that occur during Participatory Action Research. However, the best fit for this research is the use of multiple methodologies, particularly Participatory Action Research and Reflective Topical Autobiography which will be explained later in this chapter.

Impact of the Researcher

In qualitative research the position of the researcher is important for a number of reasons. First, the choice of methodology will be based on whether the researcher is an outsider to the culture looking in, that is, an insider being part of the culture, or whether the person already belongs to the culture (Denzin & Lincoln, 1994; Freedman & Combs, 1996; Hooks, 1990; Moustakas, 1994). In any case, the researcher is immersed in the data in an interactive way. Therefore the research is also shaped by who the researcher is, by his or her history and place in the world and impact on the culture being explored (Ellis & Flaherty, 1992; Etter-Lewis, 1993; Fine, 1994; Johnstone, 1999b). Pertinent to this thesis is the famous study by David Rosenhan (1973) titled 'being sane in insane places', where the researcher feigned symptoms of mental illness and was admitted to a psychiatric institution. Staff were unaware that he was a psuedopatient (Rosenhan, 1973b). Being immersed in the data gave tremendous insights into the plight of patients admitted to the particular psychiatric facility and their difficulties in removing a psychiatric label once it had been applied to them. As a researcher he immersed himself as a participant observer to obtain first hand information (Rosenhan, 1973a). Although the ethics of being a pseudo-patient was questioned, the rich data that he obtained would not have been illuminated had he not placed himself in this position (Rosenhan, 1973b). Similarly, Schulman (1969) spent years as an observer researcher in a psychiatric hospital. He found that just being present and documenting the innovations of the organization that he became an agent of change affecting the organization. In this research I am immersed in the data as a researcher and a participant and my presence in the psychiatric unit impacted on the

environment and this will be further illuminated in the results section. Suffice to say at this juncture that I saw myself as a catalyst for illuminating discrepancies in work practices within the psychiatric unit as well as for change within the organisation, as such I was immersed in the research setting and influence the research project on many levels. These levels will be explored later in this thesis.

One lesser-known methodology, which sits within the post positivist interpretive research paradigm, and which is highly valuable to practitioner-researchers is Reflective Topical Autobiography (Foster, McAllister, & O'Brien, 2006; Johnstone, 1999b). Ellis (1992) encourages and promotes the use of *emotional narratives,* which are subjective and biographical in depth encounters of the lived emotional experience. Narratives are said to be ‘an oral history that is a dynamic interactive methodology that preserves an individuals own words and perspectives in a particularly authentic way (Etter-Lewis, 1993, p.xxi). Likewise, Ellis and Flaherty (1992) uphold subectivity, that is the lived human experience and the meaning people attribute to it, in high regard. Unedited narratives provide insights in the individual’s life experience (Etter-Lewis, 1993). This type of data has been found to yield rich and thick descriptive data that gives deeper understandings to the phenomena being studied (Moustakas, 1994; Moustakis, 1990). Similarly, Holstein and Gubrium (1994) propose that phenomenology bridges the gap between theory and practice. It is anchored in experience and is concerned with the lived experience of people and the way people exist in the world(Foster, McAllister, & O'Brien, 2006). Johnstone (1999b, p.24) advances Reflective Topical Autobiography as an excellent interpretive methodology for nursing inquiry ‘in particular, apropos: (I) increasing understanding of subjectivity and making subjective experiences more visible and intelligible (ii) the search for meaning and increasing understanding of the

commonality of existential human experience and (iii) decentring the detached observer and his/her privileging the objectivist illusion in the hierarchy of research discourses, paving the way for the admission of multiple realities and interpretations of lived experience'. In a similar vein to heuristic stages of research put forth by Moustakas (1990), Reflective Topical Autobiography uses immersion, incubation and illumination to explore the subjective lived experienced of the researcher (Foster, McAllister, & O'Brien, 2006; Johnstone, 1999b). It requires the researcher to take a snapshot of their lives, of an epiphany or turning point experience and engage in a process of critical self-reflection, reflexivity and immersion (Johnstone, 1999b). It has the potential to generate rich and thick descriptions in relation to the lived experiences of mental health professionals. The importance of stories as evidence has been documented by others (Borkan, 2006; Foster, McAllister, & O'Brien, 2006; Stange, 2006) and is a central point of this thesis. In this particular research, the epiphany is the researcher's experiences of working in an acute psychiatric unit during its initial year following deinsitutionalisation as part of the governments mainstreaming policy (Ministers, 2002).

Of particular relevance to this research is the work of Michelle Fine (1994) called "working the hyphens", where she explains the concept of *'Othering'*. This is where the researcher's preconception about the *Others* (subjects) influences the type of research, who does the research, who-says-what-to–whom, and how the research is conducted (Fine, 1994). The researcher would then tell the story of the *Others* in the researcher's words (Ellis & Flaherty, 1992), the changed story reinforcing the researcher's already-knowing about the others, thereby 'Othering' the researched person (Fine, 1994). bell hooks (1990) explained this difficult jargon simply and clearly when she talked about how the lived experience of being a person of colour was a long way

from how researchers viewed such a person. The pigeon hole in which people of colour were encapsulated created a box that limited researchers' ability to see them or research them in any other way (bell hooks, 1990). This is in line with theories advanced earlier by Foucault, who said that we tend to internalise the dominant narrative and see it as the truth, preventing other possibilities of truths or realities (Foucault, 1997; Freedman & Combs, 1996). One way to avoid the pitfalls of the dominant narrative is to collaborate with the other stakeholders in the research and to incorporate multiple voices, rather than just the voice of the researcher and to have people tell their own stories. This is highly important to this research where there are multiple stakeholders with multiple voices.

Of high importance to this research is the use of *emotional narratives that* are subjective and biographical in-depth encounters of the lived emotional experience (Ellis & Flaherty, 1992; Johnstone, 1999b; Kemmis & McTaggart, 1988). Emotional narratives uphold subjectivity, that is the lived human experience and the meaning people attribute to it, in high regard (Mateo & Kirchhoff, 1991, p.24). For example, the stories that staff members tell about critical incidents within the ward, shape the culture in which they belong and affect the lived experiences of the consumers and staff within the unit. Unlocking these stories has the potential to illuminate intricacies within the culture that would not normally be able to be fully understood. Researchers have found that this type of data can yield rich and thick descriptive material that gives deeper understandings to the phenomena being studied (Ronai, 1992). Similarly, Van Manen (1991) proposes that phenomenology bridges the gap between theory and practice. It is anchored in experience and is concerned with the lived experience of people and the way people exist in the world (Moustakis, 1990; Van Manen, 1991). In the nursing

literature, this type of interpretive methodology is highly relevant with the subjective experiences of nurses adding great value and increasing the 'understanding of the commonality of human experience'(Johnstone, 1999b, p.24). To fully explore the human experience, Moustakis (1990) proposed that this be done in what he termed the *heuristic stages* of research: immersion, incubation and illumination. This is not just limited to the participants in question, but the researcher as one of those participants, is also expected to take a snapshot of his or her life, of a turning point experience or epiphany and immerse, incubate and illuminate it (Halpern, 1988; Moustakis, 1990).

To put this into context within this current research, it could be said that within the psychiatric unit, there are multiple realities and interpretations of the same events. The researcher too, has her understandings of events within the psychiatric unit. It is within those individual and common understandings held by the people who experience the culture the possibility for change occurs. Using this type of methodology demands that I, as the researcher, should take a snapshot of my experiences and also progress through a period of immersion, incubation and illumination. In this research, the epiphany is my experiences working in the acute psychiatric unit during its initial year following deinstitutionalisation as part of the government's mainstreaming policy (1995).

In summary, I have established the importance of the voice of the researcher and placed this within the context of this research. Previously, I established the equal importance of *Other* voices in qualitative research. In this research, *Other,* are the consumers or citizens of mental health services (represented by consumer consultants) and *Other* staff members (Mental Health Professionals). Having established the three main stakeholder groups, the next step is to place it into the appropriate research

methodology where all players can have an equal voice and can participate and influence change. I have chosen Reflective Topical Autobiography and Participatory Action Research as the appropriate methodology.

Participatory Action Research (PAR)

Action research is the most appropriate methodology because it is a critical collaborative approach to research, one that encourages and facilitates all members of the social system being examined to have a voice within the research (Epstein & Wadsworth, 1994; Kemmis & McTaggart, 1988; Mateo & Kirchhoff, 1991; Nelson, 2001; White, Nary, & Froehlich, 2001). The joining of research and action is highly appropriate for groups of people and communities to bring about new initiatives during the research process (Argyris, Putman, & Smith, 1985; Argyris & Schon, 1978, 1984; Halpern, 1988). It is well established that Participatory Action Research (PAR) is the appropriate method of choice in community settings, for example, Freire (Freire, 1972, 1974; 2001; Kemmis & McTaggart, 1988) used action research extensively in the education field to bring collaboration amongst groups of people forwarding the action for improvement of teaching practices. In line with this current project's focus on mental health, there have been multiple examples of the successful use of Participatory Action Research in community mental health projects (White, Nary, & Froehlich, 2001). It is remarkably pertinent to the mental health inquiry in question.

Action research originated with (Lewin, 1946) whose two major tenets were that action research focused on the group making decisions and focusing on improvements (Carr & Kemmis, 1986). Argyris and Schon (1978; 1984) first raised the distinction between espoused theories (in this case the Mental Health Act and hospital policies) and theories-in-use that are the theories and assumptions that drive action (in

this case, work practices). The theories-in-use can be illuminated by reflection (Zuber-Skerritt, 1992). This is supported by Reason (1994), who states that the primary task of PAR is enlightenment through the objectives of knowledge, action and empowerment. This occurs through reflection and critical thinking (Reason, 1994), or in the words Paulo Freire (White, Nary, & Froehlich, 2001) to develop *conscientization or critical consciousness*. Pivotal to PAR is the involvement of the collective as collaborators in all aspects of the research process (Chesler, 1991; Nelson, 2001; White, Nary, & Froehlich, 2001). Action research has four major phases: plan, act, observe and reflect (Nelson, 2001) and all of these processes can incorporate all stakeholders (McGuiness & Wadsworth, 1991). For example, in my research project, I propose to begin with consumers and staff exploring the current work practices and developing new work practices (plan), then to implement those work practices (act) and to observe the outcome (observe) and then to reflect on the outcome and the process (reflect).

Consumers are involved in this process (the four stages) from the beginning until the end. The next section focuses on the involvement of consumers as one of the multi-stakeholders who are associated with this project.

Stakeholder Participation

Multi-stakeholder participation has been used by many authors. Highly relevant to this thesis is the research by White, Nary and Froehlich (2001) who used mental health consumers as collaborators throughout their project. Consumers of community mental health services were pivotal throughout their research as evidenced by their four main components of: a) external consumer influences, b) internal consumer influences through a consumer empowered team, c) the research process and d) consumer-valued outcomes. In the research, consumer-collaborators voices were priorities of the research

and this led to consumer valued-outcomes (McGuiness & Wadsworth, 1991). Dissemination of their results was also incorporated in the total research project as part of the actions of the research.

Another recent PAR project that was driven by consumers as collaborators is a project completed by McGuiness and Wadsworth (1991). They acknowledge how much their roles changed throughout the research. For example, although from the beginning they were intent on full consumer involvement, they did not expect consumers to also assist in the writing up of the project. They were able to include consumers from the beginning which enabled the process to be shaped and led by the consumers throughout the whole project (McGuiness & Wadsworth, 1991). Their research is exemplary in empowering all voices to be fully heard as co-researchers. They also add to the body of literature in regard to the new paradigm that incorporated the researcher in a multitude of roles (McGuiness & Wadsworth, 1991). Both these recent research projects demonstrate quite clearly how to be less controlling as a researcher and more receptive to the voices of *Others.*

The participatory action research that most closely aligns to this proposed research is that of McGuiness and Wadsworth (1991). Their pioneering research within the culture of mental health institutions in Australia, was by and for the consumer of mental health services. This led to the development of new and innovative techniques of action research through a phenomenological or interpretative approach. Their methodology, termed ‘fourth generation’ or ‘constructivist’ adopted Guba and Lincoln’s (1994) evaluation methodology. It enabled the staff and consumers to speak and be heard within the research; each also listening to the other to a point of understanding the other’s point of view (McGuiness & Wadsworth, 1991, p.2). Epstein and Wadsworth

(1994) reported that their unique methodology embodied the staff and consumers as the researchers as well as the researched. McGuiness and Wadsworth (1991,p.2) stated that within consumer groups, there was a 'collective experiential wisdom that can be complemented by mainstream academic wisdom' .

The works of Epstein and Wadsworth (1994) and McGuiness and Wadsworth (1991) have many salient features. One prominent feature is that of the consumer-perspective. One can never presume to know what a consumer is thinking or needing, or how he or she may be responding to the culture of the psychiatric unit. The only way to really know what a consumer wants, needs or feels is to ask them. These researchers did just that over a six year period. They asked staff and they asked consumers and they facilitated the 'other' being heard. The methodology was particularly designed to create the conditions for 'in-depth interaction, structured conversation and mutual exchange until understanding was reached' (McGuiness & Wadsworth, 1991, p.4).

Criteria that is essential to the success of this methodology is that the individuals in the research must believe that there is a disparity between how things are and how they could be, know that they should be better and have the capacity to create a vision for this to be achieved in the future (Wadsworth, 1997; Wadsworth & Epstein, 1996a; Wadsworth & Epstein, 1996b).

In critiquing their own work, McGuiness and Wadsworth (1991) have indicated that they were not always able to engage participants in having a vision of how things could be in the future and that this depended greatly on the participants in the group having particular attributes that enabled them to be imaginative and think outside the square. Shifting away from the "way-things-are-always-done" is not an easy task and the researchers found this to be a barrier that, at times, impeded progress. They suggest

that to achieve success with this methodology, a strong critical reference group is essential. A critical reference group is a group of people who have the driving force for change and the ability to visualise the possibilities for those changes to manifest in the future (Flyvbjerg, 2001). The researchers suggest that if present staff members are unable to see past their present work practices, then inviting former staff members and consumers who have the benefit of hindsight and disengagement from the situation may enhance the creation of new possibilities (Wadsworth & Epstein, 1996a; Wadsworth & Epstein, 1996b, 1996c). A further barrier to this research was the time constraints and the researchers have suggested that a longitudinal study with more time to reflect and process information by the participants would be valuable.

Figure 2 represents the study design and process used by McGuiness and Wadsworth (1991) to graphically represent the methodology for their study. It can be seen that this research commenced with two separate groups (staff and patients) discussing their individual experiences within the psychiatric unit. The information was then transcribed and when validated by the owners of the data it was given to the opposite group to explore and discuss. The recommendations that came from this process were then typed up, validated, and then material was swapped between the groups again. This dialogic process continued until each group had heard the ”other’s” perspective (Foucault, 1997). The spiral in the graph does not have an end to it, but continues across time as both staff and consumers continue to question, create hypotheses and instigate change.

The idea of a panel of ex-consumers for evaluating hospital practice emerged from this research and has led to ex-consumers being employed as paid staff members at several major institutions, to give advice and feedback according to consumers’

perspectives. This has been revolutionary in the communication between staff and consumers and the work practices of health professionals. This is very pertinent to this current research, as consumer consultants (ex-consumers) are employed at the psychiatric unit in question and are given equal voices in the research to give the consumer perspective. This may not have been possible without the previous work of Epstein and Wadsworth (1994).

The culture of a psychiatric ward was one domain explored in a second study by McGuiness and Wadsworth (1991). Consumers raised issues of the nurse 'in the glass box' being always busy, sometimes not noticing the seemingly 'invisible' patient trying to get their attention. Domains that may have been taboo for other researchers were explored by patients and staff: power and powerlessness, consumer violence, staff violence, stigma, coercion, the medical model, labelling, the hierarchy and the culture of the ward as a whole. The information obtained was rich descriptions of experiences by both staff and patients, not left as mere stories of horror, but used as tools for change. This was facilitated by staff and patients hearing the others' perspective and exploring possibilities for change and growth (Broom & Klein, 1999).

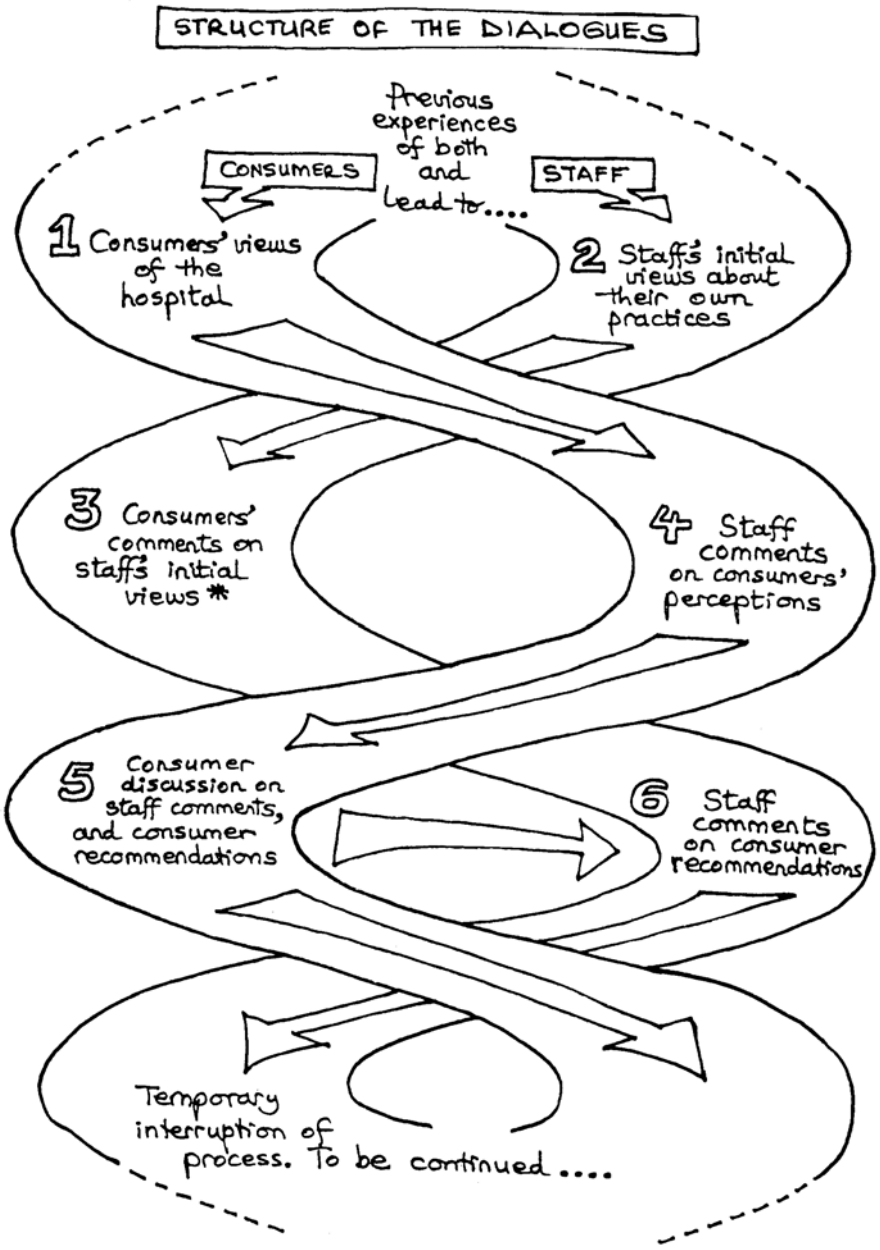
Wadsworth and Epstein (1998; 1996a; 1996b; 1996c) documented the important impact that this research has had on the culture of psychiatry. Consumer consultants are now employed at several hospitals and on committees at high levels within the psychiatric system. Consumer-staff forums for 'deeper dialogue' also became part of this ongoing study. One suggestion for future research which developed out of the study by Wadsworth and Epstein (1996c) was a recommendation that staff develop forums for themselves in regard to their own culture, with the aim of developing practices that strengthen consumer-focused services. It was noted that staff too have anxieties and

stressors associated with their own professional behaviours and culture. Figure 3. below shows the design and methodology depicting the interactions between staff and consumers in a psychiatric institution (McGuiness & Wadsworth, 1991, p.8).

Figure 3. Interactions between staff and consumers in a psychiatric institution

THE STUDY DESIGN AND PROCESS

The basic design of the project allowed for the stages illustrated.



* Time did not permit this material (at 3) to go to staff (at 6). Instead consumer discussion and recommendations (at 5) went to staff (at 6).

This research changed the culture of psychiatry by having the voice of the consumer heard and created a new participant on the multidisciplinary team (consumer consultants). The outcome is that language, behaviours, professional practices and ward routine are now matters that can appropriately be discussed by consumers in an effort to change ward culture to be consumer-focused (Flyvbjerg, 2001; Lukes, 1986; Prilleltensky, 2001a). Participatory action research has been shown by Wadsworth and McGuiness (Wadsworth & Epstein, 1996a) to respond to the needs of consumers of psychiatric services within an inpatient unit.

Table 1
Environment, Paradigms, Stakeholders and Methodologies Used

Research Environment	**Multiple Paradigms**	**Multiple Stakeholders**	**Multiple Qualitative Methodologies**
Naturalistic	Interpretive	Consumer Consultants	Lived experience of the researcher
	Critical	Mental Health professionals	Stories
	Reflective Autobiological	Researcher	Reflective Topical Autobiographical
		Management	Consumers reflections of interviews
		Consumers	Individual Interviews Group Meetings
			Mental Health Legislation
			Video Production
			Dissemination of Results

Within this current study, I mirrored some of the methodology used by McGuiness and Wadsworth (1991) to investigate the work-practices of psychiatric health professionals, from a staff and consumer consultant perspective, within a psychiatric unit. I will use qualitative reflective methods to delve into the subjective lived experience of my first year working the psychiatric unit. This personal reflection acts as a springboard to the Participatory Action Research methodology that constitutes this research.

Research Setting

This research was conducted in a psychiatric unit within a major general public hospital in the inner-city of Melbourne, Australia. Its catchment area consists of 180,000 people. The psychiatric unit is situated in a new purpose-built building that has 42 acute psychiatric beds, including ten high dependency beds. The unit is divided into two wards according to geographical boundaries. There are approximately two psychiatrists, six psychiatric registrars and 20 nurses on the roster for each ward. Five nurses work per shift and have a client ratio of approximately five patients to one nurse. The population in this area is multicultural and also consists of seven Koori beds allocated specifically for Aboriginal Australians.

Impetus for the Study

This study was driven by the experiences that I had working in the psychiatric unit and my goal to investigate it, understand it and to bring about a cultural change. The research was welcomed by the consumer consultants who were keen to participate in it, but not by medical or nursing staff who were more afraid of it. The underlying intention of this thesis was to make a difference to the quality of care for inpatients and

to improve the experiences of the staff members who work within it and finally to understand more of myself.

Management Reference Group

A management reference group was set up with members from the executive committee of the psychiatric unit. The group consisted of the two sector managers and the charge nurse. The function of the Management Reference Group was to monitor the progress of the psychiatric unit and to support the researcher. This group met infrequently and when the sector managers were made redundant, this group was disbanded. The manager of the psychiatric unit took over this function. Several meetings were held with the director of the unit and with the service development manager assigned by the hospital as the contact person for the research. During these meetings, the progress of the research was discussed and the manager assisted in bringing the research to its final conclusion by having group meetings with staff and consumers together. The director of the unit in consultation with the executive committee agreed that the group meetings could still go ahead. The service development manager assisted in the recruitment of volunteers for the project. In an effort to encourage people to participate in the project and to give feedback on the project so far, I presented a summary of the data to a ward meeting in the inpatient unit.

Recruiting Participants

All members of the multidisciplinary team who have contact with inpatient-consumers were invited to participate in this research. This included all nursing staff, social workers, occupational therapists, psychiatric registrars and consultant psychiatrists. This sample was not restricted to one discipline (ie. nursing staff) for two reasons. First, the culture of the ward is maintained by a multidisciplinary team, and as

such needs to be examined in its natural and whole status for the purpose of this research. Second, it was a given that one discipline alone would not hold the whole *story* of the unit. Prospective Staff participants were informed that they would form a group (to be called the Staff Inquiry Group (SIG). Concurrently, the consumer consultants who were already employed by the hospital would be approached and invited to participate in the research project and form a group called the Consumer Consultant Panel (CCP).

Multifaceted Approaches to Recruitment

Participants were first notified of this research project through posters placed in the nursing stations and the staff room. People, who were interested in exploring their own work practices and the culture of the psychiatric ward, were invited to join the staff groups that would be beginning in the next few weeks. Very little response was received from these posters, despite the bright and eye catching appearance of them. On one particular floor of the psychiatric unit, the poster was removed from the walls three times in one week. On the last time a staff member suggested I look in the recycling box for my poster, I found it folded neatly into squares in the rubbish bin. I unfolded it and placed it back on the wall.

Recruitment through Personal Invitation

Three weeks later each staff member of the unit (doctors, nurses, allied health) was sent a personal invitation in a sealed envelope that contained a plain language explanatory statement of the project, two consent forms (one from the university and one from the hospital) and a personal invitation to join the research project. The plain language statement assured anonymity and informed staff that they were permitted to attend group sessions in work time. The response to these invitations was extremely

poor with one staff member out of a possible 50 replying and acknowledging participation. This staff member was a social worker. No other staff member replied to the invitation.

Difficulties with Recruitment

A multifaceted approach to recruitment of participants included personal invitations, posters on the walls, personal discussions with staff members to allay fears and anxieties, encouragement from the management reference group and alternate meeting times and venues. Despite the intense effort to encourage participation, only two allied staff members (a social worker and an occupational therapist) came to any group meetings. Nurses committed to come but did not arrive and later stated the shift leader blocked them from coming. The nurses suggested shifting the meeting to the weekends when there were no other meetings. The occupational therapist and the social worker do not work on the weekend. Following discussion with these participants, a meeting time was shifted to the weekend. Again no nurses attended the meetings.

Meetings with Management Reference Group

Meetings were also held at this time with the committee formed by the psychiatric executive to oversee the project. The lack of attendance at the staff meetings was discussed at the next committee meeting. The committee members offered their support in encouraging people, that is, to let people know that they are welcome to leave the ward to attend and that management felt that this research project was a worthwhile one.

Disclosure by Nurses

Two of the nurses pulled me aside and said that it was not a '*good political move'* to be in my research project. The associate charge nurse that was on duty had indicated

to them that they should not attend the meeting. Further to this, one nurse said that she was quite concerned about how confidentiality could be maintained. She said that if they attended the meetings the others on that shift would know that they were leaving the ward to attend the meeting. Further to this, they were not prepared to attend in their own time or in a confidential location. The nurses said that they were too frightened of repercussions from other staff members to attend the group meetings. I was grateful for their feedback and spent some time reflecting on it. The question that they raised was, "How was I going to give them anonymity and ensure that they were not going to get any repercussions from participating in the research project?"

Staff Suggest Individual Interviews

Following a period of disillusionment and procrastination regarding how anonymity could be guaranteed, a staff member suggested to me that they would be prepared to give a confidential individual interview if anonymity was assured. It was proposed that individual interviews would allow participants the safety of one-to-one interactions that would remain confidential. In this way, nurses would feel safe to explore their own experiences relating to their roles within the ward. This proposed shift in paradigm was discussed with several other nurses who expressed their support and agreed to participate as long as their confidentiality was maintained. However, a specific request by the nurses was an assurance that there would be enough people interviewed so that they would be 'just one of the crowd' and therefore not easily identified. I agreed to this, saying that I would only use their data if I had ten or more interviews. I also agreed that each participant would have the choice of reading their transcript prior to it being sent to the consumer consultants and take out any data that

might identify them. The staff members were also given guarantees that at any time they could withdraw their transcripts from the research without any repercussions.

Recruitment by Individual Interview Appointments

Interviews were set during times of double staffing between shifts when there would not be a problem with one staff member leaving the ward. I made individual interview times with the nurses who wrote in the day-book that they required an hour off at that time. Although I felt that writing the name in the day book might put people at risk because they were known to be participating, the nurses felt that they would rather that and be interviewed in work time, than to come in from home in their own time. They stated that they were more concerned with someone knowing the content of who-said-what, rather than knowing that they participated. The nurses decided how they wanted this to happen and wrote their own names in the day-book. However, the nurses were again blocked from attending the interview, even though they considered the ward was not busy. The Management reference group decided to speak to the associate charge nurses and encourage them to release the nurses for interviews.

I decided at this time not to write interview times and dates in the diary, but to arrive at the ward at odd times, find out if the ward was busy and then ask if there was anyone who was free and who would like to be interviewed. This approach was highly successful and yielded 35 interviews. Other interviews with senior clinicians was by appointment. The feedback from the interviews was that staff enjoyed talking about how they felt about their work practices.

Interviews

Individual interviews were obtained from three male and three female psychiatric registrars, 28 nursing staff (including the male charge nurse), two charge nurses, two

male consultant psychiatrists and two female managers. The years of experience ranged from 3 months to 26 years. One-hour interviews were conducted on the morning shift, afternoon shift and the night shift to ensure that a cross-section of all shifts was covered. One nurse and one doctor chose to come to my private practice to be interviewed to assure anonymity. All interviews were audio-taped and transcribed. All participants signed two consent forms: one from Victoria University and the other from the hospital in question. Participants were informed that their transcripts would be sent to them and they could read them and ensure that there were no identifying statements that would interfere with the assured anonymity. Removal of the names of other staff members and of consumers was the only alteration made to the transcripts.

Staff who did not agree to be interviewed included several psychiatric registrars and a nursing staff. The feedback from the psychiatric registrars was that it was not safe to be involved in this research, whilst some of the nurses indicated that they would not participate in the research because they were frightened of the outcome of disclosing information about work practices in a research project, particularly because they knew I had a reputation for speaking out. It is highly likely that other people would not have been in the research due to their dislike of me. One person did complete an interview, but a week later, following an evening shift where I had been forced to question her poor work practice, requested that I take her transcript out of the research project. This was done without repercussion as promised.

Interview schedule

The interview questions used an open-ended format, presented in a conversational way. Its interaction style was designed specifically to encourage participants to explore their own experiences within the inpatient unit. The interviews began with broad

questions that were easy to answer and would help the person to feel at ease. They began with asking participants what lead them to psychiatry, how long they had worked in psychiatry, and if they had job satisfaction. Questions were focused around five central points: 1) culture of the ward; 2) the high dependency and seclusion areas of the unit; 3) good and bad work practices; 4) consumers' voice; 5) staff relations; 6) conclusion in the form of questions focused on completing the interview (ie if you had a magic wand what would you change in the unit).

Participants were informed that the transcripts would be typed up by an independent transcriber and then a copy given to them to peruse. Any information which they believed would identify them or information they felt inappropriate for consumers (ie names of inpatients) could be negotiated with the researcher to be removed prior to transcripts going to the consumer consultant panel for their perusal. No staff member requested that information be removed, apart from one staff member whose personal details regarding the names of institutions in which she had worked was deemed to risk anonymity and was therefore removed from the transcript.

Meetings with Consumer Consultants

Meetings were held regularly with the three consumer consultants (two male and one female), even when no nursing staff participated. These meetings gave the researcher and the consumer consultants time to reflect on their own experiences within the unit and to talk about the research and what to do next. Consumers were paid for their attendance at these meetings by the researcher. When staff were interviewed, as agreed by the participants, all the transcripts were then photocopied and given to the consumer consultants to read. Members of the CCP wrote comments on some of the transcripts, as well as discussed their findings in group meetings. These meetings were

also transcribed and also used as data. During this time, I worked in the Emergency Department as a psychiatric consultant nurse. After a conflict arose with a staff member in the work place, she withdrew her transcript from the research. I offered to give her the transcript and the tape, but she declined; asking me to ensure that her data was not included in the research.

Presentation of Summary Data

The summary data derived from the research to this point, that is, a summary from the transcriptions of staff interviews and the consumer consultant responses to the transcriptions, was presented to a staff meeting. Present at this meeting were the medical director for clinical services, the Director of the unit, the deputy charge nurse, allied health professionals and the nurses. The aim of this presentation was to give consumer feedback to staff and to endeavour to interest staff in forming a group between staff and consumers. The information presented to the staff were developed in conjunction with the consumer consultants.

Formation of a Staff/Consumer Group

Over the next few months, the service development manager emailed all staff members inviting them to participate in the research. Response from nursing staff continued to be low, but improved substantially from no-one in the initial sessions to two nurses in this proposed group. The two nurses were the female charge nurse and a male nurse in his graduate year. Two allied health professionals and a Doctor (psychiatric registrar) also volunteered for the group. This increase in the number of staff members involved in the project might have been because they were invited by the service development manager and could be indicative that the buy-in from hospital management was high, that is, that participants only joined because they wanted to

please the manager and give feedback to management. However, regardless of the motivation of staff to join, their participation with consumers appeared to be genuine and the outcomes were excellent. The impact that this had on the hospital management is difficult to assess.

A new consumer consultant joined the two male consumer consultants from the original group. This new member of the research project is an aboriginal woman who is an ex-consumer of this unit. She joined the research specifically to be in this project and is not a staff member of the hospital and has not worked as a consumer consultant before this time.

The group was scheduled to run on a Friday afternoon for a period of six weeks. A group meeting room within the unit was made available for the sessions. Staff members (this time including the consumer consultants) were allowed to come in work time and therefore did not have to be paid by the researcher. The Koori (Aboriginal) consumer consultant was not employed by anyone and her participation, as was that of the entire consumer consultants, was paid for out of my wages. It was agreed by the management of the unit that the group could run for six weeks in a row for an hour and a half per week.

During the first group meeting many Koori issues were discussed. Following the group meeting, the unit manager suggested that the nurse allocated to Koori issues may be very interested in being part of this. I approached her and she agreed to come to the next meeting. This increased the number of nursing staff to three, which made equal numbers of the consumer consultants and the nursing staff. The allied health professionals did not attend regularly and were present at only two group meetings. A doctor, who had agreed to participate, left the psychiatric unit during the week that the

research began. The service development officer was unable to recruit a doctor to join the groups. Management was represented through the nurse unit manager, who was present at the meeting.

The groups continued for the full six weeks and the group decided to continue the groups after the research was complete, inviting the researcher back to join the group at a later date. The full 90 minutes of the group meetings were transcribed and the participants were given a copy of those transcriptions the following week for their perusal and comments.

Funding of Consumer Consultants

The staff members were allowed to come to the interviews and to the group meetings in work time and were therefore being paid while in attendance. The previous unit manager told the consumer consultants that they were not allowed to attend in work time as they were too busy with other things. Each week, they came in their own time and were paid by me. I paid them from my personal wages at the same rate as the nursing staff would be receiving, to ensure that all stakeholders were receiving equal remuneration during the project.

Dissemination of Results

The dissemination of the results also became part of this research project. This is because the inpatient facility is in existence because of the new Mental Health Act, that was created from the community's stand for human rights for people with mental illness, therefore informing the community is an important aspect of this research. One such presentation was a joint presentation between the Koori Consumer consultant and me. Therefore, informing the community became an important part of the research. Further to this, informing other practitioners of these findings may make a difference to

practices in other inpatient units. It was also important for me to get feedback on the research to further my own understandings. I have also facilitated one of the other consumer consultants to present in the classroom for post-graduate nurses.

Development of Video

An innovative way of presenting the data was developed, in the form of a video. The video depicted the complexities of the inpatient unit. It turned the real life examples from the data into work practice vignettes. In line with this participatory Action Research paradigm, a participatory presentation was designed so that audiences participated in the results by aligning with characters in the video vignettes. This is discussed later in this thesis and the CD accompanying this thesis depicts this video in question.

Presentation of Video

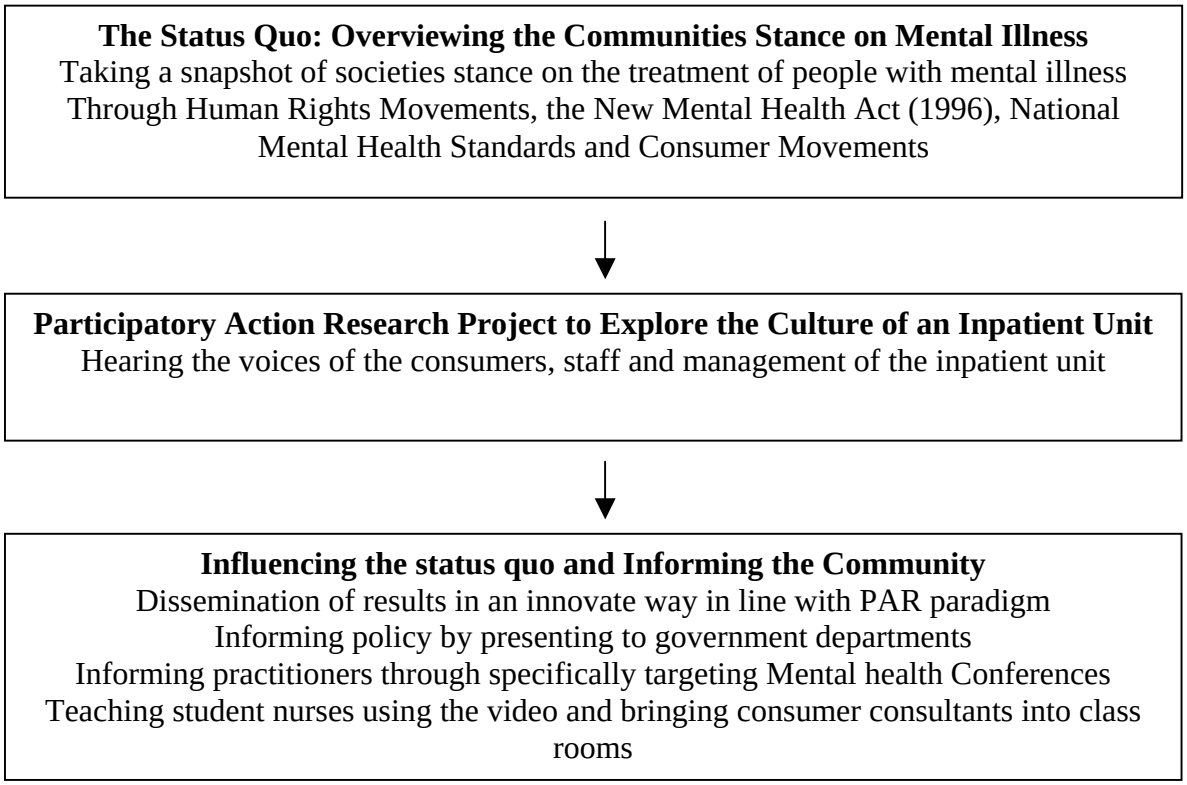
The video was used to present at a teaching conference as a way to teach students the complexities in regard to working in this difficult environment. Data were collected from the participants and have been collated and will be presented later in this research project. The video was also shown at the Mental Health Services International Conference in New Zealand. This presentation was attended by the head of the Victorian Consumer Organsiation VMIAC. She later recommended me to a representative from the Auditor Generals Department who was auditing psychiatric services and I presented summary outcome data to him.

Informing Policy

In keeping with the action research paradigm, this research continued to focus on making a difference and to bring about change at all levels from the unit to policy makers. In light of this, summary data were presented to a representative from the

Auditor Generals Department with charts summarising the findings in relation to the different dimensions that influence optimal work practices. This was in line with informing policy to help facilitate change.

Table 2: *Summary of the Research Project*



Methodology Summary

In summary, I have used reflective topical autobiography to explore my lived experiences within the psychiatric unit. In addition, this research project started out as a Participatory Action Research Project. Due to the difficulties engaging staff members, it was necessary to move to individual interviews. However, it did reach its ultimate goal for the methodology, and three years later became a collaborative multi-method and multi-voiced Participatory Action Research Project. The presentation of the results continued to reflect the complexities of this environment, and was developed consistently within a participatory framework. I have also tried to inform government

departments that have the potential to influence policy, through the dissemination of the results.

CHAPTER 4

FINDINGS ON POWER

Overview of Findings and Discussion

This section of the thesis has been organised with particular detail to the flow of the document and to facilitate a smooth integration of the many parts of the thesis. It is arranged into themes that have been data-driven. Presenting the thesis in this way decreases the repetitiveness that may otherwise have been prevalent. Furthermore, the layout of this section also reflects the chronological order in which the thesis developed over the four-year period of data collection and, as such, makes practical sense in the expression of the story of the thesis. This section has been broken into subheadings relating to the themes that emerged throughout the research. That is, values, interests and power. Sub-themes of horizontal violence, power plays, critical incidents, supervision, the system, fear and anxiety are intermingled throughout the three main themes.

Each section begins with an example from my 'lived experience' of working within the culture of the psychiatric unit in question. At this early point, when I was experiencing those examples, I was naive to the literature relating to my experiences. I researched the literature after my experiences, in the hope of finding knowledge to help me make sense of my world at that time. In light of this and honouring the true progression of the experience of the thesis within a framework of participatory action research, the literature review in regard to this section is placed next. A summary table

of challenges in relation to the each theme (power, values and interests) is then presented. The findings are presented and discussed in the same order that they are presented in the table. The data gathered from thirty eight interviews with staff members are included in this. The thesis then progresses to the consumer consultants' reflections on the staff's experiences. In consideration of this data, each section ends with a summary discussion relevant to the theme at hand. A more diagrammatic representation of the format follows in Table 3.

Table 3
Outline of Findings and Results Section

Chapter on Power
My Lived Experience
Literature Review in Regard to Power
Summary Table of Results
Supporting Data from the Staff Interviews Regarding Staffs lived Experiences
Conclusions in Relation to the Discussion of Power

Power Overview

This chapter begins with a discussion about my experience of the culture of the psychiatric unit. This is done so that the reader can capture a greater understanding of the context I found myself in. This is my reflection of the culture, and others will have another view of it. In my narrative about the culture, I cover some of the structure of the

unit, the relationships with other staff members and my relationships with some clients. I talk about how alienated I became to the core group within the culture and my reactions to it. I leave the discussion regarding this, to much later in the chapter. Secondly, I will give a short example from the data that relates to how power appears to affect work practices. Following this I discuss why I chose power as a theme. This leads on to a brief literature review regarding power. I then present a table of Challenges. By challenges, I mean obstacles or difficulties in the terrain that have the potential to inhibit optimal work practices. These challenges have been derived from the data generated from the thirty eight interviews with staff members and incorporate themes such as horizontal violence, hierarchical control and powerlessness. An explanation of each challenge or theme and examples from the staff transcriptions follow. Each theme will be addressed in the same manner and a summary discussion completes the chapter.

Power: My Experience

Originally when I started work in the unit I felt quite powerful. I was completing my honours degree majoring in psychology and social research methods at university, plus studying full time and working 5-7 days a week at the hospital. The charge nurse had asked me to work at the hospital and so I felt important and valued. However, because the culture was an amalgamation of two cultures (old psychiatric institutional staff and general hospital inpatient staff) there were big dividing chasms between the two subcultures. The charge nurse had spent many hours trying to break down the barriers of the two cultures prior to the new unit's opening; however the divisions remained quite strong. I belonged to neither group. There were also a couple of other staff members who had worked in another psychiatric institution. Although these people came from a large institution, the culture of that former institution was slightly different

to either of the cultures within the unit. These staff members were still finding their feet in regard to where they were going to fit into the new culture. They did not belong to any established cliques. For the most part, I was alone within a culture, but with a powerful ally in the charge nurse.

At the time of the commencement of my employment at this hospital, I considered myself to be an empowered person. In the decade prior to working in the unit, I had attended and then facilitated many personal growth programs. I worked in private practice as a naturopath/counsellor. I had worked through many childhood issues and felt in control of my life. I took responsibility for my actions and expected others to do the same. I considered myself as someone who cares about people and endeavoured to relate to people from the heart and from a space of equality. I didn't always succeed in these endeavours, but I believed my intentions were honourable.

On the first day of working in the unit, there was double the usual number of staff allocated. People were everywhere and anxieties were high. Any patients who were capable of weekend leave had been sent home. The ward was very much overstaffed to help people feel safe through a high staff-patient ratio. After the first couple of days and on my first full day in the ward I was allocated five consumers. I was responsible for the care and treatment of those people for the day. I calculated that I was paid to be there for eight hours; so if I spent one hour with each person, that would give them and me plenty of time to form a therapeutic relationship. I walked around the ward and located the clients; I introduced myself as the nurse allocated to their care for the day. I explained that it was my first day and that I had five people to care for and that I thought that if I spent an hour with everyone, we could really get to know each other by the end of the day. The clients were a bit shocked by this, an apparently unusual way of

going about nursing duties. Still, they were happy and thought it was a good idea. I found an empty office where we could have privacy away from the dayroom and began building a relationship with the consumers allocated to me. I told the nurse in charge that I was talking to each patient in the office and would be back in an hour; unless she needed me beforehand, then I would come straight out. “There is no need for that”, she said, “You are not their doctor”. I answered with, "I just want to get to know my patients". I was surprised because it made sense to me to divide my day by the number of clients and then spend that much time with each of them. I immediately felt torn about whether or not I should continue to see the patients allocated to me as planned or listen to the shift leader. I chose the former, to see the patients in the way I had previously decided to see them. However, while I was in the room, I had a sick feeling in my stomach, wondering what would happen next. I had one ear on the corridor, ready to respond in case I was needed, and the other listening to the patient. When I returned to the nurses' station between consumers, I felt alienated from the group. Everyone else was sitting in the nurses’ station chatting, laughing and socialising with each other. I walked in and wrote in the client’s file and then left to find the person I was going to speak to next.

Reflection: The choice I made immediately alienated me from the culture. This was the first time that I felt a conflict between my values, power and interests. I had been working as a naturopath in private practice and had developed a work ethic of delivering optimal service. I believed that to do this in psychiatry, I needed to speak to the consumers in a private area; alone and for a reasonable period of time. Yet there was also an internal part of me that wanted to socialise with the group and had a need to belong to the group in a meaningful way. As a nurse, I had been in positions of

alienation in the past and knew that it was not a good place to be. In this simple example of the beginning of my day at work; I had already experienced conflict between my values, power and interests. My power had been challenged ("no need to do that, you are not a doctor"), my interests challenged (will I do what she suggests or not and what will that mean in the future?) and my values have been challenged (I really want to talk to each patient for an hour). I continued to see my patients in this way for the first week in the psychiatric unit. Seeing different patients everyday, I quickly built up a rapport with most patients on the ward. However, whilst building relationships with patients, I was relinquishing relationships with my colleagues. When I came into the nurses' station and tried to join in conversations with the staff, I was often ignored, or conversations appeared to come to an abrupt end. This perceived rejection triggered an emotion in me that I had experienced many times before in my life and will be illuminated in the discussion.

After the first week of seeing patients in my one-on-one way, I was told to work in the locked area of the unit, the Extra Care Unit (ECU). I was frightened about this; I didn't feel as confident working with a group of disturbed people as I did working with individual patients. I was not alone in my fears; most staff members were very concerned about working in the Extra Care Unit (ECU) area. Although this is a purpose-built new hospital, the locked area is claustrophobic. The lounge area is no bigger than the average home lounge room, and houses five to six disturbed clients in an area built for three clients. In this early phase, people were concerned that clients might abscond into the city which was five minutes away by tram. To prevent patients from absconding, these patients were often placed in the ECU for short periods, swelling the number to seven or eight patients instead of three.

I remember feeling afraid; it had been a long time since I worked with really disturbed people and I hated being locked into such a small space. I was only permitted to leave if I could get another staff member to relieve me and this was only for urgent bathroom calls etc. The new duress system, an alarm button worn by each staff member to call for help if needed, was not functioning properly. I also felt quite isolated from other staff members. However, one of the glass walls of the locked area backed onto the nurses' station where a lot of staff spent their day. I remember thinking to myself, "I feel anxious being in here and I have a key; imagine how awful it must be for the clients who don't know when they will get out and have no key".

In the ECU area the staff member was alone with six disturbed clients and could not leave the area to communicate with any one client. Hence, it was very difficult to build deep rapport with patients, as all conversations were group ones. Patients were often angry that they were locked in, and therefore frustrated and afraid. They were also afraid of other disturbed clients, particularly if they were constantly intruding into their space. I understood that I would have to take my turn at working in the ECU area once per week or even twice if the need arose. But as time went on, I was being told to go in there every shift. In the last few months of my working in the unit, I worked in the ECU area every day up to five days a week.

Reflection: There was a part of me that felt I was sent into the locked area as a punishment for being different. This was in a similar way to some of the patients, who may have been placed in there due to their differences and bad behaviours, rather than mental illness. Another part of me thought that the other staff were just avoiding working in the ECU themselves and disregarded the effect on me.

I tackled my excessive rostering in ECU from many standpoints. At first, I said to the nurses that I had already been in the ECU several times this week and that it was not my turn. Their answer to that was that I was not a permanent member of staff and so the rule that applied to other staff members did not apply, replying with ‘casual staff members were employed to do those jobs’. Next, I informed the new charge nurse that this was happening; he said that people were only expected to work one shift per week regardless of employment status, and he would speak to the associate charge nurses. This made no difference and it became the standing joke at allocation to send me into ECU. Perhaps the day that I found this most difficult was my first shift back after my father had died. I asked not to go into ECU and told them I was still feeling vulnerable after the loss of my father. However, I was still allocated those patients. On two previous occasions, two nurses offered to work in the ECU prior to allocation. They did this in an effort to prevent me from being allocated in there. However, their offers were refused and I was again allocated into ECU. My protests that, ”It was not my turn” went on deaf ears. I was a casual staff member and as such, felt helpless and powerless in changing my position of being sent into ECU everyday. In the end, I know I gave up the notion of not being sent into ECU and decided if this “was my lot”, then I would become the best ECU nurse there was. There were occasional shifts when I worked with at least one other like-minded person, and these shifts were enjoyable. For most of the time, I convinced myself that I was there for the patients and did not need to be liked by the staff, or need to belong to a clique. I did however, feel the isolation of being outside the group.

Although I tried to rationalise to myself that belonging to the group was not important, perhaps I underestimated the impact that this would have in the work place.

Generally, staff members were not allowed to leave the locked area without finding a nurse who could relieve them. To go to the toilet or have a drink or even write nursing notes meant that you had to find someone willing to relieve you. I always found it difficult to get someone to relieve me. Some staff would always be too busy to relieve me, even if I had asked them while they were laughing and joking or talking on the phone to friends while in the nurses' station. Others had, what I came to call, an unreasonable time lapse before they would come in; while others said they would be back in a moment, but never returned.

Reflection: To be in the locked area on my own without relief was very frightening. I felt more vulnerable by not belonging to the group. However, I was only able to recognise this in reflection, a long time after I left the unit when I started to read the transcripts of other staff members. What I learned was that to belong to the group in a volatile environment is imperative to survival. However, I was interpreting the situation in almost an opposite way. I believed that belonging to the group would put me in more danger, because the patients would see me as 'one of them' and want to retaliate against me for abusive behaviours they had received at the hands of the core group. Generally, I felt safer being more aligned to the patients than to the staff. I felt that I could trust the patients not to hurt me, more than I could trust the staff. This is because I felt hurt by the staff on a daily basis, whereas I shared compassionate times with the patients. I was reacting in a compassionate way to clients and in a *victim consciousness* way (thinking like a victim) with staff members. This was a reflection of how each group was treating me and how I in return treated and reacted to them. Although I tried to fight reacting like a victim to the culture, I was unable to succeed during this vulnerable stage.

ECU Experiences

My experiences in the ECU were profound. I was shocked that one patient had been in the locked area for three months in old psychiatric institution before the new unit opened and continued this in the locked area of the new inpatient unit. He remained locked in the ECU area for approximately a year. He was secluded for many hours everyday and would bang and bang on the walls to get out. He was chronically psychotic and staff appeared to be afraid of his strength. I felt overwhelmed at his incarceration. He was the same age as I was, and I am sure that this triggered something within me. That someone, born into the world the same year as I, could be in this position. I was horrified about the injustices of the world. I thought to myself, “There but for the grace of God, go I”. Under slightly different circumstances any one of us could have been in the same position as he was, or perhaps our husbands, or brothers or sons. I could not tolerate the treatment and injustices afforded to him. Because this patient was at the extreme end of the continuum of mental illness and his behaviours presented the most challenge, his presence highlighted the extremes in staff members, that is it highlighted the levels of compassion or cruelty, the cliques within the unit, and the adherence or non adherence to the Mental Health Act. His situation illuminated the individuals’ struggle in regard to their values, power and interests as well as that of the organisation.

In a strange way, this patient had enormous power within the unit. Prior to the new unit opening, the staff from the old psychiatric unit would talk about their dangerous security patients and how the new unit was not going to be a safe environment for staff to look after them. This triggered fear in the new inpatient psychiatric unit staff members, who had chosen to work with people who were less

disturbed. There was a sense of fear being built up in the discussions, particularly about this patient. Staff members were saying things like ‘the new unit will never hold him’. People who had worked with him in the past considered themselves more experienced nurses than those who had not, and were letting the old in patient psychiatric unit staff know that they were superior in their experience with very disturbed people. To be locked in the Extra Care Unit or the locked area with him for eight hours a day was very difficult. It was my belief that staff members put him in seclusion to get a break from him. Their threshold for putting him in seclusion appeared to be very low. He had the power of unpredictability and of not being present to the conscious world in the same way as we were. This made him high risk to behaving in dangerous ways (i.e. smashing the windows with his hands).

To my knowledge, the aforementioned patient never hurt a staff member for the nine months that I knew him. And yet, his mother reported seeing a nurse put his feet to her son's buttocks and kick him into a seclusion room. He was locked up day after day, sometimes with 5-6 hours of the day in a seclusion room. He was also spoken to in tones and ways that professionals would never use towards their colleagues, family or friends, and should never use with patients. He was, in a lot of ways, reduced to animalistic behaviours. He was locked up like an animal and behaved like one at times. He was a very powerful person; one that was too powerful to ignore. I felt that some people saw and treated him as their enemy. His power was matched with immense power and control by the staff members who reacted in whatever ways were necessary to quash his power (i.e. locked in a seclusion room, day after day) and keep him in control. He would be in a seclusion room often for hours on end, taken out for an hour

and then put back in for hours again. He could not be medicated as he had a medical problem that prevented sedation with phenothiazine medications.

Working with this patient was indeed a challenge and very difficult. However, I managed to build a relationship (of sorts) with him, despite my own fears and inadequacies. He spoke in a word salad, that is a jumble of words that almost never made sense. He called me ‘mum’; considering that I was the same age as he, this seemed unfair, but it helped me feel safe somehow. He really loved his mother and had never hurt her. I never locked him in a seclusion room and in my own way, I related to him as though he could understand everything I said. The Extra Care Unit had no games, no activities, only a TV attached high up on the wall. There was nothing for people to do. It is difficult to envisage spending nine months of your life in a confined space with nothing to do. He spent a lot of this time masturbating and would often stand on a chair in front of the nurses’ station window and masturbate. I would usually go over to him and ask him to come down off the chair and he would do so. He was being treated like a caged animal and in my opinion, he had returned to his primitive drives. I was not shocked or upset by this. I knew that it was not appropriate and that I needed to distract him from masturbating in public.

Sharp implements were not allowed in Extra Care Unit, no pens or paint brushes, games etc., so I took a ball in with me, and the patient and I started to play ball, that is throwing the ball to each other. Amazingly, he could not communicate a sentence that made any sense and yet he could throw a ball and catch it with pinpoint accuracy. I was ridiculed for playing ball with him. In reflection, I wonder if playing ball with him humanised him for the other staff members and made it more difficult for them to work with him in demeaning ways.

In summary, I understand that I have spoken at length about this patient's story; however, it was necessary to show the complexities within the environment. People were afraid of this patient, were highly offended by his sexual behaviours, were very controlling of him and felt hopeless about his recovery, and that due to reactions from drugs, it was decided that it was too dangerous to sedate him. He epitomises the most difficult of clientele and because of this, brought out the best and the worst in staff. It is for this reason that he became a powerful figure in the unit. For me, being rostered to work in this locked area was indeed very difficult, particularly when there were four or five other people in the locked area who were also irritated by this particular patient. Working in the Extra Care Unit was a very difficult experience. Being sent in there more than one day a week was a manipulation and was unjust. It seemed to me that staff members who belonged to particular cliques were much less likely to work in the ECU than people who were in other cliques. In this way, the most difficult of patients were used as a weapon of horizontal violence, that is peer to peer aggression (this term 'horizontal violence' will be explored further later in this chapter).

Reflection: Hindsight is such a valuable tool, it's a pity it's not available earlier. I can see now that right from the very beginning I had my own values and they differed from the group. I was very sensitive to the rejections from the staff. This sensitivity comes from my personal background of being in similar situations in the past. I was prepared to stand for my values in regard to work-practices. However, when it came to myself (e.g.working in ECU) I succumbed to the oppressive forces of the group and gave up the fight to have equal rights, accepting the status quo and working in ECU on a daily basis. It seems that I would not compromise my values for clients but could not sustain this level of resistance for myself. There was a part of me that believed that the

ECU was being used as a punishment for my stand for optimal work practices. There was a part of me that just gave up, not wanting any more emotional hardship and embarrassment. Surprisingly for me there was another part of me that used my plight to attract attention from like-minded individuals. Whilst another part of me turned my positive energy into becoming the worlds best ECU nurse, and yet another part overcoming my own fears of being in a locked area. In relation to power, I felt powerful in that I strived for optimal practice no matter what constraints I faced, and yet also powerless when it came to being made to work in a highly stressful area on a daily basis. I also felt worthless as a member of the team, because I was alienated from the team most of the time, in fact I felt in opposition to the team and powerless in that I was one person against a group of people.

In summary, I have given multiple examples of my experiences within the psychiatric unit. These experiences had been viewed from my standpoint only, and others may have a different view of the same events. I became a victim in the culture and thought and behaved like a victim and in this way, would have perpetuated the culture. In the ensuing chapters this aspect will be explored. Further to this, the following chapters tease out the experiences of others and this helps me put my experiences alongside the perspectives' of others. Several themes have emerged from the data as pertinent to this thesis. Power is the first of these themes.

Why I chose Power as a Theme

In an effort to understand the complexities in regard to my experiences within the culture, I searched the literature. If there was one thing that stood out in my own experience, it was my own disbelief, in regard to how I shifted in my thinking from an empowered state, to a state of thinking like a victim within a relatively short space of

time and how stuck I felt to change it. It seemed that no matter what modus operandi I tried, I still felt powerless within this environment. The core group within the culture appeared to be very powerful and influential within the culture, while at the same time were quite low in regard to their status within the hierarchy. Exploring the literature on power seemed to be the most appropriate place to start to investigate these anomalies. A brief literature of power follows.

Power Literature Review

> *"I am optimistic that there is a super-abundance of good people out there who, once aware of their powerfulness, will want to make the quest that many have already begun. Today's ideal becomes tomorrow's reality if we choose to make it so…* (Melvin Gurtov, 1979, pp. 65-66, cited in (Walkerdine, 1997).

Real change, according to Foucault, requires changing ourselves, our bodies, our souls and our ways of knowing - it requires work of the self upon the self'(Prilleltensky, 2001a, p.123).

Introduction

Power is universal and everyone uses it. Foucault informs us that power is pervasive and is in the very fabric of our relationships (Flyvbjerg, 2001). He asserts that power is definitely not static, but is mobile. Regardless of its form, several authors suggest that rather than deny the existence of power, that we accept its reality and its omnipresence into the infrastructure of our human existence, and try to understand it (Flyvbjerg, 2001), (1990). 'Power is pivotal in attaining wellness, promoting liberation and in resisting oppression' (Flyvbjerg, 1998; 2001, p.1).

Aristotles and Plato set the groundwork for modern theorists in regard to theories of power (Foucault, 1997). Aristotles proposed that there “were three intellectual virtues, Episteme (predictive scientific knowledge), Techne (technical knowledge) and Phronesis (prudence or practical wisdom)” all containing power relations (Foucault, 1997, p.3). Of particular interest to this research is Aristotle’s concept of Phronesis as ‘a true state, reasoned, and capable of action with regard to things that are good or bad for man' (sic) (Craig & Craig, 1979, p.2; Dahl, 1968)) This is the state that I believe an experienced clinician would be aspiring to achieve. That is the ability to see a situation for what it is (the ability to reason) and then to put an action into place that will benefit the client or person in question. This practical wisdom would come from years of practice and from deep reflection on one’s actions and one’s relationship to the moment.

Since Aristotle and Plato, science has traversed many platforms in its study of human activity, such as introspection (Wundt,1879), positivism, functionalism (James, 1890), structuralism (Tichener, 1892), cognitivism (Chomsky, 1957), behaviourism (Watson, 1920) and neopositivism, all of which hold different theories in relation to understanding human action (1990; Craig & Craig, 1979; Peterson, 1990). In more modern times, Habermas and Foucault are two distinct theorists who have stood out amongst the rest in their exploration of power and taken up the theoretical challenge from Aristotles and Plato. Habermas advanced his theory of communicative action that uses rationality to reach consensus amongst populations (Dahl, 1968; Habermas, 1987) He suggests that people come together in a unified way, voluntarily giving up their own subjectivity for that of the group (Habermas, 1996). This notion will be highlighted

during this chapter, in that some staff members discuss the values they were prepared to give up to belong to the group.

I found myself in an opposite place to this, outside of the group subjectivity and isolated in my thinking. My experience is more in line with the understanding proposed by the work of Foucault, who in opposition to Habermas' theory, proposed that a desire to challenge every abuse of power and not give up one's subjectivity is most important to society and to democracy (Bertrand, 1938). Foucault focused on the dynamics of power, believing that understanding how power works (power relations) is fundamental to the action of power. This thesis will explore the dynamics of power within the psychiatric unit in the hope that through the acquiring the knowledge of how power works within the unit, the key to developing new work practices may be illuminated. Not all people agreed with Foucault, for example, Lukes (1986) suggested that the locus of power and the outcomes of power were more important. Foucault argued against this saying that the most important part of power is the relations of power and that power is definitely something that is exercised, rather than something that is concrete and that is held onto, to be gained or lost. Foucault's question in relation to power is, how is power exercised? (Lukes, 1986). There are multiple ways that power is exercised within the psychiatric unit, there are two distinct groups that need to be explored in relation to this. Firstly, how power is exercised in regard to staff members and secondly how it is exercised in relation to inpatients.

There are many models of power. The directive power model (represented by the carrot and the stick), an early model in regard to power, incorporated bribery, fear and coercion as strategies used by people to get the power that they wanted (Lukes, 1986). A person using directive power, shaped and used others behaviours to advance

his/her own personal interests (Landy, 1989; Lukes, 1986). This ‘power-over-you’ theory, focused on physical power, rewards and punishments and influencing of opinions (Lukes, 1986). Although it could easily be said that we have left this more concrete and static model of power behind and moved into deeper understandings of power relations, I can see that the behaviours of staff within the psychiatric unit are laden with fear and coercion strategies to get what they want. Although the Craigs’ theory in relation to power is relevant in regard to the behaviour of the staff towards each other and towards the inpatients, it fails to fully address the internal experiences of power. The work of Hannah Arendt in the late 70’s added another dimension to our understanding of power when she said that power is not limited to the actions of one human being over another but also of people working in unison together (Craig & Craig, 1979).

What is needed then to have a fuller understanding of power is a more pluralistic understanding of it, such as in the work of Talcott Parsons. Parsons thought more in systemic views, seeing power as a commodity of the system and society, highly influenced by a consensus that is value-laden (Craig & Craig, 1979). Power having multiple dimensions makes sense for the complexities found within the psychiatric unit. The theories postulated by French and Raven (1959), where they identified five categories of power (referent power, expert power, legitimate power, reward power and coercive power) explain some of the behaviours used to influence power within the unit (Craig & Craig, 1979).

Lukes (1991) was unsatisfied with these definitions of power and shifted the focus to include interests. He defines interests as 'all those things in which one has a stake' (Craig & Craig, 1979, p.5), that is, those things that inhibit or facilitate things he

is interested in. However, power in this sense is not limited to the individual but it is also institutionalised within groups and communities, where the interests of the group may also influence the individual (Flyvbjerg, 2001). Belonging to the group within the psychiatric unit and upholding the interests in the group is highly important in a psychiatric unit, much more important than I was able to realise when I was working within it. When people work in a volatile area they rely on each other for solidarity and support and a 'loose cannon' as I was once affectionately called, could be considered dangerous to the interests of the group.

Perhaps the type of power one should be trying to attain is one that was postulated by Craig and Craig (1979), synergic power that is, power to use *with* people not over them. Craig and Craig researched leaders in history (Ghandi, Hitler, Martin Luther King) and looked for the differences and similarities in relation to their use of power. They postulated that the main difference was the way these leaders valued their human counterparts, either seeing them as useful or obstructive, or valuing and cherishing them (Bloom & Klein, 1999a). An example of this would be the power of Dr. Martin Luther King, as a self appointed community organiser, who used non-violent methods to bring together the power energy of a collective, to enhance the wellbeing of black people throughout America. He focused only on his peaceful vision for the future of humankind, yet he was an extremely powerful man who highly valued his fellow human beings (Bloom & Klein, 1999a). In contrast, Hitler devalued human life and saw people as being either useful or obstructive to attaining his end goal of dominance over the world (Craig & Craig, 1979). In this model of power, one treats adversaries differently to their allies (Bradshaw, 1999). My experience within the psychiatric unit was more of the later, where people were measured as either useful or obstructive,

where those belonging to the clique were treated in one way and those outside of the group were treated in the opposite way. The optimum way for change to occur within the psychiatric unit, would be to mirror the work of Dr. Martin Luther King who gathered the momentum of the group in positive and non violent ways, using this collective power to make a difference to the entrenched status quo.

Definitions of Power

Power is difficult to define. Following on from physics and electronics where power is defined as ‘a force which is moving and making something happen’, Broom and Klein (1999, p. 2) define power as energy in use. They propose that power is an energy that we direct into intellectual, emotional and physical efforts. Likewise, Foucault (1997) proposed that power is present in all human relationships, be they amorous, institutional or economic. Foucault defined power as follows: ‘Power must be understood as a multiplicity of force relations' immanent in the sphere in which they operate and that constitute their own organisation’ (Bradshaw, 1999, p.201).

Power as Finite or Infinite Energy

The definition of power is also effected by how people interpret power. Bloom and Klein (1999b) suggested that power is an energy that is interpreted by people, as either finite or infinite (Bradshaw, 1999). When power is finite, one has to take it from someone else in order to build ones own supply, a win/lose scenario. Therefore, strategies to obtain that power are more likely to be underhanded and cunning (Bradshaw, 1999). Whereas when power is infinite there is a sense of abundance and the relationships around this perception of power are more a win/win type of relationship. How people perceive and use power is of high relevance to this study. People can exercise power with disdain or love and as such, power itself is not good or bad, but

rather a function of the humans who possess it (Bradshaw, 1999). This notion is well supported in the literature, most recently by Broom and Klein. who point out that power itself does not have the ability to choose to be good or bad, rather it is labeled and/or directed in this way by human choice.

Bradshaw (1999) states that power determines its own paradoxes. This research focuses on many of the paradoxes raised by Bradshaw. But rather than paradoxes where one envisages an either-or scenario, that is one thing or the other. I suggest that they are more like opposites on a continuum of the same theme in its polarised position. For example: oppression and emancipation amongst consumers of mental health services; covert and overt power relations among staff members; power and powerlessness amongst all stakeholders. Bradshaw (1999) postulates that power is usually viewed by polarities, that is, one end of a continuum is usually held in high regard while the other is held in low regard; for example powerlessness versus powerful. In her paper on power, Bradshaw (1999) explores two paradoxes of power in relation to organisational power theories. She attempts to answer the debate that is raised from the literature in regard to whether individual abilities and characteristics maintain power, or whether the structure of the organisation limits their opportunity, therefore constraining and shaping their actions and giving the power edge to the organisation (Prilleltensky, 2001a; Prilleltensky, 2001b). This is an enquiry pertinent to the psychiatric unit in question. The Mental Health Act demands by law that certain rights are upheld and the organisation sets the policies and procedures of the organisation in line with these standards. However, the practices that occur within the unit are behaviours of individuals. Bradshaw’s question of whether or not individuals hold the power will be an important one for this thesis to respond.

A further dimension that must be considered by this research fits into the second paradox explored by Bradshaw (1999), that is, of the difference between 'surface and observable power and deep and invisible power' (Prilleltensky, 2001a, p.5). That is, the difference between the positivist school of thought which stated that power was conscious and observable, and the interpretive and culturalistic approaches which thought that they were more abstruse, unconscious forms of power embedded in culture, language and other subtleties not clearly observable. Perhaps it is these nuances that I failed to fully understand when I was working in the culture. Not belonging to any particular clique, I would have failed to understand the importance of the unconscious mechanics of group thinking in psychiatry. Although I fought against it, I may have rejected it outright without trying to understand its relevance and the culture behind it.

Bradshaw (1999) extended the literature in regard to power by developing new concepts in regard to paradoxes in power. She postulated four dimensions to power paradoxes: 'surface-personal, surface-structural, deep-personal and deep-structural' (p. 6). Surface personal power relates to individual agency, initiative and is visible and clearly conscious (Prilleltensky, 2001a). Likewise, surface-structural concerns a group within the structure that holds the base of power in preference to the individuals within it. This is regardless of the individuals' characteristics or agency. Scarce resources and power games between the groups raise uncertainties that then become a power source in themselves, with groups being able to out manoeuvre others to increase their power (Flyvbjerg, 2001; Prilleltensky, 2001a). Like surface-individual, surface-structural is deemed to be visible and identifiable power. Perhaps the most relevant to this research is deep-structural where "cultural artefacts, language, rituals and values construct meaning for organisational members and how they simultaneously work to suppress

conflict, prevent issues from being identified and control personal levels. New feminist methods are required to unleash the repressed internalisations of power. Whereas within the deep-structural level, changes need to occur within language, oppression, inequality, abuse, neglect and collusion" (Broom & Klein, 1999; Foucault, 1997; Lukes, 1986; Prilleltensky, 2001a, p.20). Bradshaw's call for feminist measures is answered in this research by the personal and reflective nature of the data, in particular by my vulnerability in disclosing my thoughts and experiences within the unit. It is by my reflections and the reflections of my colleagues that the deeper cultural artefacts may be uncovered.

Power is Multifarious

Highly relevant to this research is the work of a more recent theorist (Walkerdine, 1997) who has added to the body of knowledge in relation to a fully inclusive theory of power. In his definition and explanation of power, he differentiates three dimensions: 'power to strive for wellness, power to oppress, and power to resist oppression and pursue liberation'. He also purports that power that 'ensues from the dynamics of agency and culture', can be further delineated into 'power to affect self, others and the collective' (Walkerdine, 1997, p.7). Prilleltensky suggests that we focus our attentions on how power affects these three groups (self, others and the collective) in relation to wellness, oppression and resistance to oppression. He informs us that power is the ability and opportunity to fulfil or obstruct personal, relational or collective needs ((Prilleltensky, 2001a, p.8). To simplify this definition, an individual may use their power to fulfil their personal needs, such as a need to belong or to feel emotionally supported. Collective wellness may be represented by the needs of society in having a safe environment and law and order. Relational wellness may be respect for cultural differences or equality for

men and women. In this thesis the individual power may be held by consumers, staff or management at any given time. Whereas collective wellness may be held by the staff as a group, the consumers or the unit and organisation itself as a collective.

Power can also be measured by resistance, for without resistance there would be no power and vice versa (King, 1967). My personal disclosures throughout the research will show that I resisted oppression throughout my year of working within the unit. It was this resistance of oppression that caused so much of the trauma and abuse that I experienced. It is in the understanding of why I resisted to such an extent, that will further illuminate the power plays within the unit.

Power Changes across Context and Culture

Power also changes across contexts, culture and across time (Giddens, 1997) (Flyvbjerg, 2001). It changes across gender ((Flyvbjerg, 2001), beauty and age (Arendt, 1970) and colour of skin. It has been said by many that to be white, Anglo-Saxon and male gives more power than to be black and female, the most notable being Martin Luther King (Arendt, 1970). Similarly, a Muslim woman wearing a full Shibab in a Christian environment may have very little power. However, being Muslim and wearing a Shibab at a Mosque would be much more powerful than being a Christian. Contexts affect power enormously (Arendt, 1970) also noted the importance of context and added what he termed ‘double hermeneutics’ that incorporates two aspects: firstly, the self-interpretations of the people researched within their context and secondly, the self-interpretations of the researchers and their effect on and view of the context. He later termed this 'institutional reflexivity of modernity' where he talked about how an institution reacted back on itself to bring about change. More importantly, the context creates a discourse that then produces a power of its own (Arendt, 1970). Foucault noted

that it is reflexive thought that enables us to think and act differently to the group. ‘Reflexive thought is the most important intellectual virtue for Foucault, just as for Aristotles it is phronesis. ‘Foucouldian thought and Aristolian phronesis have striking similarities’ (Prilleltensky, 2001a, p.124) in their reliance on reflexive thought. It is within my own reflexive thoughts that I will try to understand the reasons for acting against the group and whether in hindsight it was the wisest choice. Hopefully, the final conclusions of this thesis will propose other ways to uphold my own power whilst still upholding the power of the collective.

Power and Violence

'Potestas in populo, without a people or a group there is no power' (Arendt, 1970, p.64). Violence appears where power is in jeopardy. Hannah Arendt (1969), claimed that 'the extreme form of power is all against one and the extreme form of violence one against all' (Prilleltensky, 2001a, p.63). She informs us that the latter is only possible by the lack of the majority to respond and resist the outburst of the one person. She cites an example of one student abusing a university lecturer while other students not involved sat and watched without becoming overtly involved. They were, however, covertly involved because their lack of resistance, either in standing up for the lone professor or stopping the student. This is, in itself, participation by non-resistance to oppression (Petroulias, 1994). This code of silence can be seen in modern organisations where minority groups or single people are victimised without support from others within the establishment (Flyvbjerg, 2001). This relates well to (Flyvbjerg, 2001) previously stated notions of power to resist oppression and pursue liberation. This is particularly prevalent in hierarchical institutions such as the hospital in this research project. There are multiple examples of psychiatric staff members being silent while

others contravene the Mental Health Act, thus the code of silence in regard to practices involving inpatients. There are also many examples of staff not speaking up when another staff member is being humiliated or treated poorly within the unit. This participation by non-resistance appears to help perpetuate the culture of the psychiatric unit and the powerplays within the unit rely on this code of silence.

Power can be Internalised

Prilleltensky (2001) postulates that individuals internalise a set of standards and rules that serve to shape individuals' perceptions of their power and interests. The norms of society are internalised and act as an internal policeman ensuring that conformity takes place. Therefore, power can be both conscious and unconscious in its internal origins. Authors suggest that throughout childhood and adolescence we develop internal parts to cope with different situations (Fanon, 1963; Friere, 1985). It is my contention that these individual parts within people have different amounts of power, interests and values. I believe that these parts are triggered within the environment and have the potential to change as subtleties within that environment change throughout the day. For example, I could be sitting with a patient having a conversation and a staff member would walk up to me and ask me to do something for them. In an instant, I might change from one part of myself to another and along with it, my power base changing, particularly if I am at the mercy of the existing hierarchical culture of the unit.

The previously stated definition of power by Prilleltensky (2001) appears to be the most relevant for use within this current project. Within the Mental Health Unit, power will be assessed in relation to the individuals who work within it (self/personal power), the groups of people who live it such as nurses, doctors and patients (power for others)

and societies role in the structure of mental health care (collective power). They will be viewed in regard to their ability and opportunity to fulfil or obstruct personal, relational or collective needs. Agency will refer to ability, while opportunity will refer to the structure (Duffy, 1995; McCall, 1996).

Power of Consumers

Being consumers of mental health services in the 1950-70's labelled people as patients and as such, these people were afforded a paucity of power (Roberts, 1997; Roberts, 1983; Serghis, 1998; Waitere, 1998). On the hospital hierarchy, patients are stationed towards the bottom. Across time, this has altered and consumers have more power now than ever before, albeit less power than that of a staff member. It should be said that consumer consultants have raised the power stakes for the consumers of mental health services. This has come about since the research of Wadsworth and Epstein (1996a; Wadsworth & Epstein, 1996b, 1996c) and the introduction of consumer consultants, that is consumers who are paid as staff members to bring consumer feedback and consumer participation to the function of the organisation. Even though there has been this enormous shift in gaining power across time for consumers, they still remain far from equal in the hospital arena. Whereas consumers have gained power through consumer consultants, they still remain powerless in regard to the work practices afforded to them. Although there are public advocates who are available for consumers to speak to when they feel their human rights have been broken and complaints managers in hospitals who investigate complaints by patients in regard to their treatment, consumers still continue to be powerless in their day to day interactions with staff members. These staff members hold the key to the seclusion rooms and the doors to the ECU and conformity to their ideology is often necessary for the consumer

to be released. For patients to have equal power, seclusion rooms and ECU areas would need to be areas where patients requested to go for time out and where there were no locks. It seems we are a long way from attaining this in Australia at this time.

Summary of Power

The following Table 4 summarises the questions raised by multiple authors in regard to power and how their theories will be used to raise questions in this thesis.

Table 4
Power Theories

Theorist	**Main Interest in relation to power**	**Main Question in Relation to Power**	The Question the Theory raises within this research
Aristotle	Phronesis (practical wisdom) Reflexive analysis	Is practical wisdom an important factor in power	What impact will practical wisdom have into power plays within the psychiatric unit? Do practitioners practice reflective analysis?
Habermas	Macro politics of procedures and policies	Who develops the structures?	Who develops the policies and procedures in regard to the unit
Foucault	Micro politics of power relations	How is power exercised?	How is power exercised within the unit
Lukes	Interested in where power is located and what it produces	Where is the locus of power? What are the outcomes of its use? He also asks who controls whom, who can secure resources, who benefits from the outcomes of power and who holds responsibility and accountability.	Who has the power What does the power produce? Who has the responsibility and accountability in the psychiatric unit
Bradshaw	Opposites of Power	What are the paradoxes of power?	What are the opposites of power within the psychiatric unit
Klein	Power as energy finite versus infinite	Is power shared equally or held by a few	Is power shared equally in the unit?
Prilleltensky	Balancing between power interests and values amongst stakeholders	How is power balanced between values, interests and power between the different stakeholders.	Who are the stakeholders and how do they balance their power, interests and values within the psychiatric unit

In summary, as Foucault has said, institutions constitute privileged observation points (Clements, 1997; Cox, 1991; Freshwater, 2000). This research maximises this

privileged opportunity of being able to investigate a psychiatric unit in a major public hospital. I am interested in exploring power from many different angles. I am particularly interested in whether phronesis (practical wisdom) influences the power plays between staff members; that is, whether good sound judgement is as influential as membership to cliques and hierarchical status might be in staff attitudes towards work practices. Multiple questions are raised in regard to phronesis. Will individuals with 25 years experience in mental health demonstrate phronesis (practical wisdom) in their work practices and will the staff members hold this wisdom in high regard? Is it possible that the organisation itself, as a combination of the thoughts and actions of it's' staff members, develop an organisational phronesis, and if so, how would this impact on power relations within the unit?

I am also interested in the power of the Mental Health Act as well as the policy and procedures of the organisation written to uphold it, that are for all intents and purposes, formulated to set the parameters of the culture of the organisation and the work-practices within it.

Foucault said that "real change requires changing ourselves, our bodies, our souls and our ways of knowing - it requires work of the self upon the self' (Blanton, Lybeck, & Spring, 1998, p.123). To this end, I will also explore the dichotomies of power and powerlessness from my own experiences within the unit, by seeking to understand these experiences through reflexive analysis, drawing on phronesis to explore and understand my personal influence in the power relations of the unit.

In line with Wadsworth and Epstein (1996a) this thesis is particularly interested in the power of consumers within the unit. That is, which elements of power the

consumers have participation in and to what extent their power is able to be activated in regard to influences on work-practices.

This thesis investigates power from the multiple perspectives summarised in the previous table and seeks to ask the questions raised in regard to macro politics and micro politics, where power is located and who is responsible and accountable in the psychiatric unit. Further to this the dichotomies of power will be explored as well as whether power is finite or infinite within the culture. This thesis will address power from the aforementioned standpoint of the balance between power, interests and values and the influence on the individual, relations or the collective. The power of the consumer within this unit will be investigated. Finally, through reflection of my own experiences within the unit, I will explore my own power base and my place within the culture during my time working at the institution.

CHAPTER 5

FINDINGS ON POWER PLAYS AND HORIZONAL VIOLENCE

The next section of this thesis begins with a summary table of the results (Table of Challenges) in relation to power, these are generated from the thirty eight with staff and consumer consultants' responses to it. The results section is organised by the themes that emerged from the data and will mirror the format of the table.

Table of challenges in relation to powerplays within the Unit

The above table divides the findings in regard to power into three core dimensions that I have called challenges. These challenges, which can be seen in the centre column, are hierarchical control, horizontal violence and critical incidents. They are power-plays/forces within the psychiatric unit that impact on work practices. From this centre column the table branches out to the left indicating the behaviours involved in perpetuating undesirable practice and the sources within the culture that influence it. In contrast to this, to the right of this central column, are the behaviours in regard to optimal practice and their sources of influence. These challenges have been derived from my analysis of the data and have set the structure for presentation and discussion of power within this section of the thesis.

Hierarchical Control

Following in line with the challenge table, desirable and undesirable practices were influenced by hierarchical control as a function of power. As has been discussed in the literature review, institutions have functioned under a strict hierarchical control for a long time. Clear lines of responsibility can leave the staff (nurses, and to lesser degree, psychiatric registrars) on the bottom of the hierarchy, with much less power than those at the top (psychiatrists and managers).

Table 5
Table of Challenges in Relation to Power-Plays within the Unit

Sources of Influence →	**Undesirable Practice**	**Challenge**	**Optimal Practice** ←	**Sources of Influence**
Power as finite	**Powerlessness**	**Power plays**	**Power shared: powerful**	**Power as infinite**
Hierarchical oppression: fertile ground for horizontal violence between nurses endeavouring to regain power	People with the most consumer contact have less power, powerlessness leads to apathy, frustration directed towards consumers	**Hierarchical Control** within the unit ↔	Multidisciplinary team to share power, consensus needed for decision making	Interactions to be value-laden, reflective practice, consumers to participate in all areas of the culture, multidisciplinary equality for workers and consumers
Staff develop victim consciousness through victimisation, positive energy directed away from consumers and/or negative energy directed towards them, cliques form according to power bases	Sabotage, infighting, scape-goating, bickering, disrespect, withholding information, unsubstantiated allegations regarding staff, no cohesion, poor work practices, no job satisfaction	**Horizontal Violence** among staff ↔	Respect for diversity, respect for colleagues Cohesive/collaborative relationships, job satisfaction	A culture that fosters equality and encourages team work, Power shared by all players, empowered staff support each other and consumers
Culture based on fear and anxiety, understaffing, lack of trust, decisions them - against –us	Decisions forced in critical times, choices limited, react aggressively to regain control, interests of staff upheld	**Critical Incidents** leading to reactive practice ↔	Decisions made in beneficence, negotiated amongst all stakeholders. Preventative strategies to prevent critical incidents	Reflection after any forced event to minimise impact on relationships and trust, debriefing consumers and staff together
Repressed and controlled Consumers weapons of horizontal violence, no control	Consumer powerless, not heard, no participation in outcome, Outcomes staff based, no rights	**Consumer** power/ powerlessness ↔	Fully active in and involved in decisions Voice is heard and acted upon, powerful, rights upheld	Consumer-initiated and driven outcomes Consumer responsive service

This thesis has found that nurses have by far the most interaction time with the consumers, yet have the least power in regard to decisions about their treatment or care. The main power in regard to treatment is held by the psychiatrists who might see the person for fifteen minutes a week (such as in a ward round) and/or less than one hour a week if they interview the client in the presence of the registrar. This issue was raised by the participants as having a strong and often negative influence on their work practices. I was surprised to find this particularly evident for psychiatric registrars, who stated that they felt quite powerless at times to negotiate with the consumers in the way they wanted to because they did not have the power to discharge involuntary people without the permission of the treating psychiatrist. The psychiatrist is legally the only person that can admit or discharge an involuntary patient. The following example illustrates this issue for the doctors.

> *Psychiatric Registrar (Doctor): "I mean like the psychiatrist, yes, and by law they are given the authority in particularly with involuntary patients. An involuntary patient cannot be discharged unless a psychiatrist discharges them. No matter how much I might desire to discharge them I cannot. So…on the negative, I can at times, disagree with what the psychiatrist is doing and saying and yet have to carry out their orders, and particularly when those orders infringe on the basic human rights of people. For example, injecting them when they (consumers) don't believe that's the right thing. I can find that exceedingly difficult"*

As can be seen by the previous example, the psychiatric registrar wants to be able to respond to the patient from his or her own values (basic human rights) but does not

feel that they have the power to act in the way they choose to. This interpretation is supported with the following example, which also comes from a psychiatric registrar:

> *Psychiatric registrar: "There was one that comes to mind where I came out feeling defeated rather than anything else. There was a patient who was around my own age, who I found from the moment that I saw her, someone very difficult to establish any sort of alliance with. And she was in a very fragile state and brought in against her will, as an involuntary patient. And my consultant was forcing her to have depot medication and I happen to be in the nurses, well in the staff work-station, when a big hullabaloo was going on between her and the nursing staff. Them wanting to inject her and she kicking up at this, and she happen to spot me in the room and I tried to just leave it between her and the nurses to sort out. But she was actually physically restrained, so I ended up talking to her. And at that point in time I didn't feel like I wanted to be responsible for forcing an injection on her. But she also wanted to be discharged and I couldn't do that. Because she was an involuntary and I'm not a psychiatrist. When I told her that I couldn't, she got very angry and said well you know I want to talk to my doctor, the doctor who can discharge me, and despite me not forcing medication, she ended up, she came out of it still incredibly angry. Now I don't know if I would have done anything differently, maybe I would have not been in the nurse's station at the time. But I came out feeling well… that was all a waste of time, I've copped a whole lot of anger and I don't think that I've done her any good and she still hasn't had the injection which she may well need".*

This was a common phenomenon for psychiatric registrars. It seems that they often felt torn between keeping the nurses happy, doing what the psychiatrist orders/wants, and balancing between what the client wants and what they believe the best treatment for the client is. The psychiatric registrars can have their power equally disrupted by the psychiatrists above them or the nurses below them on the hierarchy. Although they are higher up on the hierarchy, they need to 'pull rank' on the nurses to assert their power. In the above case example, the nurses were already in the process of restraining the consumer and the practice would have been to give the consumer an injection and to place her in seclusion. However, the nurses' power to follow through with this was thwarted by the psychiatric registrar. This led to the nurses not being able to carry through with their original plan. It left them with a job half done and a patient in seclusion without any medication, which was far from the usual practice. The nurses became powerless in this situation in relation to the psychiatric registrar. As can be seen from the above example, difficulties arise if the psychiatric registrar is forced to make a decision in the midst of a critical incident. This will be explored further when discussing the critical incident section.

Although I asked staff to identify a work practice that was optimal, there were no examples of optimal practice that involved consensus from the multidisciplinary team. Examples of good practice sometimes reflected the opposite of this, that is standing against the multidisciplinary team leader (psychiatrist) to achieve the optimal outcome.

Let me explain this by giving another example: the following participant discussed a decision that was made for a patient admitted for the first time to mental health services. She was a person who travelled between Australia and New Zealand,

and at the end of the first admission. The treating psychiatrist put her on a Community Treatment Order which meant that she was not allowed to leave Victoria and was forced by law to attend appointments at the local clinic and take all the medication that was prescribed. The nurse in question thought that placing this legal restriction on the client was going to interfere totally with the lifestyle of the patient. She talks about how she disagreed with the decision of the treating psychiatrist and her colleagues.

> *"I disagreed with the psychiatrist and it went all the way, pretty much, up to the Mental Health Review Board. But I was very strong about it, I knew this patient very well, and I'd spent a hell of a lot of time with her, and I knew the direction they were going in terms of her treatment and her follow up weren't right. And I didn't think it would be beneficial for her in the long run, it would really restrict her career and all sort of stuff and .. yeah, I did, I went in to the ward round with my opinion and the decision was made to go ahead (with the CTO), and I encouraged her to put an urgent notice in to the Mental Health Review Board. She wrote letters, got a solicitor, and we got a great result in the end, and she was really appreciative that I stood by her, because if I didn't, you know it was like … as you said, we're an advocate, and if I'd agreed with what the doctor was saying I wouldn't have gone to that extreme. I would have perhaps still encouraged them to protest a bit, but I'd really be honest and say look, I really think that's what's best for you. And that's what I'm here for, to advocate what's best for them, the patient, not the doctor".*
>
> *"Umm … I didn't get any sort of flak as such, but I guess they were shocked that I went that far… I'll never forget to this day when she came down after*

the Mental Health Review Board hearing and said, "I'm off! I'm off the CTO, and I'm going to New Zealand, and I'm gonna do what I do best, and I hope I never see you again, and thanks a lot for standing by me!" And I've never heard from her since, which is great, you know, so I'm glad I went that step further. If I'd just stood back and said, oh well…you know, it's the whole purpose of being here, you know, you've got to be proactive, you can't just do everything that you're told. You can go against the system as such and do what's right to do".

It is unusual for a nurse to go against a psychiatrist's decision, even in a ward round. But to assist a patient to go to the Mental Health Review Board after your pleas for a patient have been denied would be very rare. It could be extrapolated from this transcript that this decision was a value-laden one. That it is the energy or power needed to take this step came from 'doing what was right'. The words used by the nurse indicate a sense of congruence and purpose, a knowing that what was happening to this patient was wrong and that she could try to help her change it. Her sense of achievement and the patient's success and subsequent feedback, reinforcing that 'putting herself out there' was worth it. Reinforcing her belief that 'you can't just do everything that you're told. You can go against the system as such and do what's right to do'. However, these examples of optimal practice are not frequent and take a great deal of courage from the individual nurse involved. I propose that if power was equally spread among members of the multidisciplinary team and the final decision regarding a consumer was one of consensus, then these feats of bravery by nurses to uphold rights would not be necessary. I believe that for optimal practice to be realised on a daily basis, all members of the team should not only be heard, but should have their input regarding a client

taken seriously. In the case of this psychiatric unit the psychiatrists had been in charge of the patients for 50 years. They did not relinquish this power when multidisciplinary teams were formed and this I believe needs to be unravelled if real change is to occur. I propose that if nurses and psychiatric registrars feel powerless to effect change then this will lead to apathy and frustration. This then leaves the psychiatrist in a position of not being challenged in regard to his decisions and a hierarchically controlled system prevails. If the nurse and the psychiatrist differ in their opinions as to the treatment of a patient, the nurse has the choice of whether to be a strong advocate for his or her beliefs in regard to the patient or go along with the psychiatrist's decision. This is also true if the nurses opinions differ from that of a psychiatric registrar, although challenging decisions at this level, is often less difficult than to challenge a psychiatrist.

For optimal practices to flourish, decisions would need to be more of a consensus rather than authoritarian. Also, interactions would need to be value-laden, with strong reflective practices. Consumers would need to participate in all aspects of the culture and there would need to be equality for all workers and consumers. On the other hand, hierarchical oppression creates fertile ground for horizontal violence between nurses as they endeavour to regain power. Such environments set the stage for undesirable practices to flourish.

Horizontal Violence

Psychiatric registrars discussed hierarchical controls preventing them from working to their best capacity. In contrast to this, it has become evident from the data gathered in this thesis that among nurses, horizontal pressures are more likely to impact on their work practices. This has been termed 'horizontal violence' (Duffy, 1995) or workplace bullying. At one end of the horizontal violence continuum, one might find

staff behaviours such as being spoken to in abrupt terms by a colleague, whilst at the other end, physical and emotional abuse. The ensuing paragraphs relay my experiences of horizontal violence within the psychiatric unit. This is followed by a literature review in regard to Horizontal violence.

Paranoia or Horizontal Violence

There is no doubt that there were difficulties for me in my interactions with some staff members in the unit. I found myself being in uncomfortable situations and wondering how and why I managed to get there. The things I noticed at first were minor and were situations where one could interpret several meanings to explain what was going on; for example, walking into a room and the conversation stopping. This could be interpreted as the conversation coming to a natural ending; or that people did not want me to be part of the conversation. Alternatively, it could be interpreted in a more paranoid way, that is, wondering if the conversation was about me. Regardless, the air felt thick and the proverbial 'cut the air with a knife' feeling was becoming more prevalent in my day-to-day working environment.

Reflection: I became a victim to the games people were playing. I held the belief that whatever lessons a person needs to learn; he or she will attract events into their lives to accomplish the learning of these lessons. This led me to ask, why me? What was it about me that attracted these behaviours, what did I do or not do, that perpetuated them, and what do I have to learn from them? I tried many behaviours of my own, to change the difficulties I experienced in the nurses' station. I tried initiating conversations and often got one syllable replies, if I received any at all. I tried ignoring other people and just focused on my task at hand. However, this only made me feel more isolated and alone and set me more and more apart from the other staff members.

Techniques of Horizontal Violence

1. Name deleted from the availability book

Generally, I worked five days a week and on occasions when they were really short staffed, I worked seven days a week. Towards the end of the twelve-month period of my employment, there were periods when I was not called for a shift for days on end. Whenever I did get a shift and went into the ward, my name was erased from the availability book for work. On some occasions, permanent staff members had replaced my name with theirs, so that they could work overtime.

2. Locked in a Seclusion Room

On one occasion, I was making a bed with a male nurse in a seclusion room. I was saying to him how awful it must be to be locked in a seclusion room, with no windows, no blankets and plain walls with only a small observation window for nurses to check on the patient. I said that it would be hard enough to cope with if you were sane, but to be insane and to be locked in a seclusion room must be horrific. I turned around to find that he had left the room. He had locked the door and thus locked me into the seclusion room. I felt an overwhelming sensation of panic and anger. I screamed and swore at him and told him to open the door. When he opened the door a few minutes later, I ran out into the open air to catch my breath. I was so angry; I did not speak to anyone for the rest of the night. The next day, I spoke to him in an office and said that if he ever did anything to me again or repeated the previous days unacceptable behaviour to the client in ECU, then I would make an official report in writing of this abuse. He said he was sorry and that he did not know that I was claustrophobic. I said “I wasn’t until you locked me into the seclusion room”. I reported the incident to the charge nurse, but the matter was not taken any further. However, this was an epiphany for me; I

had made a stand with this staff member. He did not openly behave in any harmful ways towards me after that time.

3. Patients as Weapons of Horizontal Violence

Generally the experiences I have described so far involved behaviours that I found difficult to cope with, but only indirectly affected the patients. However, as these behaviours intensified, staff members began to incorporate the patients for whom I was responsible on any particular shift. For example, the aforementioned patient, with whom I worked in ECU on almost a daily basis, would often pull his penis out of his pants and masturbate in public. I only had to ask him to “please put it away” and he would respond. However, on many occasions, if a nurse from the nurses’ station saw him, they would march him into the ECU area and lock him in seclusion, with me vehemently opposing their actions. I would be in charge of that area for the day and make all the decisions regarding those patients. This 'taking over' was often done by a group of nurses who would claim that they 'knew better' and that he should be locked up before he escalates his behaviour. Another time a nurse came into the ECU, pushed the patient into a chair and then left again. It seemed to be an ‘out of the blue’ behaviour. Later when I asked why, she said that 'he had his hand in his pants and was about to expose himself'. This manhandling of patients, for whom I was responsible, seemed to me as another way for the staff to get a reaction from me. Whereas I could try to ignore snide remarks or comments made about me, this was not possible in regard to patients. I was astonished by the behaviours that I observed in regard to patients. I often discussed these poor work practices with the charge nurse and with management, but it seemed to fall on deaf ears. Examples of unacceptable behaviours would be raised at meetings and deemed to be totally inappropriate, but would still persist after the meeting.

4. Medication of Patients

I began to wonder if it was just me. When I was on duty, I was the only one who seemed disturbed by these unacceptable behaviours. This led to self-doubt. Was I so focused on these behaviours that I was manifesting them or creating an atmosphere that attracted them to happen? Some of these incidents could be perceived to be by accident or misfortune, while others could be perceived as deliberate. It was I who was interpreting these incidents as they happened, and self-doubt would creep in. For example, the nurse in charge of the ECU was responsible for determining when the patients needed extra medication. Usually, I would assess my patients for a while at the beginning of the shift. I would get a sense of their extra medication needs to keep their symptoms of psychosis under control, but still awake enough to function and not be asleep all day. However, on one particular day, the medication nurse sedated all the patients in the ECU during the time period that allocation was taking place. As soon as he had finished medicating the patients, I was allocated into that area. He had medicated one patient to such a degree that I was forced to do half-hourly neurological observations on the patient for the whole shift because she was so dangerously sedated. When she did get out of bed, her blood pressure dropped to the point where she fell over a footstool and broke a blood vessel in her eye. Consequently, her eye swelled to five times its normal size. She had to be taken to the emergency department for treatment in regard to this. The medication nurse was only responsible for giving afternoon medication whenever the primary nurse (nurse allocated the responsibility of the patient for the day) asked him or her to do so. This situation could be interpreted in several ways: the patient had been very demanding for weeks on end and perhaps this nurse was so burnt out with the patient's behaviour that he over-sedated her to prevent another

demanding day. Or he could have been playing a power-orientated game by taking control of the ECU area's medication before I had time to assess the patients' needs. Could it be that the over-sedating the patients was one way to undermine the level of medication that I might have decided on and therefore undermining my responsibilities? This became quite a burden for me as, against the status quo, I struggled to advocate for human rights for the patients in my care, while at the same time feeling that they may be losing human rights because of my involvement. Yet, as I write this now, almost three years on, it seems like paranoid thinking. What was it about me that I processed all these possibilities when incidents occurred around me? In hindsight, it seems that I was battle-scarred, and from this, I created an internal-radar for detecting any potential harm to myself or the patients within my environment.

5. Breach of Confidentiality

There were some incidents that were clearly inappropriate. For example, one particular incident occurred when the aforementioned mother observed a male nurse with his foot on her son's buttocks, kicking him into a seclusion room. She told me that she had flashbacks and nightmares regarding this and many other issues she had regarding her son being locked in an ECU for nine months. A confidential meeting was called with a psychiatrist, a social worker, the patients' mother and me, so that she could have a chance to raise her concerns regarding her son. The meeting was purposefully a closed meeting so that she could feel safe to talk about any staff member. The meeting finished at noon and I went straight to lunch. I was surprised to hear the other staff members discussing what the patients' mother had said. "She dumped on five nurses in five minutes; that must be a record" I heard a nurse say. I asked them how they knew what happened in the meeting as I was the only nurse present. "Oh, we were

listening to every word through the two-way screen". I reported this total invasion of privacy and confidentiality to the associate charge nurse and asked her to take it to the unit manager. But the staff members belonged to the same clique as the associate charge nurse and were not reprimanded for this behaviour. This type of behaviour was clearly not acceptable and against human rights and I had no trouble being clear about this. Yet, other staff members were not perturbed by their behaviours.

6. Accusation of Being Suicidally Depressed

Perhaps the final blow for me was an incident that occurred after I was promoted out of the unit and into the emergency department as the psychiatric triage/consultant nurse to the emergency department. During the first six months of my new job, I had been held at knifepoint by a consumer, had restrained a patient who pulled a gun on a policewoman, and had a man try to stab himself in front of me. It had been a horrendous six-week period. However, I believed that under the circumstances, I was coping well. Following being held at knife-point, I was often made the brunt of bad jokes. For example a nurse in the ward said “I obviously didn't pay the patient enough or she would have finished the job properly".

Many months later, I received a call at home from a manager in human resources asking me if I was all right. I said that I was under enormous pressure at this time, but was coping with this. She pressured me a little more, saying that she had been told that my work practices were down and that I was not functioning as well as usual. I was horrified and reiterated to her that I had not had any complaints from the staff I worked with; in fact the doctors in the emergency department had been singing my praises. She said that she had received complaints about me from more than one source and that she was concerned for my mental health. I began to cry. She asked me again if I

had been depressed and if I was safe. I was humiliated and shocked. I told her that it was my birthday and that I had guests over to celebrate it. I reiterated that I was definitely not mentally ill.

The human resources staff member made me an appointment with herself and the manager from psychiatric services on the following Monday, in four days' time. I spent the next four days, wondering who-had-said–what-to-whom and was reticent about relating to people at work. I worried that my colleagues were thinking my work practices were not up to par. I asked the director of the emergency department where I worked if there were any problems with my work practices. He said 'definitely not' and indicated that he thought my work practices were exemplary. The next four days were very difficult to cope with. I had to work over that time and I had a horrific shift with a certified patient from the ward going to the roof of the hospital to jump off. She was hanging off the ledge by the time I climbed to the roof. I assisted a doctor to talk her down from the roof and eventually we were all brought down from the roof by the fire brigade in a cherry picker. Shortly after, I received a phone call from a middle-level manager from psychiatry telling me that there was absolutely no time when I was allowed to go to the roof and that it was against Occupational Health and Safety guidelines. I was feeling very vulnerable at this time and expected support rather than criticism. The next day when I was not on duty, the doctor in the psychiatric ward let the same patient out of ECU against the nurse's wishes. She went back to the roof and jumped. I felt angry that we had worked so hard to save her the night before, and simple safety procedures had been ignored for the patient to be at high risk again. This added to my sense of being bombarded at this time.

I did not sleep during the nights, wondering what the managers were going to say to me during the meeting. I felt an overwhelming anxiety. Eventually, I had the meeting with managers where they explained to me that I had not done anything wrong. They had checked with the director of the emergency department, the doctors and the nurses, and found that my work practices were exemplary. This had led them to go back to the people who had made the complaints about me. They informed me that a member of the Crisis Assessment and Treatment team (a team of mental health professionals who assesses people for admission to psychiatric facilities) had informed human resources that the team believed that I was suicidally depressed and that I was at risk of killing myself. I was dumb-founded, and so were they. At least they had the decency to tell me the truth: a fellow staff member had perpetrated the worst type of horizontal violence (workplace bullying) that a psychiatric nurse can experience; accusations of being mentally ill and indeed actively suicidal. The team and its manager were investigated by the hospital for many weeks. I was instructed not to talk to them and they were instructed not to talk to me until the investigation was over. This made my task of relating with these people very difficult and caused further alienations.

Several weeks later, I applied for another position in the emergency department. The same manager, who was investigated on behalf of his team member reporting that I was suicidal, was on the interview panel. I did not get the position. I was horrified. I found out from the director of the emergency department (where the position was) that someone in the group had said that I did not get on well with other staff members (ie the crisis team). He said that he was shocked, as he had always found that I got on with everyone in the emergency department, and was at a loss to understand how others

could say these things about me. He apologised to me and I felt relieved knowing that someone whom I held in high esteem did not believe these negative claims about me.

Reflection: In my three years in the emergency department, I had not hesitated in telling people if I thought that consumers' rights were not being upheld in the appropriate manner. If CAT team members had been eating tea at a restaurant and refused to see a suicidal person, I would document their refusal. I had been a "whistle-blower" and I had carried the costs throughout my time at the hospital. I put this down to another one of those multiple costs. However, my self-esteem was taking a battering and I was much more reactive and sensitive to criticism in my environment. A manager said to me that I spoke differently to psychiatric staff than to emergency staff. I admitted to her and myself that this was so. I felt like a battered woman in relation to the psychiatric staff and had become a victim to their culture. I was held in high esteem by the emergency department. The values of the staff in the emergency department were very high and were closely aligned to mine. I had my own power in the emergency department and was left alone to do my work in the way I chose to. The emergency department and the psychiatric department had such different cultures that I was able to feel totally different within each culture: I was a victim in one culture and empowered in another. When the psychiatric staff came to work in the emergency department and brought their culture with them, they also brought their behaviours of horizontal violence and I started to feel like a victim in the emergency department. This will be explored more fully, following the literature review on Horizontal Violence.

This polarity in my experience is well worth deep reflection. What was it about the two cultures that enabled me to be held in disregard in one culture (the psychiatric unit), whilst being held in high esteem by another (the emergency department) and both

within the same hospital. Was this about me, the other staff or the diverse culture of the unit. This will be explored further throughout the thesis.

In my search for answers to my predicament, I came across the construct of *horizontal violence* and *oppressed group behaviour*. These constructs assisted in illuminating my role as a victim within the culture.

Literature Review: Horizontal violence

The term ‘Horizontal Violence’ was originally devised by Fanon (1963) during his exploration of oppressed group behaviour in colonised Africans. He reported that rather than directing anger at the oppressor, the oppressed group expressed their anger horizontally towards themselves, equating in peer-to-peer aggression.

Oppressed Group Behaviour

Although both Fanon and Friere originally studied oppressed group behaviour in third world countries, their extensive knowledge can and has been applied to groups of people throughout the world (Spring & Stern, 1998). From entire populations of people to oppressed groups such as ethnic minorities and even smaller groups effected by hierarchical structures in the workplace such as nurses (Duffy, 1995; Fanon, 1963; Friere, 1985; Roberts, 1983). Nurses are dominated by doctors who have more power and status than they have and this oppression in nursing leads to nurses feeling less accountable and eventually to the loss of their own values (Roberts, 1983).

Horizontal violence can be defined as 'harmful behaviour, via attitudes, actions, words and other behaviours that is directed towards us by another colleague. Horizontal violence indicates a lack of mutual respect and value for the worth of the individual and denies another’s fundamental human rights” (Waitere, 1998, p.1). Horizontal violence is of epidemic proportions in nursing and has an immense impact on the individual and the

nursing profession, with some authors suggesting that 'nurses eat their young' by accepting the status quo with nurses saying statements such as 'this is just the way things are around here' (Spring & Stern, 1998, p.2). As Giles (1998) points out, a common scenario of Horizontal violence can be found in a barrage of unsubstantiated allegations of poor conduct, that then become rumors with a subsequent demoralising effect on the victim. The complaint itself was often a generalised and broad statement about the victim's attitude or manner that cannot be substantiated.

As previously stated, Horizontal violence has its roots in oppression. (Duffy, 1995; Fanon, 1963; Roberts, 1983; Waitere, 1998). If the ground is fertile enough oppression flourishes. Roberts (1983) proposed that there were three conditions or mechanisms necessary for oppression to flourish. Firstly, oppressors must have control over the education of the oppressed, limiting their teaching to what the oppressor wants them to know. Secondly, oppressors reward behaviour that is considered pertinent to the cause of the oppressor. Roberts (1983, p.30) raised the example of the members of the oppressed group upholding the values of the oppressor and then being rewarded for doing so by being given a position of importance. Thirdly, buy-off where the oppressor recognises that the oppressed group is preparing for a change or revolt and appeases them by giving them a token gesture of appeasement (Blanton, Lybeck, & Spring, 1998; Duffy, 1995; Giles, 1998; Spring & Stern, 1998). The oppressed group tend to adopt the attributes of the dominant group. For example, Duffy (1995, p.8) stated clearly that

> *'In essence, nurses internalise the norms and attitudes of the dominant group, believing that this will help them gain some power and control. Ironically, this functions as a mechanism of control. In trying to be more*

like the dominant group, the subordinate group often forfeit their own characteristics and adopt those of the group they wish to emulate'.

The following table is a summary of conditions or aspects of the culture that needs to be present to perpetuate Horizontal violence (Blanton, Lybeck, & Spring, 1998; Duffy, 1995; Giles, 1998; Spring & Stern, 1998).

Table 6
Fertile Ground Needed for Horizontal Violence to Flourish

Oppressor maintains control over education	**Oppressors** reward appropriate behaviour	**At the first** recognition of an uprising the oppressed are given token gestures of appeasement	**Unpopular people** being ganged up on by other staff
Denial, minimisation and rationalization of the effects on the victim	**Inadequately trained** supervisors and weak management	**Lack of policies** regarding horizontal violence	**Silence of other nurses** not being victimised, thereby condoning the behaviour of the bully

Horizontal Violence Behaviours

The behaviours associated with Horizontal violence can be blatantly obvious or concealed, described as "covert and overt non-physical hostility such as criticism, sabotage, undermining, infighting, scapegoating and bickering" (Duffy, 1995, p.5). The list of behaviours authors have attributed to horizontal violence amongst peers is extensive (Freshwater, 2000; Leiper, 2005; O'Connor, 1998). The table below represents an extensive list of behaviours of Horizontal Violence proposed by several

authors (Emmerson, 2003; Prilleltensky, 2001a). The second part of the table is a summary table of the recommendations for the prevention of Horizontal Violence within the literature. The final part of this table is the results of Horizontal Violence (Emmerson, 2003).

Table 7
Horizontal Violence Behaviours, Recommendations and Results

Horizontal violence behaviours

Name calling	Threatening	Intimidation	Belittling, including in front of patients
Gossiping	Talking behind the back	Minimising others concerns	Throwing objects
Sarcastic remarks	Ignoring	Pushing, shoving Physicals threats or intimidation	Behaviours that seek to control or dominate another
Slurs based on race, religion, gender or sexual orientation	Inappropriate or unwelcome physical contact	Disregard for the safety, physical or mental health of nurse employees	Isolation Alienation
Unsubstantiated allegations of misconduct or poor performance	Inappropriate comments about personal appearance	Inappropriate comments about work performance	Verbal abuse
Rumors about work performance that causes further demoralisation	Infighting	Bickering	Scapegoating
Limiting the right to free speech and to have and state an opinion	Sexual Harrassment	Elitist attitudes based on education, specialisation or clinical area of practice	Nursing manager practices such as chronic understaffing; belittling the concerns of nurses; and disregard for the safety, physical or mental health of nurse employees
Withholding of information Persistent nit picking and criticism of work	Being extensively monitored by senior management	Regular humiliation with insults and sarcasm Being frozen out	Constant trivialisation of views and options Ganging up

Recommendations For Prevention of Horizontal Violence

Public education campaigns	Anti-bullying code of practice based on human rights and equal opportunity	Immediate action through legislation
A review of grievance procedures in awards	The creation of a model workplace anti-bullying policy	Commission sexual harassment guidelines

Results of Horizontal Violence

Forced Resignations	Ill Health	Exclusion from productive duties	Low morale
Reduction in self esteem and self worth	Decrease in the energy available for positive actions		

Horizontal violence has been equated in the literature to workplace bullying (Emmerson, 2003). O'Connor raised two important components of workplace bullying, that of holding back information from the oppressed and being extensively monitored by senior management. She states that nurses who experience workplace bullying are not supported by their colleagues, suggesting that the other nurses are in busy trying to survive themselves and tend not get involved in things that do not directly affect them. O'Connor (1998, p.22) proposes that the bullied staff member 'looses confidence, assumes a victim role and then is unable to stand up to what is happening to them'. Further to this O'Connor stated that unpopular people were ganged up on. Of high importance to this research is O'Connor's statement that 'others condone bullying by their silence and lack of support for the victim of bullying' (Emmerson, 2003, p.23).

The lack of strong leadership and direction was postulated by O'Connor (1998) to foster a climate of disturbance and discontent where bullying can prosper. People who become bullies in a hospital ward and are not stopped by a strong management become very powerful. Serghis (1998, p.9) "found that the main causes of workplace bullying were: envy of skills or ability; to force their resignation; a desire to control or dominate; personal inadequacies of managers or co-workers and a workplace culture

that encouraged bullying". In a large workplace bullying research project in Australia, Serghis (1998) found that 86% of people were bullied by someone in authority and 43% by a co-worker. Yet Lybecker (1998) called it a silent epidemic saying that the International Council of Nurses estimates at least 20% of events go unreported with staff believing that reporting will not achieve anything or that they may be blamed for the Horizontal Violence. Further to this fears that they may be accused of poor work performance in the future as a reprisal for the reporting of workplace bullying (Lybecker, 1998). This chronic under reporting has been blamed on many aspects of the culture and these have been summarised in the table below.

Table 8
Why Horizontal Violence is Under Reported

Threats of Reprisals	Belief that reports will not be taken seriously	The effort will not be worthwhile	Lack of employer policy and procedure
Devaluation of nurses and their work	Prior experience with blaming the nurse	Lack of support	Denial of the problem
Reduction of confidence and low self esteem	A sense of powerlessness due to their position in the organisation.	The victims starts to think their behaviours caused the actions against them	Lack of Language Fear of loss of job

One aspect that seems to be under reported in the literature in relation to Horizontal Violence is the role and behaviours of the victim, which also influences the culture. Although some authors have said that the victim assumes a victim role and loses confidence and feels powerless to make change (Duffy, 1995; O'Connor, 1998) there is little documentation on the behaviours of the victim and there is no mention of

the internal processes driving the victim's reactions. I intend to facilitate this exploration later in this chapter. However prior to this it is important to see what the staff reported they were experiencing in relation to Horizontal Violence.

Examples from the Staff Interview Data Regarding Horizontal Violence

As has been raised by Duffy (1995) Horizontal violence can be covert or overt. When it is covert, it is often hard to tell if it is real or imagined. One staff member expressed this in the following example:

> *"Sometimes I feel that there are bits and pieces where almost anything you say is basically objected to and that's a very frustrating thing to be in. It's just the way I feel. I don't know if it is really true. So I say the opposite to what I want and they go against it and I get what I wanted in the first place".*

As has been raised by Duffy (1995) there is a lack of appropriate language to describe the experiences of horizontal violence. People use more common terms, which I believe makes Horizontal Violence more acceptable. For example the following participant said that the nurses were 'bitchy'. In the current climate in Australia, the term bitchy can be used in quite an endearing fashion in general conversation 'oh you're such a bitch' is quite a colloquialism. So describing the culture that one works in as bitchy, does not have the same impact as describing it as abuse. Furthermore, it is also suggestive that it is a 'female problem' and that when groups of women work together it is an expected behaviour. This minimises the responsibility of the perpetrator and the acceptable response by the victim. If someone is being 'bitchy' towards you then it could be suggested you just 'get over it'. Whereas if someone is perpetrating abuse towards you in the workplace one might expect a formal procedure.

Nurse: "The amount of bitchiness that we display openly amongst ourselves also at times in front of management and at times the other multidisciplinary team, and I think that's really bad, because if you speak to doctors they very rarely - or any of the other multidisciplinary team, the OT or the social workers very rarely bitch about their own team, you know. Perhaps it's because it's such a big group, it's the largest group team there, the nursing staff, perhaps that's part of it, but we certainly don't present ourselves as professionals with all the carry on".

This nurse acknowledges that the behaviour of the nurses in the ward was unprofessional but describes it as bitchiness and 'all that carry on'. I believe that the words used to describe the culture will also determine the level of acceptance and/or response to the behaviour in the present moment as it is happening.

Some staff members felt belittled in their environment and expressed frustration at other staff changing something that they had done.

"Sometimes with work practices it's like, it doesn't matter what you do, someone else will just reverse what you do or negate what you do anyway. I don't know, I often find it's very frustrating when I'm in the ward, with the situation of…well you'll come up with an idea and someone else will knock it on the head, or you feel, it would be good to do this or good to do that, and yet … no-one else will sort of listen to you or give you encouragement, they'll just knock it on the head, and that's very frustrating. You know, like it's little people down here and big people up there".

Nurses also expressed a hopelessness that they felt their colleagues expressed in relation to the 'revolving door' that is, patients who just keep coming back in. This

appears to prevent people trying to make a difference because the patients will return again and again in the same state. One nurse opposed this idea

"In most cases…I get really jacked off when I hear people say, 'Oh, don't worry, they'll be back'. And I think, well, we shouldn't be looking at it that way, using it as an excuse not to do something, we should always assume, well, we're going to get someone to a well state of health and then they may come back down the track, but they're not going to come back within that year. That's the way I like to look at it. To put in as much as you can, to make sure that that person has the best chance, the best opportunity".

Staff expressed a wish to be professional and focused on positive ideals rather than the internal bickering that takes up so much of their resources.

"I always assume that because we're all professional people, supposedly, that there should be a level professionalism, that we should all be able to work toward one ideal goal, and that's for the betterment - healthiness of the patient and things like that, rather than concerned with internal bickering".

In the following example the nurse has been able to rationalise why she had been the target of abuse. Like me, she believes that her harassment was because her work standards were high. Although this still affected her self-esteem, I believe that it is easier to cope with if it is because one is holding on strongly to their values.

Nurse: "I suppose to make what I'm saying more clear, is that when I first started at this hospital, there was lots of personality clashes that I talked about before, people didn't like my ways of doing things, which is pretty much by the book, by policy and procedure, by the Mental Health Act, and

there's lots of conflicts there. Because I didn't have any friends or support at that point in time, my self esteem went through the floor and I put up with a lot of bitchiness and nastiness, and I think people did that because they saw me as an easy target".

Let us look at the above example through the constructs of values, interests and power. The nurse is very clear that she is standing strong, by the book, policies and procedures and the Mental Health Act. This gives her high values and internal power through her own honoring of her values. However, her power within the ward diminishes for two reasons. Firstly, because this is against the status quo within the culture of the unit and secondly because she is without friends in the unit and therefore lacks the power of the group. Her interests at this point are clearly focused on high clinical standards. How long she is able to maintain this under the 'bitchiness and nastiness' is answered by her later when she states that she gave up her high moral ground to belong to the group. In this case Horizontal violence has been used successfully to socialise a staff member into the status quo within the unit, that is poorer work practices.

The internal bickering was often overt and was also commented on by the psychiatric registrars in this research project. "There is a bit of passive aggression that you notice between the nurses that were here [inpatient unit] and the nurses that came over from the institution. I think for a lot of registrars it is pretty much damage control when you are on call".

Although it is unusual for people working in disciplines other than nursing to raise issues regarding harassment, in this research the psychiatric registrars expressed their experiences of oppression:

"Junior registrars really have very little status in the hierarchy, and those who try and insist on their point of view as opposed to other ones are vulnerable….particularly if they go against the opinion of the psychiatrist who's supervising them…then they're vulnerable to having lower marks or negative feedback into the college. So certainly one is perceived as, well one sees themself as vulnerable in that way, so, although you can question, it is inadvisable to challenge".

I have described this culture as punitive towards patients, particularly in relation to ECU, however, I would not have expected that supervision for psychiatric registrars would be described by them as punitive:

"Depending on who your supervisor is, one can get very traumatic supervision as well…punitive supervision, sometimes".

One of the things that distinguishes doctors from nurses is the amount of mandated supervision. Nurses until recently have had no supervision and even when offered it nurses have declined it, not seeing the value in it. Psychiatric Registrars (doctors) on the other hand have it written into their syllabus and must have two hours a week in supervision. As a nurse, I envisaged that the supervision provided to the registrars could be likened to an intensive personal growth program. However, if some of the supervision was punitive then this could also influence the culture of the psychiatric unit, particularly if it was passed down the hierarchy by the doctors.

Nurse-patient Hand-over Ritual

The nurse-patient hand-over, a ritual that occurs three times a day, has been raised by several participants as a time when they feel their work can be undermined by their colleagues. Horizontal violence may be simply the looks that other staff members

give each other while the nurse is handing over, or a demoralising remark about how pointless the nursing intervention the nurse has planned is. It may also be as blatant as comments like ‘you really got manipulated by her today’. One nurse said that she looked after a patient on the morning shift and made good progress with the patient. She formulated a plan for the continuation of care during the next shift. However, she knows that it will depend on the incoming group of nurses (their reaction in hand-over) and the individual nurse allocated to that particular patient, whether or not her recommendations are continued on the next shift. The nurse puts it this way:

> *“I think, with some colleagues we have a similar understanding, a similar desire for direction, achievement, with some it’s like … you’re not ridiculed, but it’s like, “Oh yeah, here we go, rah, rah, rah!” If you’re trying to, perhaps make a suggestion. And I don’t think that often the nursing care plan for care of someone is followed through because of communication issues. If you’re handing over in the afternoon for example, and you make some recommendations and you document all that, that you’ll know that people won’t follow through with it because it’s too much work, too hard. Especially with certain groups of people, I suppose. "I sometimes think,* ***what’s the point,*** *because you’ll just get a “Oh, yeah, yeah, you know”.*

The same staff member also acknowledges that there are also times:

> *"When you are handing over and you know that someone who’s quite committed is taking on board that patient allocation, you know that it’s going to be done, you know that some of your recommendations or suggestions will be taken seriously, and you think,* ***Hey, that’s good, that’s great!”.***

What is interesting about this example is that the same staff member, with the same competencies can have her recommendations accepted or rejected by the incoming group of staff, even as early as hand-over and prior to the other staff members even seeing the patient. This suggests that the individual has the power to initiate recommendations during her shift, but the power needed for those recommendations to be upheld in the following shifts is dependent on the acceptance of that person and her recommendations by the incoming group. I believe that this is beyond one's ability to justify or argue for recommendations. But more depends on the hierarchical power people have, the group to which they belong within their subculture, the level of horizontal violence within the culture, and the staff members' personal power within the unit. This is supported by the following example:

> *"I feel pissed off, really pissed off. You know, when you make … when you plan something you discuss it with the patient, and you just assume that the person taking over the care of that patient will continue on. And it just pisses you off, because you think, well what the fuck are we here for? Is it only a matter of one out of six people actually doing something? Not that they're not doing something, it's just that they choose not to follow a program".*

The overt and covert conflicts in the nursing handover may be one of the influences that explain why nurses act against the system for some patients and not for others, even when what is happening to the patient is obviously against human rights. One particular nurse, who had strong values, often joined her colleagues in secluding individuals for punishment, that is secluding people for bad behaviour. This raises an important question, that is, what will it take for her to stand up against the system for

the human rights of patients and when will she join forces with her colleagues in actions that could be construed to be against human rights. It is my contention that horizontal violence is an important factor influencing these practices.

Summary of Horizontal Violence

Horizontal violence was rife among nursing staff in this psychiatric unit and appeared to be a strong influence on work practices both at an unconscious and conscious level. It was reassuring for me to find that there were other staff who had similar experiences to me. It seemed that these people were less vocal about being subjected to horizontal violence than I had been. I suggest that this is another mechanism of protection, that staff keep their feelings quiet so that it does not generate further horizontal violence towards them.

Workplace bullying amongst nurses has been extensively explored in the literature. This thesis extends that literature by exposing the use of patients, as weapons of horizontal violence, a topic not previously identified. Pushing a patient into a chair in front of their primary nurse, goading patients to the point of needing seclusion and/or medication and breaching confidentiality by listening through the two-way mirror could all be seen as horizontal violence behaviours. To explain this more fully, I was less likely to retaliate if the techniques of horizontal violence affected me only. However, if they effected the consumers that I was responsible for, I would be quite reactive. The more I reacted, the more the core group of staff retaliated against the consumers or I. What I am suggesting is that when the commonly used techniques of horizontal violence stopped eliciting an observable reaction, that the core group of staff developed other techniques that were used on clients and that elicited the strong reaction that they had been aiming for.

It would seem that some staff members would be easily socialised into the culture by merely observing others as victims of horizontal violence. Others may require stronger measures such as direct victimisation. When this does not work I am proposing that in the culture examined, consumers were targeted to elicit a negative reaction from the staff member involved. Somewhere along the continuum of horizontal violence, some nurses gave up their own values to belong to the group and reduce the risk of horizontal violence. Others left and went to other hospitals, removing themselves from being targets to this core group. While some people, myself for example, tried to stand strong against it and then tried to change the culture. In my experience, the longer the culture was resisted the more violent the techniques of horizontal violence became.

The horizontal violence continuum for me began with being ignored and left out of conversations and ended with me feeling that consumers were being harmed because I was looking after them. Again, I can only explain my feelings in parts. One part of me wanted to show the other nurses up as poor nurses, another wanted to belong to the group and be liked, another part wanted to teach the others what I already knew about human rights and heart centred care, another was isolated and afraid. Depending on what sort of day I was having, how I was greeted in the morning and who I was working with, I could have any of these parts activated. I would then either be in a retaliative part or a submissive part or maybe even an enlightened part that just got on with the task at hand and raised above the politics of the day. In reflection, I am responsible for my own internal parts and my reactions to others. While I was in the situation I wanted to blame the core group for what I was feeling. However, my reaction to them was under my control and I need to take responsibility for it.

The effects of horizontal violence are factors that assist in socialising new staff members into the existing culture. To bring about change to a culture, horizontal violence must be addressed both in relation to the perpetrators and the victims. It will also be important for all staff to be accountable for practices they observe, putting an end to those who condone bullying by their silence

Critical Incidents

Critical Incidents also influence work practices within the psychiatric unit. It influences them through reactive practice rather than reflective practice. Most of the literature regarding critical incidents focuses on stress management and debriefing and defusing. A paucity of literature is available on the impact of critical incidents on the work practices of the culture. The following pages will begin with my experiences of critical incidents and how they affected my work practices. I will then give examples from the staff interviews and then summarise the influence of critical incidents on work practices in relation to power.

My Personal Experiences of Critical Incidents

There are major critical incidents such as a threat to one's life by a consumer or a consumer self-harming. There are also other less dangerous critical incidents that may go unnoticed by some and maybe perceived as normal practice by some, whilst others may feel quite traumatised by them. I experienced and observed critical incidents at all these levels. I had three major critical incidents and almost daily minor incidents.

I had consciously tried to avoid secluding consumers, although not always possible, it was one of my intentions. This alienated me from the culture and set me aside from my colleagues who appeared to experience secluding consumers as a normal part of their day. There was a part of me that thought that this kept me safer, that if I

didn't harm consumers, then they would not harm me. My relationship with most consumers was excellent and I attributed this to my lack of aggression towards them.

One particular consumer frequently lacerated herself quite severely. Although she could be verbally confrontative towards staff, she was not usually physically aggressive towards others, more so to herself. In my last week of work in the unit, I was giving out the medications in the corridor of the ward when I heard the male staff member yell out 'put the fucking knife down or I will take you out'. I looked into the nurses station to find that I was standing behind this consumer who was lunging at the staff member with something in her hand. All the other staff members were on the other side of her and trapped in the small nurse's station. I had no option but to put my arms under her arms and bring her to the ground. I had no idea how big the knife was or if she would stab me as I pulled her to the ground. When I did this the other staff members quickly took over and jumped on top of her and twisted her arm behind her back whilst pushing her face into the ground. I was very traumatised by this, having to do something that I would not normally do. What happened after that was surprising to me. The documentation and the discussions in relation to the incident were as though I was not involved; it seemed that the other staff members were not able to accept that it was me who saved them. They wrote up the report and handed over without including me in it. A staff member later told the ex-charge nurse 'I didn't think she had it in her, I didn't think she would be able to come through when we needed her'. What I did notice was that I was more acceptable to some staff members after this incident, as though I had crossed a line and was more like them. I believed that this incident was triggered by staff treating this client poorly earlier in the day and internally at least I blamed them for it. This critical incident had called for me to act instantaneously and against my core

values. Further to this the patient was taken to the police station and charged with the assault, therefore I was not able to debrief with her about the incident, leaving the situation incomplete for both her and I.

The following incident was a major influence on my work practices within psychiatry. On the 9th of December 1997 at 5.30 pm, I was sitting in the staff tea room of a major public hospital, when I was asked to come and see a patient who had been placed in cubicle 24. As I walked towards the cubicle my intuition told me that "I was in danger and should protect myself". I was shocked at my intuitive fear and went to my office to think about it. While I was there I got a second intuition that said "the bell has rung how loudly does it have to ring, you are in danger protect yourself". I grabbed a clipboard and walked back out the emergency department. A young male nurse said, " you look really pale Robyn are you OK? I told him that I did not feel safe, that I had a feeling that I was in danger, he laughed about how weird I was.

I walked into the cubicle and asked Penny (pseudonym) "how are you", she did not answer me, I said "are you having a bad day?" she said "no I have come to kill you" and began to lift the lid of her handbag. Time shifted into slow motion. As I watched her reach into her bag I remember thinking "knife gun, gun knife?" As if I would have behaved differently depending on which one she pulled from the handbag. She pulled a knife, about 12 inches long and with a serrated edge. She raised it above her head in a position ready to stab me and lunged towards me. I jumped from the trolley I had stupidly sat on and began running through the emergency department. As I ran I screamed out "she has a knife". She chased me, but I didn't look back, I kept running. Eventually she ran back to the cubicle and stood with the knife held in her hand above her head while she stood in front of cubicle 24. While staff members rang the police and

called a code Grey (violence in the department) and then a code black (police required), I slipped under the desk in the nursing station, taking the phone with me. I rang the Cat team and psychiatric registrar to tell them that they should be careful about coming to the emergency department because we were under siege. I listened as the doctors tried to negotiate with Penny to put the knife down, they were not succeeding, and I had tried to keep my face out of her view so that I did not to incite her. The police were now hidden in the wings of the emergency department with battens and capsicum spray ready to use. The patients were being moved to a safer area. I stepped forward and told Penny that I would give her what she wanted, which was to get her label of "borderline personality disorder off the computer" because it was stopping her getting psychiatric services. I negotiated with her that I would do this and then read it back to her. We negotiated that after this was done she would put the knife down. I came back out and read it to her from the computer screen. She put the knife down and the police immediately swarmed in and handcuffed her.

As the police took Penny away, the psychiatric nurse from the crisis and assessment team (CAT) bundled me out towards the front of the hospital, pulled her cigarettes from her pocket and offered me one. I told her I had not had a cigarette for 5 years and now was not the time to begin. My pager went off and I went to my office and answered it. I paged the co-ordinators and managers and let them know what had happened. Shortly after the police came to the hospital and picked me up and took me to the police station to make a statement. Penny was in the same police station and at one point they ushered me into a holding area out the back so that they could bring her down stairs. I gave my statement and came back to the hospital again to collect my belongings and to ring my family and let them know what had happened.

A few days later, I spoke to the constable involved with the case and he told me that Penny had told them she had put the knife in her bag deliberately to come to the emergency department to cause harm. She said that she was sorry she had not stabbed me and that she had access to a gun (her fathers) and would come back to 'finish me off'. She was then charged with attempted murder.

Impact on Family

Ideologically, I might have imagined that should my life be threatened, my children (young adults) would be devastated. Not quite, they thought it was very exciting that I had been involved in two critical incidents, two weeks in a row and that this one was little bit more exciting than the one the week before. I wondered if they were worried, but their answer to that was "you're unkillable mum, no-one is going to kill you". I would at least have liked them to shed a few tears, but their adrenaline had them more excited than upset. My husband at least showed some concern for my safety and asked me "what on earth was I doing working in that place". The next day flowers arrived from the emergency department and I was touched by their compassion.

Affect of Media

Shortly after the critical incident, a major newspaper ran an article relating to the events that had taken place. They had my full name, the hospital I worked at and every detail of the crime. They did make one mistake though, they said 'it took *me* twenty minutes to put the knife down'. Now all the psychiatric patients that I had contact with had the potential to read this article and I felt more vulnerable. Several clients rang me to see if I was 'ok', and I received cards from them. I was fearful that someone else might think it was a bright idea to follow suit and copy Penny's behaviour. The media reports impacted on my sense of self in both the workplace and the public arena. People

who I had never met and were unaware of the quality of my work practices or who I am were reading this article and judging it according to their understanding of the world. Staff members of the hospital that had not really known me before were saying, “oh, you’re the one”. I was angry that they had printed my name, place of work and job title in the paper and even angrier that they misquoted me. I was also angry and disappointed that management had not pre-empted this and protected me. I wrote to the paper and received a written apology from the author of the article that had me *holding the knife*.

Impact of Critical Incidents of Work Practices

The crime affected my work practice in ways that I could never have imagined. My thinking was in how I was going to keep my fellow staff members and myself safe. I was surprised that it even crossed my mind that security should use a metal detector on every patient before they entered the emergency department. My immediate reaction was to check the handbags of patients before I brought them into the emergency department. My standard line for the next week or so was “do you have any weapons on you”. What a mistake that turned out to be. I had one particular patient bend into his bag and pull out an 18-inch blade, which I then had to carry to the security room, just touching it caused me to shake. I thought I was protecting myself and the other staff, but I was putting them in more danger because I was bringing weapons normally concealed out into the open. I was astonished by the frequency with which patients dived into their bags and pulled out a knife. Each time this happened I would have a sudden burst of adrenaline associated with a flashback of Penny reaching into her bag for the knife and I would have to repress the overwhelming urge to run out of the department.

This work practice continued until another critical incident several weeks later. I had been talking to a man during a suicide in progress (he had tied a noose and was

sitting with the rope in his hands); I managed to talk him down and prevent the suicide attempt and I talked to him until the ambulance arrived. Half an hour later he was in the emergency department hitting his head against the wall. When I spoke to him he said, "I came because I wanted to speak to the nice nurse that saved my life". I acknowledge that I had spoken to him on the phone and then asked him if he had any weapons on him, that he could harm himself with. "No dear, I gave the rope to the ambulance officer". Later during the course of our conversation, he reminded himself and me that he had been wrong before and indeed just remembered he had a knife on him. He dived into his pocket and pulled out a knife and began to hold it against himself as though he was going to stab himself. Eventually the police were called and used capsicum spray to get him to put the knife down. As I watched the nurses and patients crying through their capsicum spray tears, I promised myself I would not ask that question of my clients again. If they have hidden weapons, then hidden they should remain.

Release from Prison

My greatest fear was what would happen when Penny was released from prison. During the next few months I contacted the police informant on several occasions to find out if there was any movement in the case. He told me that Penny was going for bail, but he was fairly sure she would not get it because of the severity of the crime. I felt anxious all that day and rang the police station in the afternoon. They said the police informant was not on until 11pm. I rang him at 11pm to find out that she had been bailed in the afternoon. I remember feeling abandoned by the court and by the hospital. I had to ring security and management and tell them that she was on bail. I felt that they should have told me and protected me, but I was protecting them. Bail conditions were set that she was not to come within 200 metres of hospital or me or contact me by phone

or letter. I was still concerned for my safety, while at work and leaving the hospital at night. When I rang management the next day to complain that they had not contacted me about Penny being released they informed me that the solicitor had sent a fax after 5pm and there had been no one there to see it.

Alteration in Relationships: Colleagues

The Cost of Taking Time to Recuperate

Due to my work commitments I did not take time off immediately, but I knew that I was not coping as well as I should be. The occupational health and safety officer gave me four weeks off. I felt guilty enough about taking time off but the reactions of other staff in regard to this was quite demoralising:

> *A manager: " It is just ridiculous that you were given time off…If everyone that was in a critical incident was given a month off, where would they be then… these things happen in psychiatry all the time".*
>
> *Psychiatric Registrar: "Do you think Robyn did something to aggravate Penny and cause this?"*
>
> *Nurse " She would never have killed you, she was just manipulating you"*

A call from the Perpetrator

The day of the court case Penny rang me at work; she had been convicted of a lesser crime and had received a community-based sentence. The bail conditions had been lifted. I was shocked; I had not expected this at all. I had an overwhelming flood of emotion at the sound of her voice and began to cry. She asked me "are you crying" and I said "yes". She told me that she had 'no choice' but to do what she did. She had been trying to get a bed in the psychiatric ward, but her management plan and case manager blocked every turn she took. She felt desperate and knew that she had to do something

she had never done before to get an admission bed. She was angry at psychiatric services for not helping her and lashed back out at them. As she was talking to me I knew what she was saying was true. Oddly enough in that moment I understood that it was as traumatic an experience for her as it had been for me. She told me that “jail had been a really awful place for her and that she had been terrified there”. Penny apologised for what she had done to me. She asked me if I was going to report her to the police or her workers for ringing me. I said that I would not do so this time, that I would accept the phone call as an apology, but if she rang again that I would have no hesitation in taking out an intervention order against her and contacting her workers. In a strange sense it was a relief, I knew she would contact me at some point, it could have been worse and if I had hung up on her I believe she would have harassed me in the future. The phone call had opened the wound for me that I had repressed and I found myself crying continuously over the next few hours.

During my phone call with Penny two colleagues had walked into the office and had seen me crying. It was hard for them to understand why I had spoken to her. One worker was angry that I had given her a guarantee that I would not contact her workers or the police. She said that I had no right to make guarantees on behalf of the team, and that I may have put other people in danger and that they would decide if they would call the police tomorrow. I had an incredible sense of fear that others may interfere with what had been an apology phone call and put me at risk. She had not chased the multidisciplinary team with a knife she had chased me. In my shock and upset at lack of support, I said, “I won’t document the call then”. I cried all the way home, but the tears seemed to be a relief, as if I had opened the floodgates and let them flow. As soon as I woke in the morning I rang the manager who said, “I am glad you rang, I have had a

complaint about you". My threat not to document the call had already reached the manager and it was only 10am. There was no support offered regarding the intensity of the call, rather interrogation at why I would not document something. I had documented the call. My relationships with those colleagues were never the same again and indeed deteriorated markedly over the coming year. They had not been able to walk an inch in my shoes never mind a mile, and I was disappointed.

Altered View of the World

I feel ashamed to say that previously I thought that psychiatric staff members that were held at knifepoint had in some way irritated the client. I had known of several other incidents and could see that the individuals could have antagonised the client previously. But of course when I was the subject of the aggression I had to re-evaluate this belief system. What had I done to Penny to deserve this, nothing that I was aware of? What had happened is that Penny had a management plan forced on her that said that if she presented to a psychiatric facility that she would not get admitted. In an effort to get admitted to a hospital she travelled 12 hours on a bus and presented to two interstate hospitals. She went to another state so that her diagnosis and reputation would prevent her getting an admission to hospital. Each time she presented at an interstate hospital they rang her case manager who said that her management plan was for no admission and she was not admitted. She was so angry that she purchased a knife and caught a bus back to Melbourne with the intention of killing her case manager. She was not able to do this, so came to the emergency department to kill a psychiatric triage worker. She did not know which triage nurse was on duty at the time.

Reflection: I believe that this critical incident occurred to me because the management plan was unreasonable. The consumer was not involved in a collaborative plan that

reflected the needs of the consumer; rather the plan was forced upon her. She was therefore highly likely to rebel against a plan that prevented her admission no matter what she presented with. The brunt of such plans is often worn by workers not involved in their day to day management (ie myself the triage worker) but taking calls from the consumer when she felt desperate to be admitted. It would be far better if the plan was acceptable to the consumer and the workers who are likely to have to implement the plan after hours.

The influences on my work practices were both positive and negative. There was a debriefing session provided by the hospital the week that the incident occurred, but it included three critical incidents that happened in the same week, which minimised each incident for the individual involved. Negatively, I put other people's lives in danger collecting knifes and bringing them out into the open. The clinical review regarding the situation did not include me or the staff member involved in the incident, it was merely done by senior staff members from the critical incident form. I believe that it is in the telling of the story in a full way that the truth emerges and the possibility for learning more presents itself. This incident was preventable and I believe that the controlling management plan was a contributor to the event. I do not believe that this would have come out in a clinical review. For me personally, no-one asked why I was asking about knifes or carrying them to security, not even security themselves. No one asked how my work practices were affected. I experienced panic attacks if someone delved into their bag quickly; I had hypervigiliance and an increased startle response if I thought the client/perpetrator was in the vicinity of the hospital. In the months following the critical incident I was overwhelmed with fear when she tried to extort one million dollars from Qantas airlines saying she had planted a bomb on the plane. No one ever asked me how

I was feeling or approached me about the incident. These major critical incidents occurred on a weekly basis for a short while; I personally was involved in six critical incidents in one week. However, I believe that the culture is also affected markedly from the daily incidents that may be considered less dramatic but are still critical incidents in their own right. Take the following example from the original data of secluding a pregnant patient:

> *Nurse: Umm … we had a young Koori girl in here, she was eight months pregnant. And she'd been admitted over the weekend period, and come Monday morning, coming off the night shift, she was becoming quite distressed, and you know she needed to be assessed by the doctors on the Monday morning, and she said, "Well, look, I'm going, I'm leaving" and it was just on handover that she proceeded to verbalise that she was going to leave. We're having handover and this is going on, and we had to actually go out there, cart her into ECU, and because of her presentation at the time we had to give her medication, and it was actually quite a distressing thing, because she was eight months pregnant, and you know, I felt really inadequate, because … there was this pregnant woman being dragged into ECU, and I actually left feeling really ghastly, and thought, if I had that time over again perhaps we should have assessed that she was going to leave earlier than that, and just asked her to go to ECU rather than having to cart this eight months pregnant woman in there. I actually didn't feel that an eight months pregnant woman should actually be in the ward, because of that, her physical state. And I felt inadequate because I didn't know what to do. That was quite a feeling of inadequacy when I left that day.*

One factor in this example is that the consumer is pregnant and this makes seclusion seem more unacceptable, added to this is the fact that this consumer is a Koori (Aboriginal) consumer and as such, staff members are educated that Koori people do not like to be secluded. Secluding a Koori consumer is likely to have a backlash from the Koori community. The staff member states that she walked away feeling inadequate, it appeared that she knew that secluding this person could have been avoided. I know for myself, that I felt like I failed anyone that I was involved in secluding, because I believe that other methods should be implemented prior to seclusion. This raises the question of what thresholds individual staff have in regard to secluding people and when their own values will be set aside to seclude someone. This will be explored later in the chapter on values. It seems in this example, the decision was made in haste because the situation became critical and as such other choices become less available.

The following example also illustrates the dangers in making decisions 'on the run' in critical situation.

> *Nurse "Well, it wasn't a real bad event, I mean it turned out bad, it looks bad hearing the story, but it was done in the first best interest really. This is another guy in ECU, he was Samoan, big, very angry, very mad and already belted a few people around. He hit a guy who's still in Royal Talbot with brain damage, so this guy can't be taken lightly anyway. He attempted to belt one of the girls on one of the night shifts, at the end of night shift. I was pretty much petrified of this bloke because he was my height and 220kilos, and Samoan and I'm certainly no body builder or Kung Fu expert, so it was only me and pretty much one other bloke on nights, and we had to restrain him, it was impulsive, we had no time to call a team or get prepared. And he*

went faced down and I dislocated his shoulder and it was done aggressively. So reflecting back we had no choice but to put this guy on the ground, because we were fearing for our lives really. We had no choice but to have this guy dislocate his shoulder on us. And that's what it was, it was purely a rugby tackle, out of our fear to get this guy down. I mean it was a restraint done in the most basic style, because we had to make do with what we had in an instant".

This example supports the notion that decisions made in critical incidents are sometimes made from a base of fear '*we were fearing for our lives really*' and that in self-preservation sometimes the consumer is injured, in this case a dislocated shoulder. Staff rationalise this to themselves as 'we did the best we could in the circumstances'. The underlying core belief here is that the nurses were afraid of this strong man and for good reason. But critical incidents such as these, need to be managed well before it is a physical assault between staff and patient.

Summary of Critical Incidents

Critical incidents add another dimension to decision making, decisions needing to me made 'on the run', without time for reflective practice. These decision are often based in fear of staff being hurt and as such it appears that staff may engage practices that would not normally be acceptable. They rationalise these behaviours to themselves as 'we did the best we could in the circumstances'. However as one of the nurses said in the above example, these incidents may be preventable if more time was spent before the critical incident sorting the issues out. It is my contention that as in the last example a consumer feels more powerful than the staff member, that seclusion adds enormous

weight to the staff power base. Consumers can do little to prevent seclusion once it has been initiated by a staff member.

I believe that critical incidents force people to act in ways that they might otherwise find unacceptable. Personal safety (interests) appears to come before values in the power, values, interests equation. Also within this argument is group thinking or compliance to the group. Often critical incidents involve a group of people (as in seclusion) and it is more difficult to act against the group and easier to go along with the rush of the group at the time. If a staff member is involved in a seclusion as everyone on a shift usually is, then it is unlikely that they will complain that it was an inappropriate thing to do.

Critical Incidents and their influence on Values Alignment

Although I had worked in the psychiatric unit for a year, I was shocked to hear that a female consumer had been secluded naked:

> *"There was one incident recently, it's fairly fresh in my mind, about a month ago, a client who suffers from borderline personality disorder was attempting to self harm. She ended up ... I don't know how to say ... in seclusion, with no clothes on because she kept putting them around her neck ... um ... and medication was refused for this client because she was acting out. And I felt quite disturbed by that personally, because I thought that this client would need something [medication], because she'd worked herself into a state by which she did need something to help her ... and she actually got very upset about it, to the point where she actually wrote a letter to the ombudsman and to other people and made a complaint about it, that she'd been refused medication. I mean, she'd been attacking staff and all sorts of*

other people, and I just think, it was just really hard for her, it was hard for me, because I do honestly believe in giving medication to people who are needing the medication. And then in fact she said she felt so frustrated that she attacked one of the staff, and, well, you can't attack a staff member and then go around expecting the staff to stay too close to you, either, cos they need to keep their distance … I mean, it depends on the situation … Yeah, it was … it did upset me a lot, and I thought … I don't know, that was a pretty negative experience for me. I felt very apprehensive about it.

In some ways I did, but in another way I felt helpless. Because I wasn't actually allocated to the patient, and I wasn't in charge of the shift, so I was sort of like an onlooker. So I sort of felt responsible and yet … not there, if you know what I mean, I was there but I wasn't there. Fortunately nothing happened, I'm really glad about that. But it did disturb me".

What surprised me about this staff member's concerns was that their questions were solely about whether the patient should have had medication or not. The staff member was not up in arms about the patient being secluded naked, without clothes or a sheet and being observed every fifteen minutes through a small glass window by male and female staff. However, the staff member was able to see that it was inappropriate for her to be secluded without medication. More astonishing was that she quotes the patient herself as writing to the ombudsman about medication, but again no mention of being secluded naked. I propose that the relationship with the client had deteriorated to the point where secluding her naked had become acceptable to the status quo. The staff member relinquishing her responsibility by saying that she was not in charge on the shift, therefore she was more of an onlooker.

There were other issues raised in regard to being in charge of a shift. It became apparent from other staff members transcripts that being in charge of a shift was often thrust onto people who did not want to be in charge and who felt scared by it because of the increased responsibility.

Nurse: "Well, actually that day it fell on me that I had to be in charge. And that's not easy to do. Some times you can come onto a ward… it happens too often on night shift, we might just come in and they say, well, you're it, you're in charge. And you just think, Oh my God … because being in charge just puts you ... puts another hat on your head, and you think, oh my God, I'm responsible … my duty of care has increased".

Nurses are able to deflect responsibility further up the hierarchical tree, however there are many occasions, particularly on nightshift, when the nurses find they are in charge of the shift and the most senior person overnight. These fears directly affect their work practices.

There are nurses who do advocate for their clients but still come away feeling hopeless about a situation.

Nurse: "Once again I go back to borderline personality disorder and the arguments that I have had with other staff who I've tried to make accountable for suffering that I've seen and when treatment isn't provided straight away and I know that this patient needs treatment right away, but they're punished and put on the end of the line. They really need immediately care, say they've slashed up or they've damaged themselves, therefore they're punished by not giving them attention straight away. Very difficult one to, I mean each time I've tried to advocate for a patient in that

sort of situation, I've come off feeling really frustrated to the point where I sort of think, you know, it's hopeless, a hopeless situation. It's a frustration because there's not enough communication or understanding about, particularly people with borderline personality, that even though they've taken the responsibility to harm themselves, they don't need to be blamed. Blaming is not going to get them anywhere. They deserve immediate attention as much as the next person and good treatment".

The staff member was able to identify the distinction between two groups within the unit.

"The trouble is you have very strong feelings for these people, you'll have some people who'll want to protect them and other people who want to kick them out. So there's these two view points that come with these people and that's well documented".

Another staff member discussed how if you have had to be heavy handed, then it is important to at least try and talk to the patient and explain why you took that particular stand with them:

Nurse: For instance people who have been put into seclusion and given injections when they're extremely unwell. A lot of people think that they don't remember that, because they were so unwell, they just don't remember. But of course, we know that they do remember and they're traumatised for many years later. And it's so important to debrief them afterwards, and once they've passed through, once they're more aware and alert, so you can actually talk about it in meaningful way with them and they can give some input as well. I think it needs to be two way and explanations

are owed to them because we have taken their freedom, and we have in a way, we've abused them and that's the balance we have to strike here, we have to provide safety and balance there, freedom against safety for others and for themselves. All of those sort of things need to be explained to them. Yes I think when people's freedom are taken away and people treated unjustly it certainly has an effect on your self-esteem.

This is also supported by another nurse who was able to articulate how difficult it can be when a patient moves into a state that needs to be contained.

Nurse: There's probably a few like that in the sense that they become very tense, that a person presents as though they want to make a difference in their life, they want some help, they can recognize that they're unwell for whatever reason. And then all of a sudden they change and they become quite aggressive and quite threatening. And I suppose if you had a good rapport with them, I know things fluctuate really easily, and then you've got to put on the big, sort of, well, we're going to medicate you and put you into a safer environment, and that's really traumatic sometimes. Because you know that people who are involved in that sort of incident when they think back about it and it's all very real, it's like that unconscious patient who's very well aware of the people around them, and afterwards they can verbalize to you how they felt and how unfair it was, and how hurt they were, you sort of think about that in the back of your mind, and you want to minimise that trauma, but sometimes it's impossible, in the sense that you are taking that heavy-handed approach. And I suppose you have to justify it to yourself, well, it's for their own safety and security. And that's traumatic.

RECOMMENDATIONS

Critical incidents are reactive practice, that is practices that occur when people are feeling out of control and afraid of what is going to happen. It appears from the transcripts that these practices are often made by staff from a self-preserving bias when they are afraid they might be harmed and that this becomes the justification for practices that are totally unacceptable. I postulate that when staff members are afraid and their adrenaline is released that they are more likely to act in primitive self protecting ways and that it is more difficult for them to act in rational ways. Exploring this hypothesis would be an excellent project for future studies to address.

Staff on duty can take an onlooker stance and do not feel responsible even if they are assisting with secluding someone. If they are not the primary nurse for that patient or the charge nurse they do not feel as responsible for care within the unit. This needs to change. That is, onlookers need also to be accountable for their practices. It is recommended education about the code of silence that perpetuates poor practice and horizontal violence. In my opinion an onlooker is just as accountable as the person initiating the action.

Hearing patient's stories when they come out of seclusion and trying to understand where the seclusion could have been avoided would be invaluable in developing methods for early prevention of critical incidents. Out of all the people interviewed only one person said that they debriefed patients when they came out of seclusion and that person relayed a story that was more of a warning to the patient not to behave like that again or they would be straight back in the seclusion room. It is recommended that nurses are trained in listening to patients stories as they come out of seclusion.

It is recommended that the effects of critical incidents on future work practices of staff within the unit should be examined. Debriefing is not enough. From my own experience, there appears to be influences that go on for weeks and months after a critical incident. If another critical incident occurs in the meantime, then this is likely to compound the situation further.

Prevention is better than cure. Training staff in preventative strategies to prevent critical incidents occurring would be most appropriate. I have found that when staff sit in the nurses station talking to each other, they are often not aware of when consumers are deteriorating or escalating in their behaviours. Prevention begins by being more present and spending more time understanding the mental state of each consumer.

CHAPTER 6

FINDINGS ON VALUES

This Chapter is written in the same format as the previous chapter on Horizontal Violence. It begins with my lived experiences while working in the psychiatric unit in question. Again it should be clarified that I experienced the examples that follow, when I was naive to the literature relating to my experiences and when I was deeply immersed in the culture. This is followed by the literature review in regard to these values and the summary table of challenges in relation to the values theme. The findings are presented and discussed in the same order that they are presented in the table. The data gathered from thirty eight with staff members are included in this table and are presented next. The thesis then progresses to the consumer consultants' reflections on the staff's experiences. This section ends with a summary discussion relevant to values. A diagrammatic representation of the format follows.

Table 9
Outline of Methodology

Chapter on Values
My lived Experience
Literature Review in Regard to Values
Summary Table of Results
Supporting Data from the Staff Interviews Regarding Staff's lived Experiences
Conclusions in Relation to the Discussion of Values

Values: My Lived Experiences

As previously mentioned, the first time that my values were tested was on my first day in the psychiatric unit when I arranged to spend an hour with each consumer that I was assigned to. When I walked back into the nurse's station where all the other nurses were, I was confronted by the nurse in charge of the unit, asking me if I thought I was a doctor and what did I think I was doing. Her derogatory remarks placed me in a position of choosing between my values of being there in my best capacity for the clients and hearing their stories, or being there to get on with the staff and tow the line. There was a part of me that wanted to get along with the other nurses and have a sense of belonging, but the part that was there as a professional nurse wanted to do the best I could do by the consumers.

I tried to belong to both worlds, being as professional as I could be when I was with the consumers, and trying to be professional and part of the group when I was with the nurses in the nurses' station. As time went on my values were tested on almost a daily basis, causing moral dilemmas for me on a frequent basis.

One example of moral dilemmas that occurred on a daily basis was witnessing the treatment of consumers in regard to cigarettes. Cigarettes are a commodity of great value to mental health consumers. In contrast, money has very little use in a psychiatric unit unless you can buy cigarettes with it. Cigarettes can be swapped, bartered, smoked or shared with a friend, therefore buying comradeships within the unit. If staff felt that patients were smoking too much they would put the cigarettes away in the drawer and give the consumer one cigarette every half hour basic. Also cigarettes were kept as punishment by staff members who used them as a behavioural control, i.e., "If you are well behaved you can have a cigarette". When I worked in a psychiatric institution in

the late 1970's staff were in control of distributing government issued tobacco. Consumers were not allowed to leave the grounds to go and buy cigarettes and so they became a scarce commodity. Two decades later, in the psychiatric unit in question, I again witnessed consumers begging for a cigarette at the nurses station door. The same scenario might present itself many times in a day. A consumer coming to the nurse's station door, asking for a cigarette, being told by the staff member that they are busy and to come back in ten minutes time. The consumer who was often already agitated because they wanted a cigarette found it very extremely difficult to wait. But wait they did, pacing outside the nurses station and would come back and knock on the door at maybe nine minutes. In a typical scenario, the staff member might then say I told you to come back in ten minutes not nine, and send them away for another ten minutes. This rejection at the nurse's station door could go on for several attempts. Often it would result in the consumer getting angry at the nurses for not giving him one of his cigarettes and if he or she demonstrated their frustration, they could be jumped on by a group of nurses and locked in a seclusion room. On some days this was a frequent occurrence.

It did not take long for consumers to work out who out of the staff members were going to use cigarettes as a weapon against them and who was going to comply with their simple request for something that belonged to them. On one occasion immediately after I had walked into the nurse's station a consumer asked me politely "could I please have a cigarette out of my packet in the draw". I acknowledged him and went to the draw and passed him his cigarettes. Another nurse jumped up from her chair took the packet out of his hands and told me I had no right to give him a cigarette. The consumer was brought to the ground by four nurses and locked in a seclusion room. I felt like I

had let the consumer down and felt aligned to the consumer rather than the nurses. This also gave the nurses another opportunity to say that I was not working as a team member and make another formal complaint accusing me of not maintaining the continuity of care and not working well with the others. Therefore I become the perpetrator and they become the victim of my consumer driven practices, the consumer suffers because they are in seclusion and still do not know when there next cigarette is coming from.

This caused a moral dilemma for me for two reasons; firstly, I believe that consumers should have the right to their own cigarettes when they choose them and should not be withheld from them for punishment; secondly, I believe that consumers should be spoken to in respectful ways. The dilemma for me was, do I condone the behaviour of the other staff members by keeping a code of silence, that is, watching a consumer be demoralised at the door of the nurses station and not have their needs met, or do I stand up for the consumer against the other four nurses in the nurse's station and become even more alienated from them. Further to this, in my interactions with the consumers I had already built a rapport where they know that we have mutual respect for each other. This was being tested, would I maintain that respect in front of the other staff members by standing up for the consumer or will I simply sit down at the desk and mind my own business perpetuating a code of silence? For me this simple example demonstrates the ethical dilemmas that I faced many times a day, every day that I worked in the unit. (The accompanying CD, gives a visual image of this scenario).

Values: Literature Review

Definition of Values

Values are ideals which are held in the conscious and subconscious minds of individuals and are a springboard for action. Uustall (1983) stated that 'values are general guides to behaviour, standards of conduct that one endorses and tries to live up to or maintain. This is echoed by Prilleltensky (1999) who states that, 'values are principles of action that benefit other individuals and the community at large'. The ubiquitous influences of our values in our lives has been defined by Scott, Jaffe and Tobe (1993, p.19) who stated that, 'our values are the deep seated pervasive standards that influence almost every aspect of our lives: our moral judgements, our responses to others, our commitments to personal and organizational goals'. Whether actions are conscious or subconscious they pervade our thoughts, our actions and our dreams and as such are the cornerstone in the search for understanding humankind.

Ethical Considerations in Relation to Values

'Today, ethics is regarded as a critically reflective activity fundamentally concerned with a systematic examination of the moral life and is designed to consider and reconsider our ordinary actions, judgements and justifications' (Beauchamp & Childress, 1994; cited in Johnstone, 1999a). Although values and ethics are frequently used as equivalent terms, they are not (Corey, Corey, & Callanan, 1993). Leowenberg and Dolgoff use the terms, 'what is right and correct' in relation to ethics and 'good and desirable' in relation to values (Leowenberg & Dolgoff, 1988). Corey et.al., (1998) discusses two levels of function in relation to health professionals ethics. The first, he termed mandatory ethics where an individual does what is necessary to avoid legal action and to adhere to professional codes. The second, called "aspirational ethics" is

where practitioners reflect on the effects of their actions of the consumer (Corey, Corey, & Callanan, 1993). They further delineated between professionals who are more likely to respond in terms of professional codes and practitioners who are more likely to act in accordance with their own personal values. This is in line with Prilleltensky (1999) who stated that individuals are more likely to align with their own interests when under pressure. In the health arena these precarious situations happen on a regular basis. For example, Chambliss (1996) "reports that the ethical difficulties nurses encounter frequently involve the practical problem of accomplishing some task over the opposition of other people: recalcitrant physician , a family that doesn't understand, administrators who must meet budgets (p.92)".

Organisational Values

Organisational values are enduring beliefs which direct decision making (Bilanich, 2000; Gibson, Ivancevich, & Donnelly, 1997) and provide the source of power for people to take action (Scott, Jaffe, & Tobe, 1993). Within the nursing literature, Sundeen, Stuart, Ranking and Cohen (1998) propose that nurses identify some values easily with little conflict, while others (for example those which include ethical and moral decisions) may cause high conflict and may be very difficult for the nurse to even identify (McNally, 1990). Sundeen et al. (1998, p91)informs us that a value can also be defined as an 'enduring belief that a specific mode of conduct or state of existence is personally or socially preferable'. The notion of values informing decision-making and shaping our decisions is upheld by many authors (McNally, 1990; Raths, Harmin, & Simon, 1978; Scott, Jaffe, & Tobe, 1993). These authors also state that values change and develop over time. "Values need to be staunch enough to sustain us in times of trial, yet flexible enough to adjust as our body and mind change with age

and experience. A tall order indeed!" (Sharp, 1996). It would be reasonable then to believe that as nurses develop in the work place and gain more experience, their values constantly realign with their new knowledge.

Values Clarification

Raths, Harmin and Simon (1978) developed seven criteria for assessing a value. If a value did not reach all seven criteria then they deemed that it was not a true value. They saw values as being based on three processes: choosing, prizing and acting:

Choosing	1. Freely
	2. From alternatives
	3. After thoughtful consideration of the consequences of each alternative
Prizing	4. Cherishing, being happy with the choice
	5. Enough to be willing to affirm the choice of others
Acting	6. Doing something with the choice
	7. Repeatedly in some pattern of life

Rokeach (1968; 1973) discussed values as belonging to a hierarchy whereas Kluckhorn (1962) and Maslow (1959) placed them on a continuum. Regardless of their mode of representation, these authors believe that values are ranked in importance. Judgements are made on the basis of weighing and balancing one's values (Raths, Harmin, & Simon, 1978). More recently Prilleltensky (1999) has discussed values as belonging to sets. This is supported by Hall (1993) who suggests that values cluster in core sets, which help us understand the environment in which they are operating and form our world view. Schein (1992) called this culture. Once the values of the organisation have been identified, then the organisational culture can be understood.

Regardless, values are particularly pertinent in regard to decision making. Values are, "the guidelines and beliefs that a person uses when confronted with a situation which a choice must be made, moreover the importance of a value constellation is that, once internalized, it becomes (consciously or subconsciously) a standard or criterion for guiding one's actions' (Gibson, Ivancevich, & Donnelly, 1997, p. 29). A value conflict can occur when two or more values deemed worthy in a given situation must be weighed and prioritised and one value must be chosen as the framework for decision making and action (Uustal, 1983).

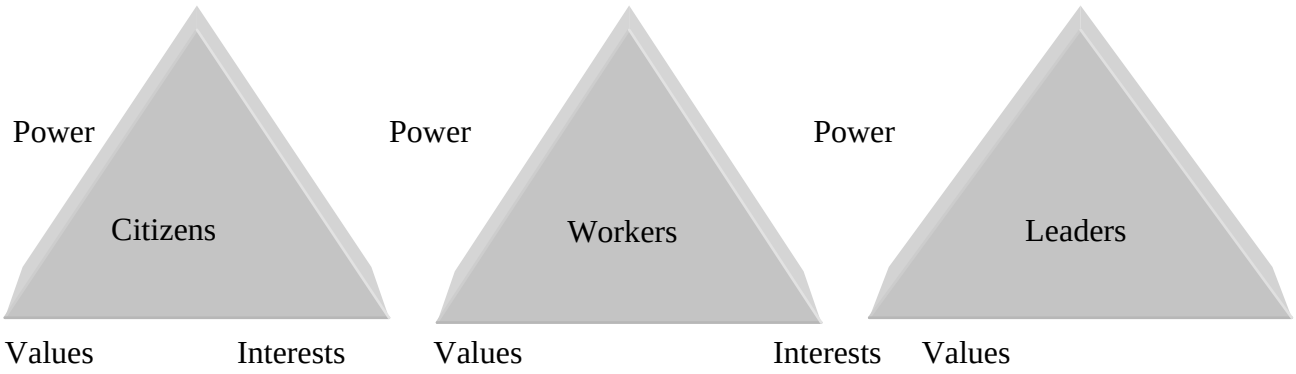
Working in the health environment in this time of economic rationalism can cause moral dilemmas in relation to the values that individuals hold. "Moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Chambliss, 1996, p.92). As well as these restraints there are also times when the health professional may feel threatened. Chambliss (1996) informs us that at these times the person is more likely to think of themselves in preference to the client. Chambliss suggests that ethical dilemmas in organisations reflect the conflict of powerful interest groups. Prilleltensky (1999) reinforces that if individual interests are in jeopardy then the pledge to values may be forfeited.

Personal, Collective and Relational Values

The work of Isaac Prilleltensky (1999) in relation to understanding values is pertinent to developing a deeper understanding of values which is applicable to this paper. He defined three categories of values; individual, collective and relational. That is, that values were either personal to the *individual,* or part of a *collective* or *relational* that is the interconnection between the individual and the collective (Prilleltensky,

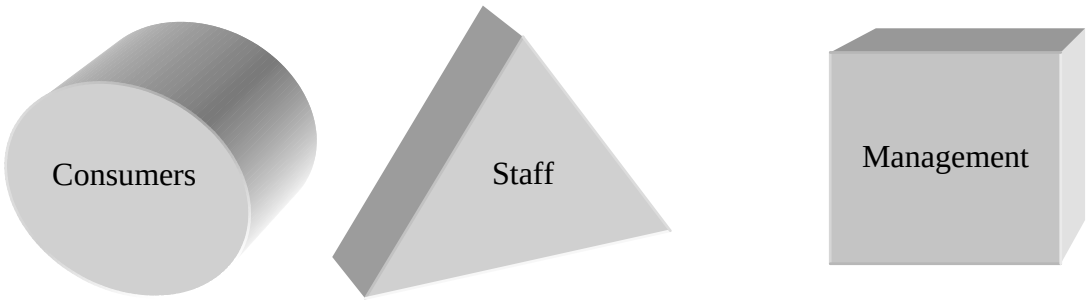
1999). Prilleltensky states that each of these three groups makes decisions according to their power, interests and values. He illustrated through the following diagram:

Figure 4. Decisions based to power, interests and values



However, one could diagrammatically represent the three groups associated with the Mental Health Service in the following way.

Figure 5. Consumers, staff and management



In Prilleltensky's diagramatic view of his three groups of actors, they have differences in their interests, power and values. However in the mental health service, I believe that the values of the groups are not yet clearly defined enough to fit together in a similar way. The boundaries of each group have historically been so different. The Mental Health Act altered the interests and the power of each group, giving consumers more rights than they had previously been afforded. However, very little has been done to address the alignment of the values of each group. I see a clash between the alteration

to power and interest (on paper through the Mental Health Act) and the failure to put resources in to facilitate a flow- on regarding the values of the pertinent groups. To be able to bring consumers, staff and management into a reflective inquiry into work practices and open ethical discussions will need a re-negotiation of the boundaries between each group. The old boundaries between consumers, staff and management must be rendered flexible and their shape altered to be more in line with a value-laden organisation, which responds to the needs of consumers. To achieve this the consumers need to be asked what they value.

What do Consumers Value?

I asked one consumer what she valued in relation to the mental health service.

> *I value human dignity… human rights, I have a right to be heard, a right to feel safe, a right to access mental health services, a right to a mental health bed, the right to be supported when I feel I need it, and a right to complain about a staff member without fear of reprisals.*

Let's follow through one of these values, that of *the right to access mental health services,* demonstrating an example of a negative outcome.

The final decision by the staff member supports the notion of Chambliss (1996) and Prilleltensky (1999), that when it comes-to-the-crunch, individuals will take the self-preserving option. But what if the consumers, staff and management had aligned their values regarding the allocation of resources prior to the request to access services and everyone was clear about the equality of power and interests. Then perhaps the outcome for the scenario would be different.

Table 10
Power, Interests and Values in Relation to Players

Player	**Power**	**Interests**	**Values**
Consumer	Low	High-need is to engage meaningfully with mental health services	Right to access Mental Health Service
Staff	Moderate	Two fold a. respond to consumer's needs b. Be accepted by colleagues and management	Human rights Relationship to colleagues Position in organisation
Management	High	Must remain within budget Resources scarce	Resources are valuable Reaching budget Minimal Complaints from staff or consumers
Outcome	Decision made by Staff member	Access to the minimum required to avoid 'trouble' Interest upheld is that of being in line with management	Value upheld is that of Resources

The choice may be to ensure that the consumer's needs are met to the maximum rather than the minimum requirement to avoid trouble, and that this reflects the ideals of consumers/staff and management. Staff is then not being put in the ethical dilemma of

choosing between a rock and a hard place, that is between resources and excellent outcomes for consumers. It has already been said that values are the guidelines and beliefs that a person uses when confronted with a situation in which a choice must be made, yet values per se are not directly discussed by these three pertinent groups.

Questions Regarding Values

The question, which has been raised from this research, is when is a value is given up for another one? When do values change their position on the hierarchy of values? Are they given up for the higher good of others, or for the benefit of the individual, or because they are deemed to cost too much to uphold in the present moment. For example, secluding a person naked goes against the value of dignity and respect for all human beings, but if the cost is thought to be death through suicide is this value exchanged for that of safety above all else?

Does our need to belong to a group at times mean that we would be prepared to give up some of our values to do so. If so, does every value have its price, that is, does everyone have their limit to what they are prepared to risk in regard to the particular value before giving it up? There is no doubt that values drive people's behaviour, even to the point that in war people have been prepared to die for their values. Values can also compete with each other for energy for action. For example, if one has a value that says all people have human rights and should be treated with respect and dignity and then you work in a psychiatric hospital where you see and are asked to participate in individual's being secluded for punishment, then a value dilemma arises. I presume that not adhering to values can cause anxiety. If you value honesty and you tell someone a lie then anxiety will result. If you value integrity and you cheat on your income tax, this is likely to lead to anxiety.

Value Personal Safety Above all else?

Do people value their personal safety before the absolute rights and dignity of patients? If so, then they could rationalise that they do hold the value of patients having rights and dignity, but their personal value of their own safety is a stronger value and energy is directed to that value first and foremost. Therefore, making staff able to cope with their decisions whilst secluding people for punishment. But later when reflection occurs and the values need to be justified to the self, will they hold water, or will the person experience guilt? Perhaps then over time, some staff members could jump straight into a self- protection mode and not see other win/win solutions where both values could be upheld. Practitioners, consumers and managers collaboratively reflecting on their values in relation to work practices could enhance them.

Synergistic Values

Synergism is a term used in science to explain the principle that the combined action of an entity is greater than the sum of its individual parts(Scott, Jaffe, & Tobe, 1993). I propose that if the values of the three pertinent groups are aligned and focused on specific outcomes then the strength of those values will be much greater than the combining of each individual's value. I will use the phrase synergistic values to explain this. A synergistic value can be defined as a group value where the combined action of a group of people who are aligned in common values for a specific purpose or outcome, is greater than the sum of the values of each individual within the group. Aligning the values of the three pertinent groups within the psychiatric unit has enormous potential for transforming the culture and improving the outcomes for mental health consumers.

Management to Resource Synergistic Values

In line with Bilanich (2000) who states that managers have five important tools at their disposal to demonstrate their values within the organisation. They are; (1) their time, (2) the questions they ask, (3) their reactions to problems and crises, (4) what they reward and (5) what they sanction. I would ask the question, 'do staff really know what management value?' Perhaps they surmise what they believe management value from the response they get from their immediate management when they go to him or her with a problem. Let's look at an example from the data, the following nurse participant, openly proclaims that she gave up her values to further her career. She expresses that 'not whinging' about what wasn't working, decreased her stress and helped her career, but at a cost:

> *Sally: I give management what they want* ***because they don't want to hear what you really think****, because then that's just* ***too much trouble*** *for them to fix it. So … and you get so angry and frustrated too, and the job's too hard to do, you know, so it's just easier just to go along with what management want and agree with it, so that way at least it's better for your career, if you want a career, it's less hassle, less stress; what's going to be changed? Nothing, because we're not going to get any more money, so you may as well just shut your mouth and just do the best you can with what you've got, which isn't the best possible care they could be getting, it isn't. But you just … you can't do anything. Whinging to management,* ***they've got no power to change it****, they* ***don't have the money****, and you're just a trouble maker. For an example, I've done a lot better with my career sine learning to shut my mouth! I've just got an ACN (associate charge nurse) position after the*

third time trying. I learned quite a few months ago when to shut my mouth about things, and there's your final outcome! (ACN)

The conflicts that she was going to management about were the work practices in the unit and her relation to other staff members who she believed did not hold her values in relation to good work practices. She was able to identify that her work practices in this unit were not as high as had been previously and that this was a deliberate choice to avoid conflict with others. Her example is not one of a dramatic work practice but one of the small day-to-day conflicts she experienced:

"Nurse: I could think of lots of events, but I don't know which one to choose, I don't know what's most appropriate … um … I've had situations that … in the past … that my own practice hasn't been as high due to not wanting to have conflict with others. I can talk about recent night duty, that I think you were actually present at one of these days where one of the staff's children who had just received good news and came to the unit with her boyfriend and there were photos in the foyer, which was all very nice, but it got louder and louder and was really over the top, and all I really wanted to say was 'Everyone, OK, it's fine that we're all excited about this, but let's just keep it quiet, because we've got patients here trying to sleep (it was 12 midnight), but because I had gone through so much conflict up to that point in time, I just felt like I couldn't deal with any more conflict, so I let them yell and carry on and scream and whatever, for nearly I think an hour and a half because it was easier. And I think because I was on nights for so long I was tired, and I suppose when you're tired conflict's just the last thing you need, especially the sort of conflict that we have with certain

people, that we've had in the past with certain nurses on the ward, because they can be really nasty and bitchy and mean. So that's one example where I think I let patient care decline because I felt I couldn't deal with people having conflict with me about it. And at the time I felt, well, of course, if it's a major thing then of course I'd do the right thing, but it was just people being loud which was bad enough, but I couldn't over that cope with any conflict, so I let the staff be loud for that period of time, just let it go. So that something that I didn't handle all that well for patient care, because of certain cultures I suppose in a way…"

Eventually this staff member experienced so much dissonance between her personal values and her perceived inability to uphold her work practices that she took time off from her employment to reflect on her situation and eventually resigned from her position. She chose to leave work because she did not want to experience the wrath of the core group that she had consciously dropped her work practices to belong to. However, she changed her mind when the unit manager asked her to stay. She reports that she then felt more confident:

Nurse: …but things have changed now, that would never happen now. I'm much more confident and I don't wear other people's crap anymore, if they don't like what I have to say, what I'm doing, that's their tough luck, and I'll try to be professional about it, but if they can't cope with it, tough titties to them.

I asked Sally if she felt that she had compromised her standards of work and she replied that:

> *"For a long period of time I did, now I don't, not since I became an ACN (associate charge nurse)…not for the last three months. I don't, and if people don't like it that's their own tough luck. But I did for a long period of time because I couldn't cope with anymore stress or bitchiness or anything else. I didn't have the energy even to go for a job outside. I wanted to get out of what I was in, but didn't have the self esteem or energy to do that. But now I have the self esteem and energy to stay, or to go, whatever I choose. I've chosen to stay and feel like I've been very involved over the last few months and people's personal problems or ongoing conflicts don't worry me. I mean other staff, that's their own problems, their own issues, if they want to be bitches about things, let them. It's not going to touch me and it's not going to destroy my high quality care that I do offer. Not anymore.* ***They're not worth it****, and the patients suffer.* ***The whole reason of being employed is for the patients****. So I've really developed over the last couple of years. Up and downs, but now I've worked it out. Finally, and I'm sure the patients will be better off because of it! Because I've finally worked out me, and where I stand at this hospital. Without bad influences from other people.*

I propose that the shift for this staff member was in her sense of alignment with management in regard to her professional values. Originally she gave up her values because she felt her need to be acknowledged and promoted in the service outweighed her need to hold onto her previously high values in relation to optimal work practices. She aligned her values with that of management, but the distance between her values and those she perceived from management were too distant. When she resigned she

raised this with management saying she could not tolerate the drop in the standards of work practice any longer and needed to terminate her employment. It was only then that she discovered that management valued her values. When her values were in alignment with management she re-reenergised her values. This value was now a synergistic value where the energy of the two people in alignment had a combined effect that was greater than the two of them had experienced individually.

This staff member demonstrates that values can change over time. She has explained previously that she held high standards in her work practices in the ward but consciously chose to lower them for several reasons, firstly to gain promotion and reduce stress and secondly to avoid conflict with fellow workers. However, overtime this altered. After the unit manager asked her not to leave and gave her the promotion she felt supported and was able to re-establish her high work standards.

For this staff member, the value of being accepted by the other staff members had once been held in higher regard than the quality of her work practices. It is not clear from the transcripts whether or not she has changed her value in relation to her need to be accepted by management as 'not being a big mouth or a whinger'. However it is clear that her values are changing over time as she grows and develops.

There was one interview from the original data that stood out amongst the rest in regard to values. His values were clear and well defined and he was very articulate as an advocate for the consumers of the mental health service.

> *"My background is in working with homeless young people with mental illness……I identify with a particular philosophy or an ethos, which is based in very deep gospel core values or the Christian values such as permeates the hospital in which the psychiatric services are situated and I*

believe in those core values which are to do with compassion and dignity and respect and equity etc. I suppose they had been searching a long time for someone to enter into that environment to do the work I do [deleted job title for the purpose of anonymity].”

Within the culture of the psychiatric unit he became a person that the patients could trust, that would listen and believe their stories relating to their treatment by other staff members. He relayed a narrative told to him by a patient in this psychiatric service that caused him immense grief:

“The pain of one particular person, the expressed pain, though I didn’t see it, was when a client said to me ‘John, what right have they got to have me stripped naked, have males there and search my vagina, making me bend over and making me do things that there was nothing left for me to hang on to that told me I was a human being, if they are going to treat me like an animal I’ll behave like an animal’. What right do these people have?” This particular patient I had known for 15 years but look at her story, what she had been treated for, bi-polar, but she was raped before the age of seven, molested from seven to fifteen, sexually molested by females in authority, never known the relationship of love. Her body has been poked and probed by people wanting their own needs met, who was she? Was she asexual, bisexual, heterosexual? Who am I? Will I go to hell? What has happened to me? This is the cluster of deep angst and spiritual chaos because spiritual in this context of ‘I have no meaning in life, none at all, I mean people are using and abusing me and glad to get rid of me and fearful when I come in,

I can't help me who I am, they made me who I am' How do you deal with that? How do you deal with that professionally? People can't.

In psychiatry, these searches are called cavity searches, they are illegal, psychiatric nurses are not allowed to give vaginal examinations to clients. This man was not the first person to disclose this behaviour occurring in the unit; however he was the first that had the courage to say it in a transcript. Another participant informed me off tape that in this particular case the nurses said that they were looking for razor blades and believed that the patient may have hidden them in her vagina. This person stated that the nurses wore gowns, gloves, masks and goggles for their own protection, but that this had been so traumatic for the patient that she had disassociated during the examination. The participant alleged that the vaginal examination was not documented or reported to the doctors or other nurses. The current participant explained that when the patient complained about the cavity search that it was brushed off as delusional and that the patient and the staff knew that she would never be believed. I asked him if the patients cavity search had been taken to the appropriate people:

"If you want to believe this person you have to understand what this person has been diagnosed as because that will measure truth. If it is a person who is having illusions and delusions and the person is displaying a particular personality disorder that justifies people having a doubt. If you like, many of the professional staff are like jury's 'is there a reasonable doubt here?'. In effect you have a permanent jury and often kangaroo courts. But you have a permanent jury there that has to look for that reasonable doubt. Now, you are working with people who are your colleagues or you're someone who has come in, in the last five years and you're up against someone who has

been for twenty years. That person who has been there for twenty years can make your life very miserable if you don't be silent, support or make a contribution without rocking the boat. That's still there, so it is a question about people holding onto their job. The high turnover of people, people went, but the high turnover was people who worked in the place for less than five years, people who went to university, people who were skilling up, people who wanted to make a career out of this. But there were people retrenched, but I still say, in all my experience in 12 months, the power of the psychiatrist who often didn't keep appointments, often didn't tell the patients that the appointment was cancelled. These hurt because you need assessing. There are guidelines about people being assessed every 24 hours , even their medication. People were not available, but if the psychiatrist has to deal with 15-20 patients and they all want to see him or her, whoever speaks the loudest, whoever has the best relationship with the staff, but the one who is a trouble maker, you can lay down and die, you're not seeing anyone. A lot of lies, a lot of deceits, a lot of miscommunication, a lot of people not filling in the file of the story of the person in the file properly. There was a lot of, this is outside formality, and this is the informality of people, because they were dealing with someone that was less than human. Now, the good things about being there, was pastoral care was needed, pastoral care person working in a team and across discipline was needed. To this day they haven't put anyone there since I left. When I realised that 13 hours paid by the service needed to be doubled, they weren't going to find the money to do that. The high turnover of people, in one day, gone the

next. They may be dead, they may have found accommodation. What are you treating the people for? We had people in there stoned, people in there taking dope, but they're not there for drug treatment, they are there for mental illness. You had people who had been abused, sexually and physically abused as children, that's not been dealt with. Where is the psychologist? Where is the therapeutic community? We are very good at hiding behind these words like 'the community', 'the therapeutic community', 'the clinical team'. When you lift the blind up about and see what's behind these sorts of easily thrown away statements, you find nothing is happening. Absolutely nothing.

Although I was aware of the poor work practices within this unit, I was shocked to hear the allegations of staff performing a cavity search. Placing this into context, it would mean that five nurses on one shift would have to be aware of the cavity search and that none of those nurses reported it. I was equally shocked that staff secluded a 21 year old patient naked without sheets or clothes. I was never asked to participate in such behaviours during my 12 months working within the unit. I was deeply troubled by the high amount of secluding people for punishment, by nasty comments made to patients and by the demoralising way relatives were spoken to and controlled. I had no idea that there were behaviours like this occurring in the unit and I was shocked by it.

How these archaic practices could be upheld in a culture based on such strong core values. The same staff member expressed his views about this:

If there is no privacy don't talk to me about dignity and compassion and equity and justice. If you want to know what justice is in the absence of these core values then go to a psychiatric hospital. There you will learn the

meaning of justice by being immersed in injustice. There you will learn the absence of compassion by being immersed in the power over and the lack of sensitivity towards human beings. In fact, in a hospital as you move amongst people, particularly in psychiatric hospital, you will see the opposite of those values. In the inter-play of so called service providers. Who would I give top marks to? The patients themselves would get ten out of ten for their care for each other.

They had no confidence in me, the fact that I was a pastoral care, they needed to tell someone. I knew that whatever I had to say didn't carry much weight because of their own perception of that form of advocacy. 'Your not a doctor', 'your not that', never did they know that my background had certainly qualified me enough to interpret and to make some, not only observations but some very clear diagnosis of this persons situation. Over and above their mental illness it was the treatment as human beings and yet there was those who were loud like this girl and this patient, there were some that were loud and you know they can get a lot of attention but the ones who aren't don't get any attention at all. What I am saying is that there are those who know how to ring bells and what have you. But these were skilled survivors, these were skilled operators.

It is a culture that is dehumanising because the people whom are caring often marginalise themselves of the reality of their experience of pain. We medicate it. I don't know what the answer is but I know what it isn't. The answer is not to treat them other than being human. I think it is an absolute disgrace that a Catholic/Christian hospital would allow for such activity to go on because quite frankly the psychiatrists and the super professionals don't feel accountable to

these people. If you don't feel accountable and no-one calls you by your name, sorry you're nobody. You're nobody and therefore you don't exist. Therefore the loss of story means the loss of life and I am sorry the acceleration of the loss of life, of psychiatric, mentally ill, homeless people is accelerated more than any other group in society. But they have one thing in common with the psychiatrist, the psychiatrist as a profession is one of the high risk groups, of suicide. So what is it that they have in common? They don't know who they are with each other. It is very sad".

Conclusions in regard to Values

It is obvious that the latter staff member is passionate about what he does and his interview was cathartic and emotional, but beyond that he managed to stay aligned to his values and to hear the narratives of the consumer and to be their advocate. In contrast the aforementioned female staff member took nearly two years to find common ground with management and to align her values in the work environment. I propose that urgent work needs to be done to explore the potential of synergistic values amongst consumers, staff and management of mental health services. The strength of these values has the potential to transform the relationships and the lived experience of the individuals belonging to each group. Values are strong pervasive influences, which have the potential to produce powerful synergistic effects on the work practices of staff, leading to benefits which can be reaped by those the service was developed for: the consumers.

CHAPTER 7

PARTICIPATORY ACTION RESEARCH

Action Phase Chapter

Consumer/Staff Development Work Practices Group Meetings

The following phase of this Participatory Action Research was the Action phase. In the original structure of the thesis this phase was expected to be at the beginning, where Consumer Consultants and Medical and Nursing Staff met together to discuss and develop new work practices within the unit. However, I was not able to achieve this step as I had originally envisaged it. Understanding this is invaluable to the unravelling of the nuances within the culture. It is my belief that the work practices within the unit were so poor and the nurses were so fearful of horizontal violence that they were unable to speak openly about their experiences. The forty individual interviews gave staff an outlet to debrief about their practices within the unit. Although the level of disclosures in regard to poor practice shocked me, it seemed that these discussions were important because their cathartic release facilitated a psychological space for the action phase to commence.

Formation of a Staff/Consumer Group

As previously stated in the Methodology section, the group was formed with the assistance of the Service Development Officer. Participants included two nurses, that is, the female charge nurse and a male nurse in his graduate year and two allied health professionals. A Doctor (psychiatric registrar) also volunteered for the group but resigned from the hospital prior to the commencement of the project. There were three consumer consultants, two were the staff members of the hospital that had been involved from the beginning of the project and a third person was an Aboriginal woman

who was an ex-consumer of this unit. She joined the research specifically to be in this project and is not a staff member of the hospital and has not worked as a consumer consultant before this time. The Koori (Aboriginal) consumer consultant was not employed by anyone and her participation, as was that of the previous payment to the other Consumer Consultants, was paid for out of my wages. The group ran for the 1.5 hours and for the full six weeks as had been arranged with management. It was clear from the first group that the Koori Consumer Consultant was adding great value to the discussions and with this in mind the unit manager invited the nurse allocated to Koori issues within the unit to join the group. This additional nursing staff member meant that there were three consumer consultants and three nurses which brought about an equality at least in numbers. The staff/consumer group was finally able to commence after many hurdles had been traversed.

It was explained that the group was formed to reflect on work practices that had been raised in the transcripts and to develop positive strategies in regard to improving work practices. It was made clear that the group was not to denigrate other staff members work practices, but to focus on positive changes.

Data from the Groups

During week one, the Koori Consumer Consultant talked about the Koori experience of the Mental Health Service and put forward some important ideas for change in regard to the care of Aboriginal people within the unit. The following recommendations were generated from the group meetings.

The Koori Consumer Consultant discussed the use of seclusion, saying that ‘if you lock up an Aboriginal person you will **exemplify and magnify their feelings of suicide,** locking up an aboriginal person is like giving them a death sentence’. She

stated that ‘confined spaces magnify rather than resolve’ mental health problems with Aboriginal people. Further to this, she proposed that if a Koori consumer *must* be placed in the extra care unit, it would be appropriate to give them a time limit, that is, a time when their status would be reviewed, so that they could see the possibility of an end in sight to the restriction of being in the ECU.

The Koori Consumer Consultant also noted that a holistic approach which was more in line with traditional ways of healing was missing from psychiatric inpatient care. She stated that this could be obtained by bringing in complimentary medicine practitioners to the unit. She suggested Massage, Reiki, Reflexology, Acupuncture and Spiritual healing would add a more holistic approach to the treatments available in the unit.

The Koori consumer consultant also stated that ‘unless you really understand Aboriginal culture, unless you are developing long term relationships and your face is seen in the community, you can’t expect an Aboriginal person to trust you’. This is an important understanding for staff members to embrace in regard to the type of relationships that need to be built to improve the relationships with Koori consumers.

It was also proposed that the Koori nurse Liaison spend more time at the Victorian Aboriginal Health Service (VAHS) and introduce as many nurses as possible to the staff and consumers there. The idea being that if nurses could build respect and a sense of community prior to admission, then the Koori Consumers would feel safer, having been introduced to some of the staff members prior to admission. It was noted that to go to the VAHS and meet Aboriginal people in their own space was quite a respectful thing to do and respect is paramount.

A further suggestion was that where possible, the Aboriginal person should have continuity of care and consistency, in that if they related well to a staff member, then every effort should be made for them to have that same staff member care for them during their inpatient stay. The Koori consumer consultant stated that ‘provided they feel comfortable with that person, having consistency is likely to meet the needs of the aboriginal person a lot more effectively because they are going to open up and talk more to that individual, which means their healing process is going to happen in a far more effective way’.

In preference to ECU and as a preventative measure, it was suggested that a quiet room be established for Aboriginal people to go to when they feel they need space from the others. It was suggested that this may prevent the escalation of unacceptable behaviours that could lead to being placed in ECU. This could also be a room where family members could spend time with the Aboriginal person, a place to talk privately with elders and a room where the Aboriginal person could have a sense of their own culture while in the unit.

In summary, it was agreed that the suggestions of the Koori Consumer Consultant were invaluable in creating a sense of community where respect and cultural understandings lead to a sense of being respected. The trust built within this community will assist in facilitating mental health.

Discussions in regard to ECU Practices

The Extra Care Unit and Seclusion areas were raised as issues to be discussed in the group meetings. The ECU is a locked area with a very small lounge room, three bedrooms and two seclusion rooms. The seclusion rooms are solid brick rooms with only a small window in the door for observation in the middle the steal door. The ECU

area backs onto the nursing station and this area has glass windows for observations, hence its colloquial name of 'the fishbowl' by staff and consumers. The ECU area was meant to be a quiet area, a non-stimulating environment. But at times, I would be in there with five really disturbed people on my own, all 'in each others faces'. Often it was a high stimulus environment not a low stimulus area.

To begin the conversation in regard to the ECU, I informed the group that the ECU emerged as a theme of contention in the original interview data. One of the nursing staff talked about a prior meeting where staff had voiced their concerns in regard to working in the ECU. One issue that was raised by a group member was how difficult it is for staff to work in this area. She informed the group that:

> *"A couple of months ago we had a discussion about ECU and people [Staff] get very uptight if they're in there too much. They feel it's unfair and I put forward a suggestion that there should be a thirty minute relief period every shift so the person [staff] can get out of there, have a coffee, go to the toilet, pick up things they need. People all said what a great idea, but it never, ever happened. That's a frustration that also adds to it and I was in charge maybe once a week at that stage, so every time I was in charge I'd do it and people would say 'this is great' and then the next day they'd say that it doesn't happen"*.

One of the consumer consultants who had been in the ECU many times himself, replied with "Yeah…it's amazing how if you're in an environment like that, just a little bit of leeway or freedom for half an hour can really help you through it".

For me, this was an important acknowledgement, that as staff members we can't bear to be in the ECU and yet we expect consumers who are mentally unwell to be able to stay

there for two weeks or three weeks without ‘going berserk’. One client I looked after had been in there for nine months and a great deal of that time in the Seclusion room, it is no surprise that over that period he became animalistic in his behaviours.

The Koori CC, talked about all the things we should do to keep Koori consumer’s out of ECU. Why aren’t we also under the same sort of pressure to keep non-Koori people out of ECU. She raised the question of why we have an ECU in the first place. The charge nurse stated that ‘There is a push though, at the moment, to try and reduce our use of the ECU’. A recent fire had prevented the use of ECU and staff did not have the option of putting patients in this locked area, yet they managed without it for many days. The charge nurse noted that:

> *‘It was actually fun too, because people were so relaxed, staff and patients…it was so much fun. I suppose too… I mean, there are ethical and legal things that can come out of that and the only reason why they probably don’t is because the person that is in there is too sick and their relatives don’t know the difference. But it’s only going to take one person who’s got a relative that’s powerful enough that can take it to a lawyer if they feel that that’s being abused and that’s something that you need to keep in mind. The other thing is that because there’s a policy, it doesn’t always mean it’s a good policy and especially not for Aboriginal people”. It’s just really not. It’s so destructive. Just really detrimental and it doesn’t aid the healing process. I think it inhibits it”.*

The charge nurse stated that the ECU should be used as ‘a final resort’ and that placing someone into seclusion should be seen as the next step on, ‘even more serious’.

"I think sometimes, and I know the staff members in here are probably sick of hearing me talk about it but they really have to think seriously before they use it. And make sure when they do use it, they use it properly, because it is a serious thing to have to use. I also trained and worked for 'x' amount of years without ever knowing what seclusion and what an ECU was because we didn't even have them. [She trained in Scotland]. I've never come across them before until I hit Australia".

This aligned with information gathered in the original data where someone else said that they didn't have them in their country either. If patients were feeling out of control, they would just go to their rooms and if they needed an injection they'd lie in their bed and get an injection, with no need for locked doors.

The charge nurse reiterated that "people find different ways because they have to. We find a different way to nurse. Because if it's there [ECU], then people use it…if they've got something there then they use it and if they haven't then they find an alternative'".

Discussion ensued about the ECU policy being reviewed at this time. What had surprised the Charge nurse was that recently she had a meeting with a doctor (psychiatric registrar) about the ECU policy and that they were naive to its existence:

'They had not read it and did not know it existed, so, that was a good place to start, you know, read it. Because the policy itself actually says it should only be used in these sorts of circumstances and the whole idea is to have that area open and not to have that area locked. But the way it's been used has been the opposite".

One of the CC's backed up the charge nurses suggestions saying:

> *"Well, hopefully, I think the way things have been going over the last ten or so years, ten or fifteen years, the ECU's are getting smaller and less people compared to what it used to be like. Maybe one day, hopefully in the near future, they'll be disbanded all together".*

Staff Fear

The graduate nurse's first experiences in ECU were recent ones and he had the courage to disclose to the group that he had been scared:

> *"Like, I had one situation where I was in ECU with a client who had just been brought in and he was quite aggressive and I was actually quite scared of this client. I think he might have been the only one in there and I was in there with him and I guess because of that I wasn't sure what to do".*

He informed the group that he was able to ask the charge nurse for help

> *"Yeah, she basically just took over, which I was glad about, because she knew that I was quite scared at that time and she just said, 'look, this guys going to need this and this and this' and he actually ended up needing seclusion and things.*

Although he did not tell the nurse in charge that he was scared until after she had taken over and the situation was in control for him. He did have the courage to discuss it with the charge nurse later and he was heard and encouraged to speak up about his fears earlier. This is a far more positive experience than the graduate nurses that were interviewed in the original data, who had felt thrown into ECU without support or experience in their first month in psychiatry.

The graduate nurse disclosing his fears to the group gave me an opportunity to discuss a theory that I had gained from my years of experience and from the original

interviews, that is, that fear underpins a lot of our work practices. And fear is a normal thing. If you are confronted with a consumer who is aggressive and dangerous, then fear is an appropriate response. Because our natural instinct is for survival and the reptilian part of our brain senses when we are in danger and will produce fear which will set the adrenaline cycle in place for our survival. Some level of fear is therefore important to help a staff member sense when something is not safe, too much fear may cause the staff member to overreact to minor situations and cause unnecessary distress to the client.

A further issue which had been identified from the original interviews was that graduate nurses in their first two weeks out of university were being placed in ECU on their own. In the transcripts one graduate nurse said that she was ‘proud to be in the ECU area that early’. For me this showed a naivety, because they didn’t know enough yet to know that they shouldn’t be there. This particular nurse had said that she had spent the first hour with their mentor and the mentor had said to her ‘you’re doing such a good job I am going to leave you here on your own. You’re really doing a good job’. And so the nurse actually thought, ‘wow, isn’t this good. You know, I’m sensible and I’ve got what it takes’. The consumer feedback on this issue was that a nurse needs years of experience to have ‘a bag full of strategies’ to use prior to placing someone in ECU or in seclusion. I believe that no matter how good the person is that in their first year out of university, in the first three or four months or six months, whatever it is, that they shouldn’t be making decisions about whether people get locked into seclusion rooms and they shouldn’t be under the pressure of being in ECU. This should be, because they do not have enough experience to give different strategies to consumers who are already at their tethers end or terrified. Further to this and in a more self-

preserving stance for the nurses, going into ECU too early puts them at a greater risk of 'burning out' far too quickly by putting them in areas where they can't cope and feel overwhelmed. It may also prevent them from a natural progression of building multiple strategies to use with consumers prior to going into ECU, that is, they may not develop the underlying strategies of prevention if they are working in the area of last resort.

The graduate nurse in the group had been working in the ECU area on his own, and felt safe because he had previously completed an aggression management training workshop. He felt supported by the other staff members on that day, however, they were not in the room with him, but available to him if he had a question, this is the beginning of a good change but needs to be extended further. A senior staff member with good work practices should be in the ECU that is in the room with graduates, and role modelling appropriate behaviours for new staff members. A staff member should be in there showing him how to deal with someone who is starting to escalate and how to engage with agitated consumers and how to de-escalate situations before they get out of control. Looking through the window and saying 'you're doing a really good job' is good, but it is far from perfect. If you're a new staff member straight from university and experienced staff are role modelling behaviours to you, then the staff member should be in there with you, not saying 'how did you go with your five patients today'. The staff member should be discussing and role modelling appropriate strategies and interactions with consumers. If this does not occur, the graduate will spend their years in psychiatry developing and accumulating their own work practices. They'll have flaws in them but no-one will pick them up because they haven't worked beside the person. At times their work practices will be criticized but their practices will be entrenched and more difficult to change. Supervision is also inadequate in the same way, a staff

member goes to a supervision session and talks about their work practices, but the supervisor doesn't know the person's practices well enough to be able to bring up the techniques that are inappropriate.

In opposition to this thinking, the trained nurse in the group felt that the graduate nurser's experience was a good one:

> *"On the other hand, I was here when he started in ECU and I can remember really clearly how we did it. What would happen was I think you simply don't get allowed to make decisions, do you. That's not what you're in there for. The slightest problem, it was brought to the attention of the nurse in charge. Someone was getting a bit agitated and often the nurse in charge was in and out, in and out. So, I think there was a fairly strong consciousness of when a person first goes in that you must not ever leave them to it, which is not fair. I don't think that's a problem here, do you?*

My challenge to this is that the staff member had only been an employee for three months. If he is in the ECU area, then he should be able to make decisions, and not have someone that he can call for help when something feels like it is going wrong. He needs a strong role-model in the room with him. The fact that 'it goes well' is not good enough here, structures need to be put in place so that the staff member is not 'baby sitting' patients, but an experienced team member that can be active and proactive in their care. This is one area where the patients are meant to be the most disturbed, so why would you not want the most experienced people looking after those clients.

Perhaps to lighten the seriousness of the conversations in regard to ECU, one of the CC told a story about when he was a patient in the ECU at Royal Park Psychiatric Hospital where the power bases were turned very quickly:

"There was a couple of us in the HD area. I was a patient at the time and there was a door that locked from the outside and a bloke in there who was pretty full on and he was in the bedroom in the seclusion room bedroom where they slept and he called the other people in and he organised… Sorry, there was three of us in there at the time and the organiser was the other guy who put on a bit of an act, a bit of a turn, so the three staff went in there and while they were in there the other bloke locked the door behind them and they were stuck in there. And so you've got three nurses and one patient in the room and two patients outside and the nurses were calling for me, saying, come on Leam, let us out. I said, 'yeah, okay, just hang on a minute'. I got to the door eventually, so that was pretty funny. Well, this other bloke wasn't going to let them out. They'd probably still be there".

The Consumer Consultants disclosures opened the door for others within the group to talk about their experiences: One of the senior nurses explained her story about being in the ECU in Forensic at Mont Park.

"A friend of mine was working on night duty and there was this particularly difficult patient and there were two that were playing up and they went into the room to deal with one and the door slammed behind them and the keys were in the door. And this really difficult violent man, I think he'd just murdered somebody, he came to the door and he was looking through and he's got every key to the building. And they're saying 'open the door' and they knew that he could just walk out. Eventually, he stood and looked at the keys and he kept them in there for half and hour and then after the half an

hour, he said 'I'll let you out' and they never told anybody. The never reported it. It must happen every so often".

The personal stories in the group allowed staff and consumers to talk freely about the ECU and this led to participants wanting to know more information about the extra care unit. For example one staff member had noticed that in the last few weeks most of the people in ECU were female. She asked the charge nurse if they could look at the ratio of sexes and time spent within the ECU. Most interestingly, she wondered if they could look at the reasons people were placed in there. Having the staff and consumer group meetings gave staff the time to reflect on work practices instead of just surviving the shift in ECU. Out of these conversations were emerging an interest in understanding the use of ECU.

With tongue-in-cheek, one of the Consumer Consultants said, "Well, we could close down the ECU tonight", the charge nurse responded with:

"We actually had the ECU closed upstairs for the last two weeks. We've had one client in there and she was in there for other reasons than the normal consumers would have actually been in the ECU. It's quite funny because we haven't had any great demand from the community for those beds and we actually thought we'd still fill the beds now there's nobody in ECU. It's quite funny. The ECU was closed because of the behaviours of the patient, which made it unmanageable to utilise ECU while the patient was in there and weirdly we did not have either".

One staff member proposed that the ECU doors be left open and I was able to tell them about a couple of times when I did just that. I actually work the ECU with both doors open, when I only had two or three people at a time. I told the consumers that you're not

meant to go out that door and if you go out, we will need to get someone to go with you, but I want you to feel that we're not actually locked in. I think it was a great success.

One staff member began brainstorming about the possibilities for using the area for artwork and a special creative space. " I really would love to try that."

It was noted that mostly when the staff members work in ECU they are stuck watching the television for hours on end. The consumer thought that the staff would be better off because they could leave the area and go to the office and write notes. However, the outcome of such a powerful suggestion to keep open the doors of ECU was not so that the nurse could be less involved in the consumers care (I don't have to be in there now), but rather a better environment for the nurse to gain rapport and develop deeper relationships with the consumers. The senior nurse stated that the interaction in ECU between nurse and patient can be less than anywhere else in the ward. This seems astonishing given that they are locked in together in a very confined environment. It is such a close environment, that sometimes, like an elavator, people don't talk to each other. Further to this, having keys gives nurses power and security. If we diminish the locked areas, then we diminish keys and barriers and therefore also diminish power.

Outcome

It was concluded that I should send the recommendations from this research to the inpatient committee.

Debriefing Following Seclusion

Another theme generated from the original data was that of debriefing patients as they come out of the ECU and seclusion. In the original interviews, only one staff member out of 40 people said that they debriefed patients when they come out of seclusion. And one other person said 'I told them, if they behave like that again, they'll

be right back in there.' This would not be considered to be debriefing, rather chastising. Therefore it can be assumed that appropriate debriefing was not occurring.

The debriefing I was proposing was as in depth as appropriate for the consumer. The most optimal being the staff member and the client trace back the steps that led to being placed in ECU and trying to understand how it happened and then developing strategies to prevent the same outcome again. Debriefing would then be a tool that is excellent for learning and a healing experience for all involved in the event. It's a great means for educating nurses on preventative strategies. Each step would be evaluated including any over or under reacting on the part of the secluding staff members. However, for this to occur staff members would have to be capable of being in a space where they do not merely justifying their actions, but rather being able to hear the narrative being delivered by the patient from the patient's perspective. Being in that space requires modeling and training. Given that no staff members said they were already debriefing consumers, a training course would need to be developed to address this.

It was noted that an award was won in regard to the policies of this unit and that there seemed to be an enormous cavern between the policies and the actual practices and that this was where change really needed to occur.

One of the CC's talked about how in one of the transcripts a staff member talked about how 15 people arrived in the unit to put a new patient into seclusion. He raised a very interesting point when he said 'imagine how intimidating that was and yet I wonder about the other consumers in the ward witnessing something like that and whether they would be debriefed about witnessing something like that. I know staff

members talked about it being traumatic and things like that, but what about all the other consumers in the ward".

The point made by the consumer was a really valid one and if the unit had more of a sense of community, then when things happened like that, we would have a community meeting and sit and talk to everyone about it. People would get a chance to debrief in a group and that could be staff members and consumers together. When someone's marched through the ward like that, it's frightening if you're a patient and it's frightening if you're a staff member too. As a staff member you might think, 'how are we going to cope with someone that takes 15 people to place in seclusion', as a patient you might feel terrified for yourself and the person involved, or you might wonder could that happen to you in the future.

In summary, the importance of debriefing not only to the consumers involved in an incident, but to the staff and other consumers is of high importance and it needs to be role modeled, encouraged and enacted within the unit.

Debriefing Following a Critical Incident

The hospital that the psychiatric unit is part of has a debriefing program in place. It is called the Critical Incident Stress Management (CISM) program and responds with critical incident debriefing and to individuals through peer support. However, in the year that I worked at the psychiatric unit there were frequent critical incidents, but I only attended one debriefing. In contrast to this, the following year when I worked in psychiatry in the emergency department where I attended four critical incident debriefings. During my employment at the hospital I was part of the Critical Incident Stress Management Debriefing Team. There were difficulties in the relationships between the CISM organisers and the staff of the psychiatric unit. Because the basic

premise of the CISM is *peer* support, that is, other staff at the same level supporting each other. Staff in the psychiatric unit felt that they did not want people not employed in psychiatry debriefing them, they also felt that as they were psychiatrically trained, they should be doing the debriefing and not people from the breadth of the hospital staff such as cleaners and ward assistants.

I raised a work practice with the Staff Consumer Group that I labelled as the second worst work practice that had been disclosed in the transcripts, that of secluding a young woman naked. I explained that my initial reaction was one of disgust, shock and horror, that in 1999, psychiatric staff could still be using archaic measures towards inpatients. Of course it is unacceptable to seclude anyone naked, whether they are a girl, woman, man or child. What was even more surprising was that it had occurred on a regular and often on a daily basis. Many nurses on the unit were aware of it and at least the six nurses on duty each time she was secluded naked and the charge nurse (who has since left). During the initial interviews for this project, the psychiatric registrar in charge of her care disclosed that she was also aware of this treatment. Yet, management informed me that they were not aware of this treatment at all.

The initial response of the Koori Consumer Consultant was very clear and strong:

> *"I just find that outrageous. I find it legally and morally outrageous. Because morally it is treating that person in a very undignified manner because no-one should be secluded naked, I mean, that's like what the Nazi's did to the Jews, right. It's just a total violation and total exposure for that person. And legally, it's a violation of human rights. It has really severe legal implications and she obviously didn't have the family support*

structures to fight it because if somebody was putting a relative of mine into seclusion naked, there would be hell to pay. The wrath of everything that I could muster would be brought down on that because that is just so undignified and because a person has a mental illness, they don't deserve to be treated like that".

The charge nurse was also very clear that this was totally unacceptable saying "She [the patient] should never have been placed into seclusion in the first place… But it's also an indication that whoever was managing this place at that time really had severe problems in terms of their management ethics and their fitness to be a manager".

What surprised me was that the Consumer Consultants who were employed by the hospital were not as shocked at this, even though they had read the transcripts of all the incidents.

I explained to the group that I believed that it was important to try and understand how a culture could sustain such derogatory practices. What would have led them to have such poor practices? In my discussions with participants in the original interviews, it became apparent that in the six months prior to the indecent seclusion, there had been a death in the Extra Care Unit. There was incredible fear; the nurses were frightened that they would lose another patient. The patient that was secluded naked had similarities to the girl who had died in seclusion. She was constantly suicidal; she had multiple suicide attempts, often daily suicide attempts on the ward. The girl who had successfully suicided in the seclusion room girl was also someone who had frequent and often daily suicide attempts and had told staff she was going to kill herself on the day that she did commit suicide. I proposed that staff actually dehumanised her in their minds, had actually pushed aside their ethical values and somehow weighed up

their values in their mind and came to the final determination that naked is better than dead.

Following the death of the young woman, I imagine that the nightshift workers involved were debriefed. However, I believe that we failed to debrief the rest of the staff within the unit, including all staff and patients. To my knowledge nobody actually ever assessed the impact that an incident has on work practices. I think this is a huge gateway that we can open and make a difference because I know that work practices changed enormously after that incident. One of them was that, work practices deteriorated to the point where a woman could be secluded naked over several weeks and that this did not filter through to management. The Koori Consumer Consultant pointed out:

> *"That keeping it a secret to the group meant that they knew it was morally wrong to do it, I think. If you're doing something and it's okay to do it, then you don't mind talking about it, but when you create that element of conspiracy and secrecy, which his what it is, to keep it in it's true perspective, then there's an inner knowing that what they're doing isn't right."*

The charge nurse added that "there may also have been fear, that whole thing of not feeling adequate in themselves and knowing that they've done that and that's the only way that you can deal with it. I mean, it's a vicious circle. If you don't feel supported then your work practices are going to deteriorate and you're going to end up doing probably very silly things. And then you do that and then you don't tell people because if you're inadequate anyway and you haven't got the support, so it just keeps perpetuating itself."

I added to the argument that:

> *"I think that these people, these staff members were out of control with someone that had been trying to kill herself everyday, day in day out, over a period of many weeks and they got beyond their expertise. They had no idea, they didn't have enough guidance, they didn't have enough expertise or support"*.

One of the Consumer Consultants raised the question of:

> *"Yeah, what happened at handover? I mean, what were the communications happening at that time. There would have been psychiatrists there. I mean, we say psychiatrists are the pinnacle of authority in the ward. If they were to report back and say 'this girl has been suicidal last night' and what action did they take, surely, I mean. I don't see how it could go unnoticed."*

The other Consumer Consultant suggested that it "would have been written up all over the place. It would have been on a file note, certainly they would have seen it. I think that's unbelievable that it went unnoticed."

I replied that it may not have been documented at all, there is no place on the seclusion to document what clothes the person was secluded in. On the forms when someone is secluded you have to sign them every fifteen minutes to say how they looked ie were they asleep or restless, but not whether or not they were naked. The charge nurse agreed while adding that the only place it says anything about clothing is in the policy. We are all well aware that policies are rarely read.

One of the allied health workers asked if this could be a one-off thing? When I suggested that this was not even the worst event that I was informed about he said then maybe they are just two things that went wrong. The allied health professionals walk

around the unit and speak to patients and staff members, but obviously had not noticed unacceptable practices occurring. The allied health professional had wondered if I had just highlighted these two because they were the only two that existed. He replied with, "I am sorry, I am not that critical of the service. I don't believe there are lots of unacceptable practices within the unit. I'm just expressing my disagreement quite strongly". I believe that this allied health professional avoids conflict, however, being outspoken about his disagreement had the potential to silence others and stop the honesty about the work practices and therefore inhibit change. Change can only occur if the discrepancy between acceptable and non-acceptable practice is highlighted.

Critical Perspective

It is totally unacceptable to seclude any individual naked. It is against human rights, against the Mental Health Act and degrades human suffering. All staff members who observed or heard about these practices (including the psychiatric registrar) should have reported this incident and ensured that it never happened again to this patient or any others. It is an example of controlling, dominant staff members who are ignorant to the rights of all human beings to be treated with dignity. Given that the staff members who psychologically and physically abused this patient had over 25 years experience in mental health, there is no excuse for such treatment. Strategies must be put in place to prevent this happening again.

Group Suggested Outcome

The charge nurse suggested that one way to address this is to broaden people's knowledge base in regards to working with someone who is suicidal and that the state wide training in progress at the time would address this. She believed that then staff would know that seclusion is not the only method. I noted that the behaviours were not

present when she was specialed (one nurse to one patient with continuous supervision). However, she did jump from the building and broke both her legs and was specialed after that time.

Management at the time had stated that with funding cuts employing agency nurses to Special patients was not allowed on a regular basis and was only to be used in rare circumstances. The current charge nurse informed the group that her stance was more proactive in that, ‘well, if you need to use it, you need to use it’ and that’s it and it doesn’t really matter and you can’t argue about that. Money can be found”.

Cases of abuses of human rights and dignity must be reported and the individuals held accountable if changes are to occur.

Debriefing after seclusion

The suggestions that came out of the group were that debriefing consumers and staff in

regard to all seclusions could prevent these behaviours being repeated in the future. The choice of who to debrief would be very important, for example, if it was management then perhaps information might be withheld from them. The past has shown that outside debriefing from people not trained in psychiatry and not seen as equal would not be accessed by the staff. The change needs to be managed in an educational way and not in a critical way. It is important that after critical incidents we must put checks in place to see how the incident has influenced work practices because critical incidents bring so much fear and they change the way staff members think and behave.

Outcome of ECU Practices

I proposed the implementation of debriefing consumers when releasing them from seclusion as an optimal work practice. My suggestion for optimal work practice was two-fold, firstly to debrief the consumer on their experience of being in the seclusion room and secondly when appropriate, to ask the consumer to trace the episode back to the beginning and find out where things went wrong and what could be done to prevent a similar episode from ending up in seclusion. Rather than this being only what the consumer did, it would also include how staff reactions also played a part in the episode. The outcome was excellent, the unit manager was happy to facilitate debriefing consumers when they come out of seclusion. The unit manager reiterated her vision of a unit where there was no ECU, saying that if there is no ECU then staff won't be able to use it and will have to use other strategies to assist consumers to cope when they are out of control. The unit manager also extended the proposal by suggesting that we collate feedback from consumers in regard to positive and negative experiences in regard to these areas.

Horizontal violence

I raised the topic of Horizontal Violence as one of the themes that emerged from original interviews. The nurse unit manager responded with the following comments:

> *"… doctors, tend to actually stick together and they back each other up. You'll never see them argue a point in front of anyone else. They all stick together, whereas nursing staff don't. Nursing staff are quite hideous really in that way. They're back biting all the time at each other and make noises. It's just a question of why that is. It's a big question. Whether it's the fact that it has been a subservient sort of group anyway for so long. Maybe*

that's one of the reasons why. We talked about it being very much female orientated and, you know, we admit…women are bitches'. All you can do is try and cut out that behavior, not to let if go by, actually to challenge it when it actually happens, at the time when it happens rather than, you know, somebody coming to you two days after the event and saying this happened and that happened, and then I ask them, well, what did you do, and they say nothing.

One suggestion from the group was that speaking up for yourself when the problem is happening should be a behaviour role modelled from the existing staff to new staff members. However it was felt that it was more likely that the new staff would role model the envisioned behaviours to the institutionalised staff. The consensus of the group was that the new graduates enter the workforce expecting professionalism and are shocked to see the horizontal violence that occurs.

The Charge nurse reiterated that it's the culture that needs to be changed, that the nurses need to do it for themselves within the culture.

One of the nurse participants said that:

'There has to be very clear management, doesn't there? Because one of the horizontal violence issues is giving someone you want to have a go at, the dirty job to do. I mean, that's horizontal violence. With a big smile saying, 'oh, by the way, you won't mind looking after such and such today, knowing it's a very difficult job and then that person has that job maybe three days out of five, comes into work angry ***but is not expressing it in any other way but getting tense and angry****. So, if the management says these*

are the guidelines, well, no, these are the rules. *These jobs must be shared around equally. I think these sort of things help a lot.*

I supported her stance by discussing my experiences within the unit of being sent into work in the ECU often 6-7 days in every week and having my name rubbed out of the roster. I talked about how I became a victim to a particular group within the unit. The Consumer Consultants were shocked that I could not get out of the ECU. I was surprised by my response when asked by the group what I would do if I had my time over again, in regard to Horizontal Violence.

"Now I would actually have a meeting and talk to people about horizontal violence, educate them. I would actually be very tempted to take out a law suit against someone, or just say to someone 'if you continue harassing me this way, I will go to equal opportunity and inform them that I'm being harassed in this environment and that it's an inappropriate environment.' I think it would only have to happen once for people to really get it. I don't think you'd even have to do it. People would only have to really get that you would not allow someone to speak to you or do that to you again and you would stop the cycle".

Logically, one of the Consumer Consultants asked "So what made you feel like you couldn't do that then?" I did try to do things about it, I spoke to management and I told them that 'this is what I did about it', but the core group of nurses would have been to management before me and created a scenario that was biased towards them, often fabricating complaints against me. I tried to be nice to the core group, I tried to ignore them, I tried to just be the best person I could be, I tried to talk to management about them, I tried to talk up in meetings but mostly to no avail. I thought that it was about

me, that it was something about my personality. It was only when I interviewed people for this research that I realised that I was just one person in a long chain of people who were being victimized by the core group within the culture. Staff explained to me during their interviews that when I went to tea, the core group of staff would plan what they were going to do to me when I got back. They were so confident about getting away with their abuse of me, that they discussed what they were going to do out loud. Other staff members did not want the same treatment as me and therefore did not make waves or stand up against their behaviours. I realised it was an across the board abuse and that if you weren't in the *in* group, then you were perpetrated horizontal violence on. And that's why I'm doing the research, because I want to make a difference so that other nurses can work in psychological safety from their colleagues. I don't want other people to be stuck in that victim role too. Because if nurses are bitchy to each other and horrible to each other, they are spending their energy and putting their energy into themselves and not being there in appropriate ways for their patients.

The Charge nurse restated her position:

> *"I still think it's about stamping it out, or trying to". It's just about acting on it rather than just sitting back on things. She cited examples "I mean, even the short time I've been here there has been a couple of incidents where people have brought things to my attention and basically what I've done is, I've actually got people to sit down with each other and face to face talk it out. In some ways, yes, you can bring it to management, but you really have to be doing it one on one. Okay, I'm the manager of the unit and I can deal with situations, but you really have to have the individuals*

actually talking to each other, otherwise it's just going to get absolutely enormous".

The Koori Consumer Consultant was also aligned to the ideology of the charge nurse stating that:

"When someone is taking a piece out of you and you know it, you have to stop it right there and then. You have to stop and you have to question it because what we do as human beings is we just try the polite way out. But when you confront a behaviour, and you don't have to do it in a bad way. You can say 'can you please clarify that for me? Is this what you're saying? Is this what you mean? Can you please explain to me what you mean by that?'. In those simple terms. It means that the other person is put in a position of explaining what is going on and that, to me, I thought is a really simple thing but whatever our emotional state is at the time, we don't always have the courage to do it. And I can say that I have been practising that I'll tell you what, it works.

Surprisingly the CC thought it was a 'funny thing that the nurses needed help with situations and that they felt subordinate to the doctors'. Even though these consumer consultants had been working in the psychiatric unit for the past 3 years, they had not noticed that the nursing staff members were struggling with their own interactions with each other. I propose that this is likely because they were not seen as 'staff members' in the full sense of the word. For example they were not allowed in the nurse's station and were not allowed into nursing handovers, so were prevented from being in the two main areas where nurses interact with each other and discuss consumers. The Consumer

Consultants were only privy to the interactions between nurses in the day room or corridor and therefore only viewed nurses in their powerful role.

Ego-state Therapy

Ego-state theory was a new concept to the staff at St Vincent's Hospital and no-one in the staff/consumer group had any knowledge of it. In the last week of the group I gave a brief presentation of Ego-state therapy. In this presentation I was able to use Ego-state theory to explain my inner psyche and what parts had been triggered in me whilst working in the unit. Further to this I was able to discuss my proposed theory of Organisational Ego-state Theory to understand the culture of the psychiatric unit. The theory was well accepted and I felt it was an appropriate way to summarise the work so far. Detailed explanations in regard to Organisational Ego-state Theory can be found in the next Chapter.

In summary, the six weeks of the group work with staff and consumers working together was highly successful. All participants shared candidly with each other and there was a sense of equality and freedom of speech. The proposed suggestions for change that came out of the groups have the possibility to affect change. The following is a one page summary of the group experience sent to me by the graduate nurse a few weeks after the group work had finished.

> *"As I walk in the door to the meeting room, I see chairs set out in a not so perfect circle, papers on the floor and a tape recorder in the middle, sitting on a table. Fear instantly struck me as I thought about that horrible monotonous voice that always seems to come out on tape. But most of all anxiety hit. I had never been in this situation before, being my first year in Psychiatry. My heart pounded and I was suddenly thrust out of my comfort*

zone, as the door was shut for the meeting to start. Unfamiliar faces met my eyes as we each introduced ourselves, and I suddenly realised that it would be almost impossible for myself to take a back seat in the discussions. I was the only person there to represent the nursing staff, much to the opposition to my previous thoughts. I thought there may be a few, more experienced nurses to comment on the nurses perspective. The meeting began and we discussed various items, my heart began to race when I was asked what my comments are from a nursing perspective. Managing to chain some words together, I said something that I hoped was intelligent and comprehensible. My anxiety lifted as the session moved on and I was able to freely contribute to the discussions".

Various sessions continued on a week to week basis, for approximately six weeks. As the sessions continued, it was inspiring and eye opening to gain other perspectives on work practices and views of nursing staff in particular on the ward. It was wonderful to receive the feedback from the Consumer Consultants, whom I had never officially met or spoken to before. As a nurse, or even any health professional, you tend to see things only from that profession's point of view, such as being a one eyed pies supporter, or something similar. With the Consumer Consultants involved, a whole new perspective and realisation was incurred, which helped me view my practice that much more critically than before.

The sessions continued, my anxiety ceased and things started to come into action, more people were involved and seemed to be gaining some benefit out of the meeting, and that is apart from the chocolates and cool mints that were provided.

When looking back it seemed the sessions progressed, as they should do, from a learning and getting to know each other phase, to what can we do and how can we do it phase. From this was the idea to develop a newsletter with consumer and staff involvement, as just one of the examples. The unity of the group developed into a team, we were all working for the one cause, the consumers, and joined together from our different areas to accomplish that goal.

Most of all, I believe we were able to learn and benefit from that experience. I myself learnt, apart from the fact that there is a lot to learn, that it is possible to work as team, like all the text books say we are doing. It is possible to better our skills and practices, and can be more effectively utilised and developed through input from the different disciplines in psychiatry.

Overall, the experience was valuable for my own learning and my own practice development, being able to comfortably sit down with different people and be placed out of my own comfort zone, to my practice and help in the service that our consumers receive.

CHAPTER 8

EGO-STATE THEORY

Theoretical Interpretation of Data

Overview of Chapter

This chapter explores the use of Ego-state theory in relation to the individual psyches of the staff members who work within the psychiatric unit. This theoretical part of the thesis will draw upon the personal reflections of my work history, as presented earlier, however, it is important to note that this part of the thesis was written after I was able to achieve a more reflective understanding of what happened to me in my work place and my understanding of what occurred to others within the workplace.

It begins with a definition of Ego-state theory and a brief look at its historical antecedents. This is more simply explained with the ‘circle of selves’ diagram. Following this, I will give examples from the data that led me to incorporate Ego-state theory into this thesis. I will extend the literature in regard to Ego-state therapy in several ways. First, I will apply Ego-state therapy as the model/construct to explore the work practices of individuals. Secondly, Ego-state theory has not, to my knowledge, been used before in an organisational sense. I propose to expand the findings in relation to Ego-state theory and practice by using it to understand my own reactions in the psychiatric unit, those of the individuals interviewed in this thesis, the culture of the psychiatric unit and the organisation to which it belongs.

I propose to further develop the concept of the organisation as an entity and view it as a living organism that responds to changes in its environment, just as within individual psyches where people respond with different parts of themselves. I will translate the ‘circle of selves’ diagram for individuals to the ‘circle of member-states of

the organisational' diagram, to explain the personality of the organisation. Examples from the data taken from interviews with managers and staff will be used to explore the concept of organisational Ego-state theory. I will suggest in the conclusion that this organisation is an entity, which responds to changes within its member-states in a similar way to individuals responding to Ego-states within themselves. This chapter will also include a treatise on the importance of the influences of the psyche of the individual and the people of organisations on the work practices of the individuals who work within them and the lived experiences of the consumers/inpatients who are admitted to the unit.

Ego-state Therapy Literature Review

The underlying principle of Ego-state theory is that the normal personality is segmented into parts (Emmerson, 2003; Schmidt, 2005; Stone & Stone, 1989; Watkins & Watkins, 1997). "These parts are termed ego states because, when a state is out, or conscious, we identify that part of us as 'me'. That is, we consistently have ego identification with the conscious state" (Emmerson, 2003). These parts of the personality or Ego-states are clustered together by similarities (Watkins & Watkins, 1997) . "An Ego state may be defined as an organised system of behaviour and experience whose elements are bound together by some common principle" (Watkins & Watkins, 1997, p.233).

Ego-state theory emerged from the psychoanalytic theories of Freud whose three part theory of personality included the id, ego and superego (Watkins & Watkins, 1997). This was later expanded by many authors, for example Paul Federn (1952), Helen and John Watkins (1997), Frederick and Phillips (1995), Torem (1993) and more recently Emmerson (2003; 2006). Transactional analysts purported that the psyche was

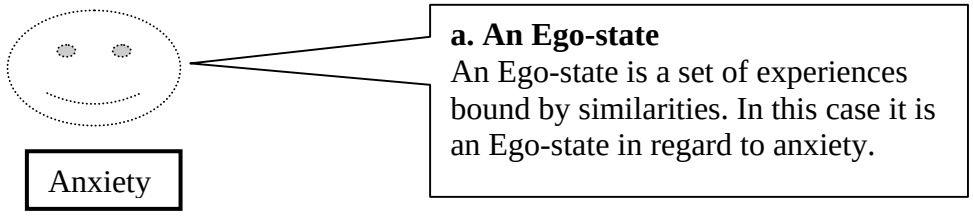
composed of five separate parts incorporating parents, adult and child parts (Berne, 1961; Emmerson, 2003). However, in Ego-state theory the individual has multiple parts to the self with states being specific to the individual (Emmerson, 2003; Schmidt, 2005; Schwartz, 1995; Stone & Stone, 1989).

Physiological understandings of ego-state therapy have been postulated by Emmerson (2006) to be linked to dendrite and axon development in the brain of the developing infant. Neural network models propose that connections between different neurons are strengthened according to experiences creating engrams (Hawkins, 2002; Schacter, 1996; Weiner, 1999) and may even begin with experiences in utero (Hartman & Zimberoff, 2002; Piontelli, 1992). Most authors agree that ego-states develop during the development of the personality and to a lesser extent can continue to develop throughout adulthood (Dyak, 1999; Emmerson, 2003; Emmerson, 2006; Stone & Stone, 1989). “They are a result of brain development. They are a result of axon and dendrite development early in life, of dendrite development later in life, and of the synaptic training learned through repetition at any time in life” (Emmerson, 2006, p.21). Ego-states are formed by the reoccurring firing of neural pathways and networks (Emmerson, 2006). A recent author has suggested that an ego-state is “an engrained neural network with a point of view” (Schmidt, 2005, p.2). In summary, Ego-state therapy is based on the assumption that brain growth takes place through reoccurring neural firing along neural pathways, and that through this ego-states and their associated behavioural patterns are formed, thereby postulating that ego-states are physiological (Emmerson, 2003; Emmerson, 2006; Schmidt, 2005). For example, if a child is beaten when their father comes home intoxicated then they might develop a part that runs and

hides when their father comes home. In later life this part might continue to remove themselves from people who drink alcohol or might run away from confrontation.

When Ego-state theory is used in clinical practice it is termed Ego-state therapy and it focuses on trying to resolve conflicts between the internal Ego-states of the individual using an eclectic approach of counselling and family therapy techniques. More recently, specific ego-state therapy techniques of talking directly to the internal parts of the person have been developed (Emmerson, 2003; Emmerson, 2006; Schmidt, 2005; Schwartz, 1995; Watkins & Watkins, 1997).

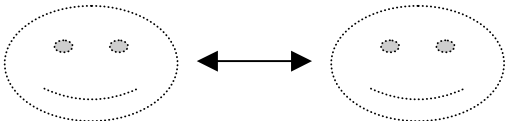
Figure 6. A diagrammatical representation of an ego-state



For example, an Ego-state may develop in relation to one's understanding of and reaction to authority figures. It is suggested that childhood experiences associated with authority figures will shape this part's reaction to authority figures in later life (Emmerson, 2003; Stone & Stone, 1989; Watkins & Watkins, 1997). As such, an Ego-state defines a person's behaviours in certain situations (Schmidt, 2005). While one Ego-state may define the behaviours in regard to authority figures, others may define behaviours in regard to love, jealousy, fear, commitment, values or power (Watkins & Watkins, 1997). Some authors suggest that an individual may be made up of over 100 Ego-states and that at least ten of those become executive (or active) throughout the day or week (Emmerson, 2003).

Ego-states have what is termed boundaries, which facilitate or inhibit communication between parts, with a healthy permeable boundary (Figure 7).

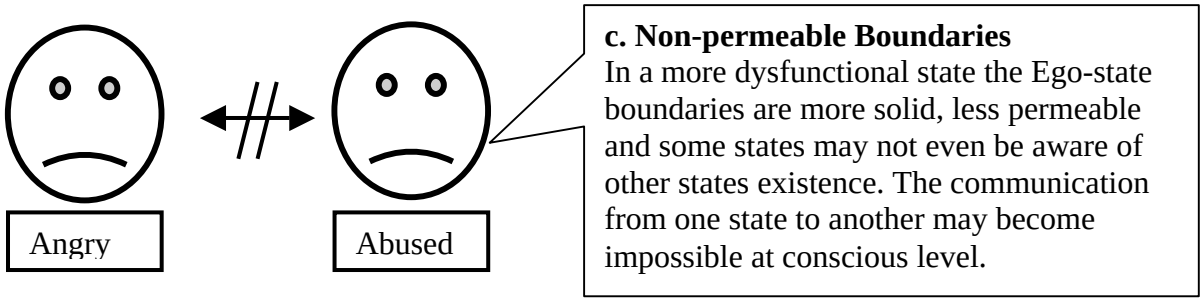
Figure 7. A diagrammatical representation of the boundaries of an ego-state.



Professional Mother

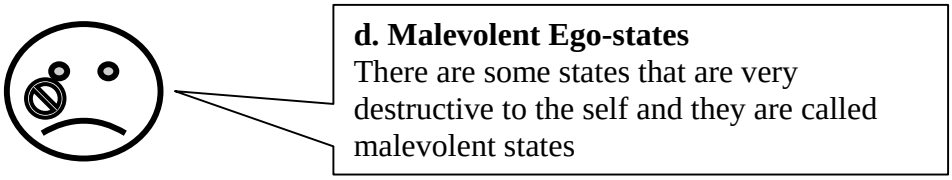
Ego-states communicate freely with each other. The rigidity of the Ego-state boundary relates directly to which end of the adaptive or maladaptive continuum the Ego-state will belong (Emmerson, 2003). For example, a child that has been sexually abused may develop strong impermeable boundaries (diagram part c) to protect the self from constantly communicating from state to state the psychological pain associated with the abuse. Ego-state boundaries may be so impermeable that Ego-states become split off leading to Dissociative Identity disorder (Multiple personality disorder)(Watkins & Watkins, 1997). A common example of a lack of communication between states is the sudden awareness that the last 10 minutes of driving is unremembered. Following an ego state change, the driver has no memory of the thoughts or actions of the previous state.

Figure 8. A diagrammatical representation of non-permeable ego-state boundaries.



There may also be malevolent Ego-states that are destructive to the self (diagram part d).

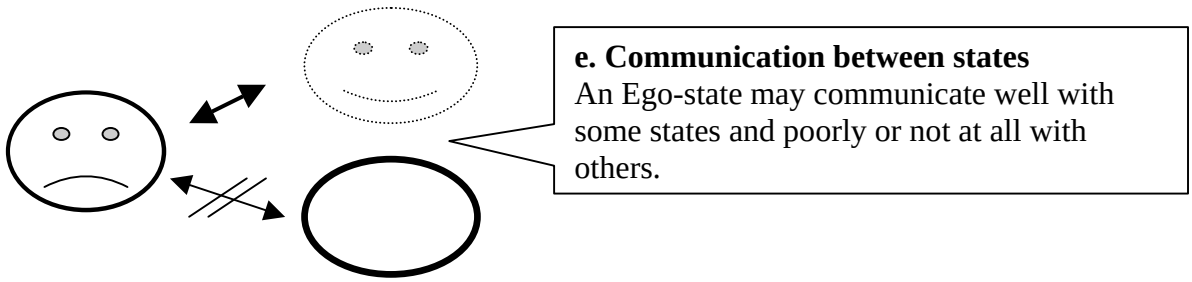
Figure 9. A representation of malevolent ego-states



When malevolent Ego-states are executive or active, the individual is more likely to engage in self-harm behaviours or be actively suicidal (Watkins & Watkins, 1997). These states are either aggressive towards others or destructive towards the self.

Communication between Ego-states can be varied. For example an Ego-state may communicate well with some other Ego-states and not communicate at all with others (Figure 10).

Figure 10. Communication between ego-states

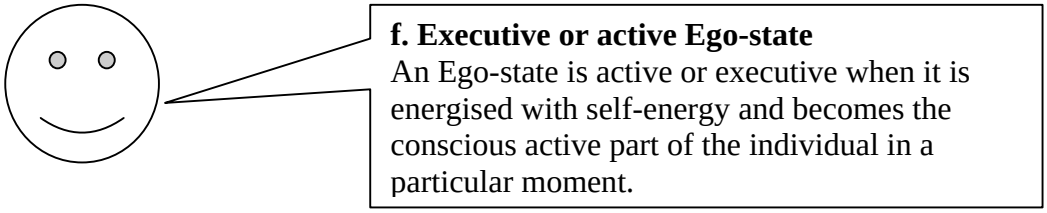


Ego-states may be surface states or deep underlying states. A surface Ego-state is one that is frequently conscious, is said to be able to retain memories of the experiences of other states and is 'most often executive…and experiences normal daily functioning'(Emmerson, 2003, p.7). An underlying state may be very deep or close to

the surface and its level of communication between the states may vary considerably from no communication to adequate communication and childhood memories, the good and the difficult are usually held by the deeper states .

An Ego-state is executive when it is the conscious part of the individual. If an insecure, reactive state is executive the individual may be angry and defensive, but if there is an ego-state change, and a more reflective, understanding state becomes executive and the individual may feel and demonstrate understanding behaviour. The executive state may change from one to another in a moment.

Figure 11. A diagrammatical representation of an executive or active ego-state



Ego-states also cluster together with other Ego-states to form groups of selves. These groups of Ego-states are similar to a family; hence I have called them a ‘family of selves’ who have varying relationships with each other. For example, a weak and vulnerable part be attached to a strong part for protection or relate more frequently to other parts who feel afraid .

Figure 12. A diagrammatical representation of clusters of ego-states

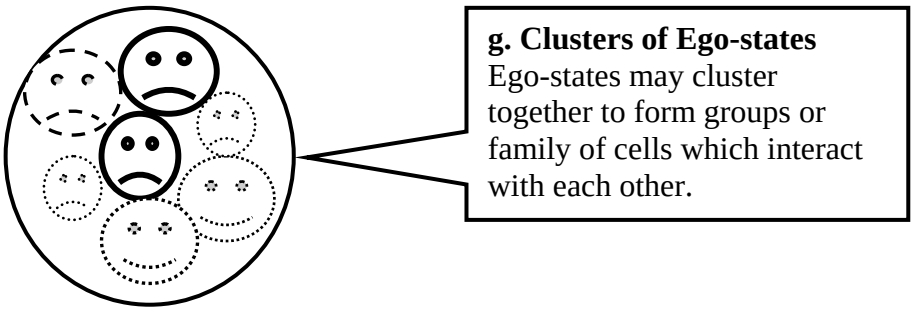
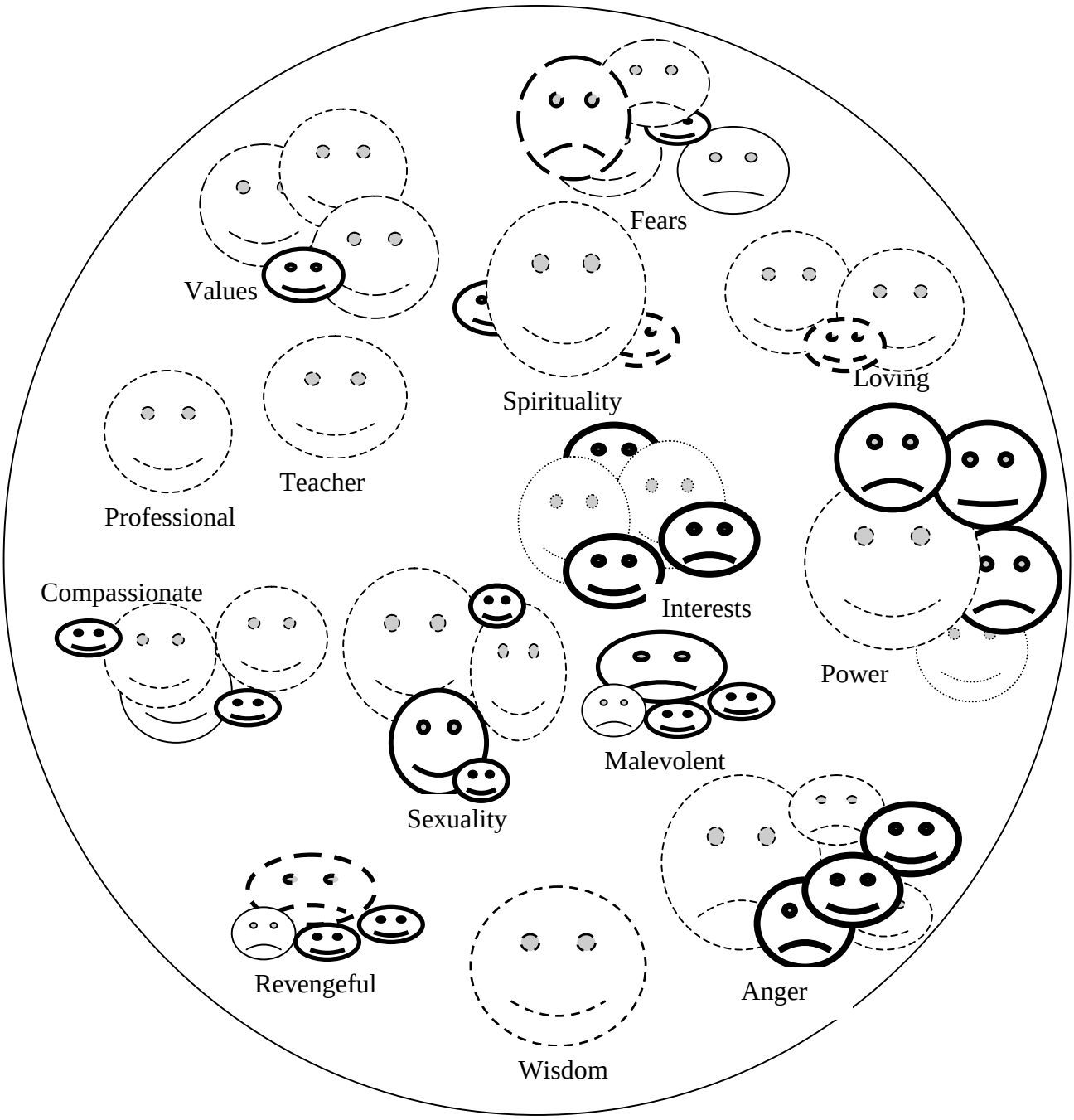


Figure 13. The Circle of Selves: multiple ego-state themes within the individual



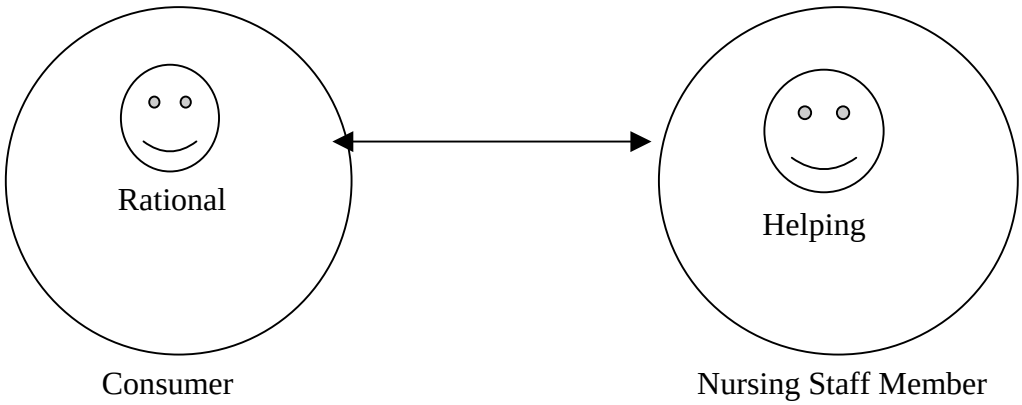
Examples from the Data

The following examples are taken from the data of the thirty eight of staff members. Many examples from the data demonstrate staff members oscillating between states as they reflect on their work practices and as they tell their stories in regard to their experiences.

Participant 1.

This participant is a female nursing staff member who was responding to a question regarding her experiences of poor practice. She responds by saying that 'sometimes a consumer presents as though they want to make a difference in their life, they want some help and they can recognise that they're unwell for whatever reason'. The staff member is describing an executive part of the consumer that is rational. This rational part in the consumer wants help and thus triggers a corresponding part in the nurse, a helping part, which wants to help others who are mentally unwell.

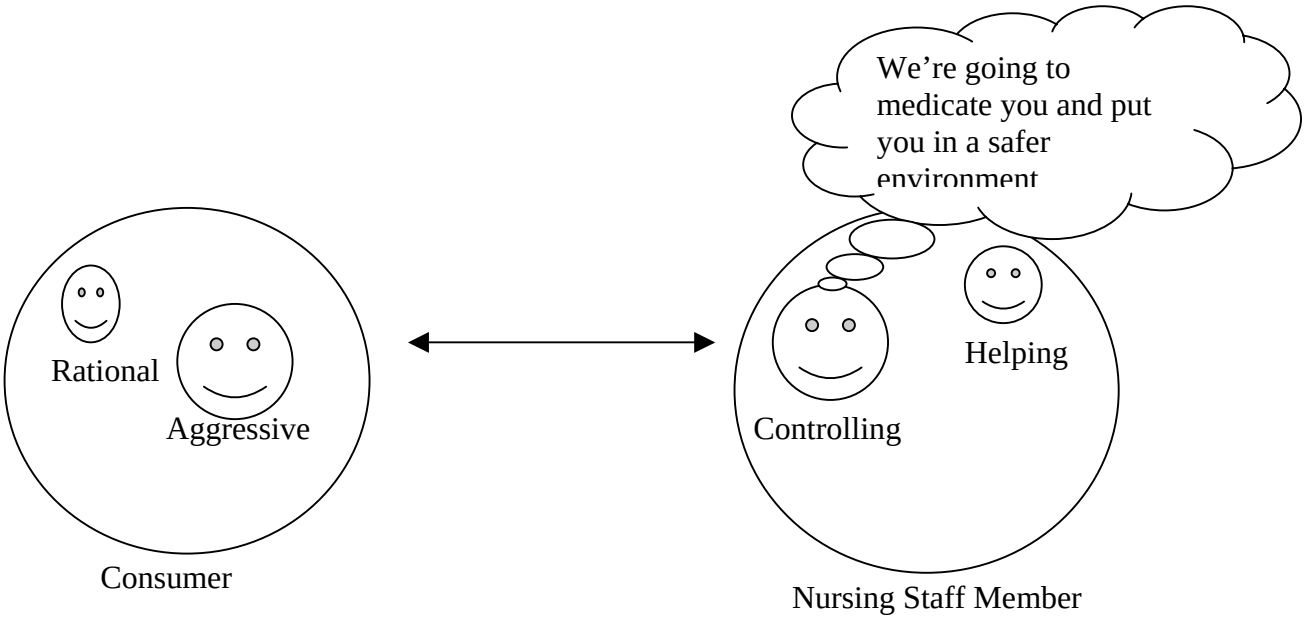
Figure 14. Helping response of nursing staff to rational need of consumer for help



However, in psychiatry, consumers can change parts (ego states) very quickly and the staff member explains her experience of this in the following way: 'and then all of a sudden they change and they become quite aggressive and quite threatening'. This

indicates that the consumer has shifted to another Ego-state, particularly an aggressive one. The staff member then reacts by triggering a state that she finds it traumatic to be in, a controlling state, one that finds her in a position where she believes she needs to seclude the consumer. The nurse states that ‘especially if you have a good rapport with someone and then you’ve got to put on the big, *we’re going to medicate you and put you into a safer environment.*… and that’s really traumatic sometimes’

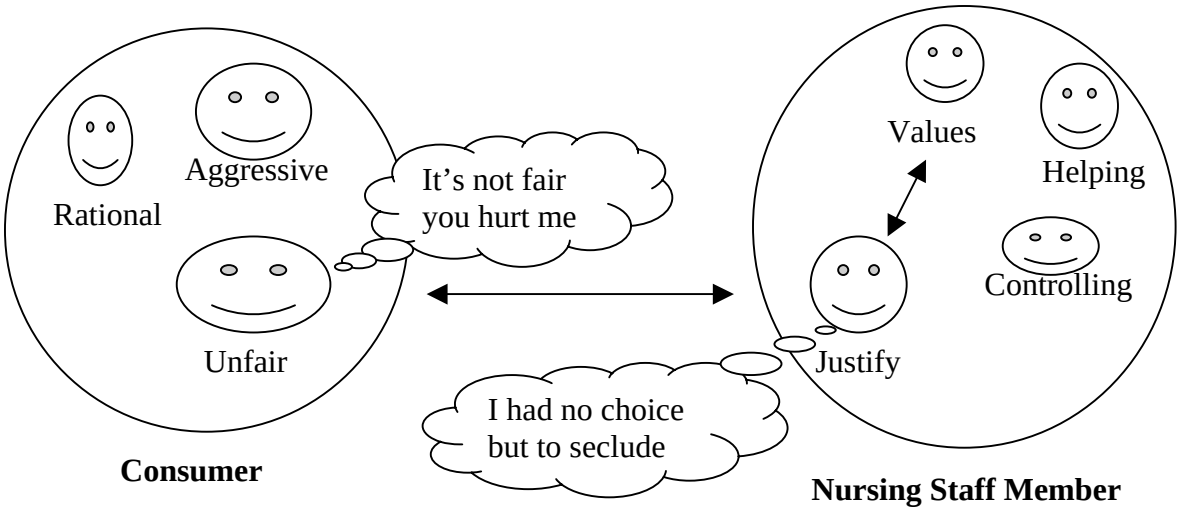
Figure 15. Controlling response for safety



It appears that at the same time as being controlling, this staff member also has a part in the back of her mind, reminding her that the consumer is going to remember the seclusion and be emotionally hurt by it. Perhaps the part within the staff member may have been a part that holds and informs the person’s values, indicating that secluding a consumer goes against the staff member’s core moral judgements. This can be evidenced by her continuing statement:

This nurse expresses thoughts in the back of her mind reminding her to minimise the trauma, that even when she is secluding a consumer, there is still a part of her that is considering the effects of the trauma that the consumer is experiencing. Further to this, I propose that when the consumer moves from their aggressive state into a traumatised state and expresses how unfair the treatment was, this triggers the nurse to respond from a position of justification, but in this case one that is informed by values. The following figure demonstrates the Ego-state of the consumer and the staff member in this scenario.

Figure 16. Ego-state of the consumer and the staff member



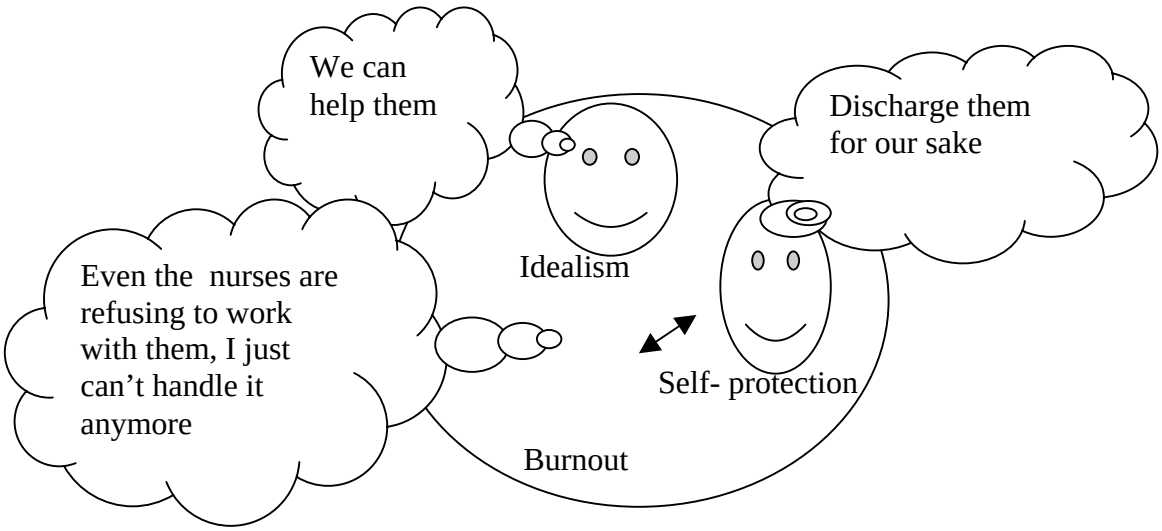
The following interview is a female psychiatric registrar, who is a medical doctor training in psychiatry. The doctor expresses an Ego-state that is in a self-protective mode, one that is protecting her own interests. .

> " We've got a patient on the ward who is a particularly severe personality disorder. Which I think all of us find, well the vast majority find, exceedingly draining to work with. And, there are some nursing staff who say *"I'm not going to work with them any more, I just loose it when I do, I*

just can't handle it anymore"…that sort of thing…and I try to get them discharged as much for our own sake as anything else".

In this example the doctor begins by stating that person is a severe personality disorder, perhaps justifying to herself that this case is extreme. She further justifies her position by stating that even the nurses are 'refusing to work' with such patients, finally admitting that she tries to discharge them as much for 'our own sake (staff) as anything else. In other parts of this doctor's transcripts it is evident that she has high moral standards and values, and as such would not be able to discharge a consumer for her own good. She then justifies that the other staff members are unable to cope with consumers with severe borderline personality disorder and that everyone (not just herself) would be better off if they are discharged. She also sees a culture of burnout as the following quotations suggest:

Figure 17. Burnout



"I see a culture of survival where the staff is attempting to survive the job, which I think emotionally survive it and protect themselves from further

burnout. Yeh, then there's also a culture of wanting the really, what's the word - idealistically wanting to help. And those two can clash I suppose. I see a culture of general good will, trying to work together. Trying to tolerate really, quite emotionally difficult situations, but I think, finding that very difficult" (Psychiatric Registrar).

The clash that the psychiatric doctor describes is between burnout and idealism, and fits well with the notion of Ego-states having ideological clashes and depending on which part is executive or triggered depends on the action that a staff member might take in regard to work practices.

Many of the staff members interviewed talked about themselves and the consumers in parts. The following example from the transcript is a psychiatric doctor identifying that parts of the consumers triggered similar parts within themselves:

Psychiatric Registrar: Part of it [hopelessness] is from the patient, part of it is communicated I believe, from the patient to us, that they in their heart of hearts at least part of them really truly believe that there's nothing that can be done to help them. And part of them I think wants us to experience that futility that they experience, wants to share some of that hopelessness with us. And so we, yeh, however they do it unconsciously, non verbally communicate that and by their actions communicate that to us and share it with us and we end up feeling very much the way they do.

Organisational Ego-state theory

As previously mentioned, Ego-state theory has not been applied to the organisation in the past. I propose that the organisation becomes an active organism when it responds to the nuances within the culture of the psychiatric unit. Likewise, the

culture of the psychiatric unit responds to the actions of the individuals within it. The internal parts of the individual then respond to triggers within the culture by activating internal Ego-states to cope with the individual's situation at the time. Viewing this sequence in reverse, the individual may encounter a situation that is unacceptable to his or her conscious state, this may cause conflict and the individual may activate other Ego-states to cope with this. This change in personality part then influences others within the culture of the psychiatric unit, who may activate a different Ego-state to cope with the alteration to the culture. Any change in the culture of the psychiatric unit may cause a response from the organisation overseeing it. In this way the organisation reacts and responds to changes in similar ways to those of an individual.

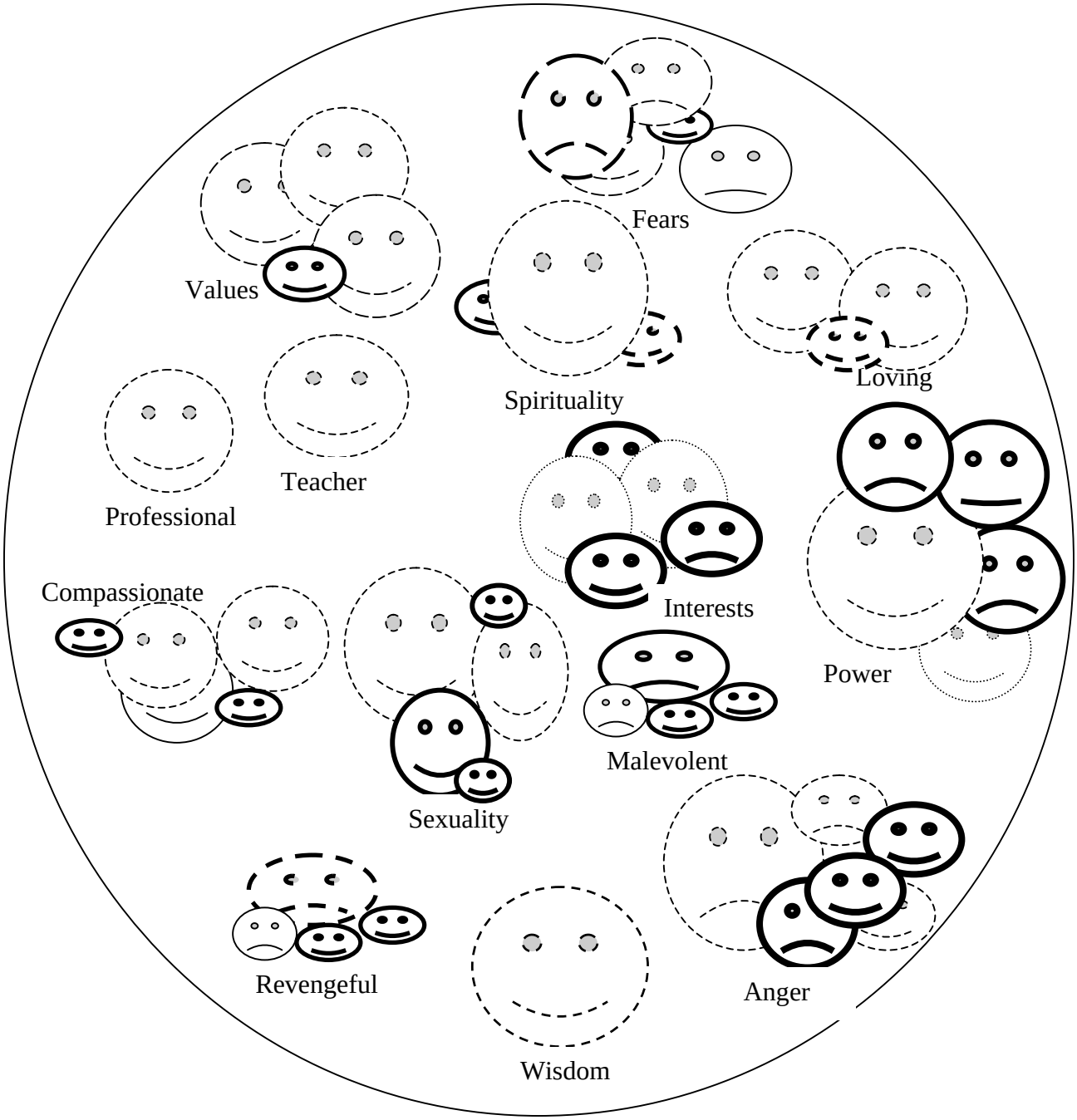
The values, power and interests of our society shape the health sector. The organisation (in this case the hospital) is mandated to base itself on the funding and policies of the government of the time. In turn, the psychiatric section of the hospital is mandated to have its core policies and procedures firmly based on the Mental Health Act (1986) and its more recent amendments. The aforementioned sets the parameters for the functioning of the acute psychiatric unit within the mental health service of the major public hospital. However, within these parameters are the individuals who through their own values, power and interests, shape the culture. Not only do they influence their external environment (the culture of the psychiatric unit) but they also influence their internal world through conflict or resolution of their inner states. I propose then, that a shift in the microcosm of the inner-selves within the individual has the potential to have a responding shift in the macrocosm of the organisation.

The individual is composed of multiple Ego-states or inner-selves. The state which is executive or active at any particular time is triggered by something or someone

in the external environment. These states are commonly known as the family of inner-selves that reside within an individual. Watkins and Watkins (1997) talked about malevolent Ego-states, that is Ego-states that are malicious or hostile, while other Ego-states may be gentle, loving and kind. There are Ego-states that uphold strong values, whilst others may hold onto power or interests. There may be up to 100 Ego-states within an individual, and approximately ten which an individual may be conscious of at any one time. These 100 parts may be clustered around themes such as reactions to authority figures, values, power, interests, self-efficacy, self-esteem or sexuality.

In a similar way the psychiatric unit is made up of 30-40 people who group themselves into cliques that often cluster around different belief systems in the unit. For example, those who are more authoritarian in approach and those who are more compassionate in their interactions with consumers. There are also cliques of those who are more focused on their personal interests of being promoted, whilst another group may be more interested in just getting the job done. Belonging to a clique gives the individual a sense of normality and security as they align themselves with like-minded others. Just as within the individual the parts or Ego-states can be in conflict and hold opposite beliefs, the cliques with the unit can be in conflict with one another. Individuals may also move between one clique to another, thus changing alignment with different groups on different issues. *Figure 17.* Circle of member-states of the organisation clustered into cliques themes.

Figure 17. Circle of member-states of the organisation clustered into cliques themes.



I propose that the psychiatric unit itself is comparable to a family of selves, with the individual staff members becoming the Ego-states of the organisation. The new term of *member-states* will be used to describe the staff members as Ego-states within the

organisation. The themes or clusters that Ego-states form within an individual can also be mirrored within the organisation through staff member alignment to groups or cliques. These will be called *clusters of member-states*.

Some parts within the unit are specifically influenced by the Mental Health Act, especially those parts within management who write the policies and procedures of the unit. Other parts maybe more activated by safety concerns and fears. Just as there are malevolent states within the individual who have destructive behaviours, there are also member-states within the organisation who poor behaviours (ie secluding people naked for punishment). These parts are often repressed by the culture via the code of silence of the other people within the unit, sometimes to the point of denial of their existence. Although some of the behaviours are known by the organisation (through client complaints) they deny their existence as widespread or recurrent and as such this denial and repression prevents acknowledgment and the possibility for change. Just as the individual must be willing to fully explore their internal selves to facilitate change, the organisation must be willing to illuminate that which it is trying so hard to repress.

Within this research I acknowledge the existence of the darker side of the culture of the psychiatric unit. It is not my intention to only illuminate the darker side but to illuminate the functions of the parts of the unit to find the windows of opportunity for change within the culture of the psychiatric unit.

Unexpectedly, the interviews conducted in this research became cathartic releases for the individuals within the unit. Being interviewed, gave staff members an opportunity to be really heard and for their voice, opinions and conflicts to be documented anonymously. Previously, I had been focusing on trying to illuminate the darker side, the malevolent member-states of the unit and as such giving them more

power and also sending them more underground or repressed. Following the cathartic release through the interviews the need for this lessened, and I was then able to redirect energy to illuminate futuristic and optimal visions, less energy is then expended into the dysfunctional parts.

For the organisation to change through Organisational Ego-state therapy, it must be ripe for change and must be willing to learn and change through illuminating the dysfunctional parts and negotiating and resolving conflicts with those parts so that their energy is redirected towards the optimal vision of the organisation. It is important that the bad parts be acknowledged but not to get stuck on them. Sacking people who are actively behaving badly will not facilitate permanent change, as others will always step into their place. Just as within the individual if a therapist tries to send parts away they get stronger and more malevolent, so too individuals who are targeted for poor practice in a psychiatric unit become more controlling and destructive.

The following examples from the interview data may illuminate the theory that I am proposing.

> *Nursing staff member: 'There was one recently, it's fairly fresh in my mind, about a month ago, a client who suffers from borderline personality disorder was attempting to self harm ended up ... I don't know how to say ... in seclusion, with no clothes on because she kept putting them around her neck ... um ... and medication was refused for this client because she was manipulative. And I felt quite disturbed by that personally, because I thought that this client would need something, because she'd worked herself into a state by which she did need something to help her ... and she actually got very upset about it, to the point where she actually wrote a letter to the*

ombudsman and to other people and made a complaint about it, that she'd been refused medication. I mean, she'd been attacking staff and all sorts of other people, and I just think, it was just really hard for her, it was hard for me, because I do honestly believe in giving medication to people who are needing the medication. And then in fact she said she felt so frustrated that she attacked one of the staff, and, well, you can't attack a staff member and then go around expecting the staff to stay too close to you, either, cos they need to keep safe, I mean, it depends on the situation … Yeah, it was … it did upset me a lot, and I thought … I don't know, that was a pretty negative experience for me. I felt very apprehensive about it.

In some ways I did, but in another way I felt helpless. Because I wasn't actually allocated to the patient, and I wasn't in charge of the shift, so I was sort of like an onlooker. So I sort of felt responsible and yet … not there, if you know what I mean, I was there but I wasn't there. Fortunately nothing happened, I'm really glad about that. But it did disturb me.

This is an excellent example of the staff member negotiating between the different Ego-states in her mind. She knows it was a negative experience for her (therefore the first part that is activated experiences negativity). She states that she believes this patient needs medication that is being denied. She felt 'disturbed by it', this is her strong values part that wants to uphold this persons rights to be medicated in a seclusion room. Following this she raises several different internal parts 'in some ways I felt helpless (the helpless part) …I was sort of an onlooker (a part that dissociated from the experience, but observed) I sort of felt responsible (a responsible part) fortunately nothing happened (lucky part), I'm really glad about that (a relieved part), I was there

(executive part) but I wasn't there (dissociated part), but it did disturb me (disturbed part). Perhaps it disturbed her because an Ego-state in regard values was activated, informing the person that what was happening was unjust. But rather than act on these values, the individual dissociated and tried to tell herself that she was not in charge so it was not her responsibility, yet, she battled with this causing conflict in her inner selves. However, as part of the culture or the organisation, she maintained a code of silence. This means that a group of 4-5 people managed to seclude a consumer, naked and without medication, and yet no-one higher up in the hierarchy was informed of it. It is as though the people who make up the culture of the unit repressed this unacceptable group by their code of silence instead of illuminating it as a conflict that needed resolution. This is similar to how individuals repress unacceptable parts of themselves and keep them at an unconscious level.

Parts of the Unit

As previously mentioned the individual's Ego-states in people are triggered by stimuli in the environment. For example, a critical incident in the unit will most likely trigger different emotions in different people; fear, anxiety, control and even aggressiveness in staff members. What was particularly interesting in this research was that individuals within the psychiatric unit are at risk if they do not belong to a group of like-minded people, therefore, they form groups or cliques. These cliques form powerful alliances within the unit and are sometimes at opposing viewpoints to other groups within the unit.

Hostile environment

Different people will react to different situations depending on their engrained neural pathways. If someone was victimised as a child and learned to react to the hostile

environment with feelings of being like a victim, weak, vulnerable and disempowered, they may avoid conflict as an adult. It appears that staff members aligned themselves to similar people within the unit and formed groups that withdrew when they sensed a hostile environment and become disempowered onlookers, backing off and staying out of trouble, out of the way. Whilst other staff members formed alliances within the unit that might react in a more controlling way and aggressively seclude someone. This group of people in the unit are the ones who felt that they did not know if they could rely on me, because I was not like them.

So where did that leave me in the group alliances. I propose that this is where it is more obvious that I was labelled a 'loose cannon', not really belonging to any particular group. I tried to find like minded people who wanted to uphold human rights, but these people were unable to tolerate the horizontal violence afforded to them and soon joined groups that backed off and stayed out of conflicts. These groups or alliances that formed within the unit helped people to feel safe because they were backed up by other likeminded people. Each group has their own way of reacting that assists them to cope with the conflicts from staff and patients that occurred on a daily basis. Anxiety was increased when the groups were forced to act in ways that were against their alliances, just as anxiety increases for the individual if they are asked to do something they do not feel capable of doing.

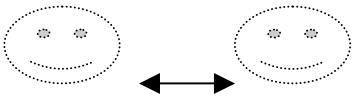
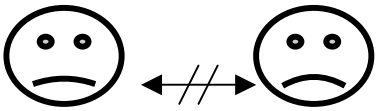
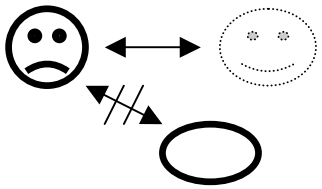
Group Alliances within the Organisation.

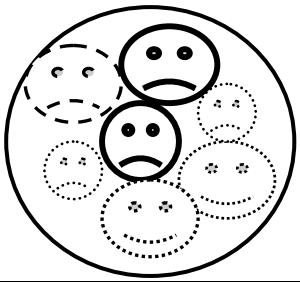
The nurses talk about themselves in cliques and alliances for example "*with some colleagues we have a similar understanding, a similar desire for direction and achievement…especially with certain groups of people.* Often staff talked about *the group* meaning the group that dominated the unit and perpetrated the most horizontal

violence. Generally, they weren't named with most people saying " *you know who we mean"*. This is very similar to individuals with dysfunctional parts not wanting to talk about the darker sides of themselves.

In line with Emmerson's (2006) neural network theory for the individual, I propose that the organisation is as an entity that also has set neural pathways that it responds to triggers within the culture. The same incident could trigger different responses depending on which member state was active or executive at the time. For example, in one of the transcripts the psychiatric doctor talked about a consumer that was allocated to be under her care. She explained that the consumer was secluded naked and not covered by sheets or any other material. I believe that the staff members felt hopeless about this client, who self-harmed on a daily basis. In their effort to stop her self-harming she was stripped of everything, but she would either self-harm in seclusion or when she was taken out of seclusion it was not long before she self-harmed again. Seclusion was not meant to be a punishment, it was meant to keep people safe from harm. Trying to understand this from an organisational Ego-state perspective, the organisation responds to danger, extreme behaviours and disobedience with 5-6 people controlling that person and placing them in seclusion for time out. Often the time out was for the staff member rather than the best choice for the consumer. Over decades this pathway of reacting with seclusion or extreme physical restraints has been embedded in

Table 11
Individual Ego-State Compared to Member-State

Individual Ego-state of the Individual	Diagrammatical Representation	Member-state of the Organisational
a. An Ego-state An Ego-state is a set of experiences bound by similarities. In this case it is an Ego-state in regard to anxiety.		**a. A Member-state** A person within the workplace that is bound together with other staff members by similarities in experiences and/or by necessity through being rostered on together
b. An Ego-states permeable boundary The boundaries of Ego-states are usually permeable with one state being able to communicate or gain information from another.	 Professional Mother	**b. A Member-state's permeable boundary** The boundaries between Member-states (people) in a healthy organisation are permeable with one person being able to communicate or gain information from another person.
c. Non-permeable Boundaries In a more dysfunctional state the Ego-state boundaries are more solid, less permeable and some states may not even be aware of other states existence. The transition from one state to another may become impossible at conscious level.		**c. Non-permeable Boundaries** In a more dysfunctional organisation member-states may withhold information from each other and have a them-against-us mentality which prevents communication
d. Communication between states An Ego-state may communicate well with some states and poorly or not at all with others.		**d. Communication between states** Some member-states in the organisation may communicate well, while others do not communicate at all

e. Executive or active Ego-state An Ego-state is active or executive when it is energised with self-energy, becoming the conscious active part of the individual.		**e. Executive or active Ego-state** Member-states in the organisation are active or executive when it is given energy by the organisation. A member-state may be may be energised through power obtained by distribution of resources, hierarchical or political status or by its allocated role.
f. Malevolent Ego-states There are sometimes states that are very destructive to the self and they are called malevolent states These parts can be overt or covert		**f. Malevolent Member-states** There are some people are staff members within the unit who are destructive to the functioning of the organisation as a whole. These member-states can be overt or covert.
Ego-states cluster together or gather other Ego-states that have a stake in the problem.		Member-states cluster together in groups or cliques within the organisation. These cliques may form because of like-mindedness fears or through necessity.

the organisation of psychiatry. I believe that when the nursing staff feel afraid or sense a situation getting out of control, that it fires off this automatic reaction of placing people in seclusion or the locked area, in an effort to contain the situation. This reaction is an engrained one. I coin the phrase *engrained automatic response (EAR)* in the organisation, to mirror Emmerson's (2006) firing of neural network pathways for the individual.

In the life of the new psychiatric unit in question, a greater majority of the staff members came from the institution and had over decades cemented their automatic ways of firing their engrained automatic response. Being amalgamated with different staff members who already worked in the hospital meant that the core group of nurses had to fight to maintain their engrained automatic response. They did this through horizontal violence.

How an organisation handles complaints highlights particular engrained automatic responses. There were many complaints made by the psychiatric consumers and/or their relatives. These complaints were directed to the complaints officer of the general hospital. I was working in the unit on one of the days when the charge nurse came in to the office to say that the Officer in Charge of Complaints was coming to the ward to address complaints by the patients that they were locked in the ECU with no staff members present to supervise the consumers and that they felt abandoned and afraid, especially given that people in that environment were there because they were already out of control in some way. The Complaints officer said that she was coming over to specifically talk about this issue with staff. The charge nurse informed all nurses of the reason that she was attending the unit and specifically informed the nurse in the locked area that her area was going to be under investigation. However, ten minutes later when the complaints officer arrived in the unit, there were no staff members in the extra care unit and the consumers were locked in their on their own. The staff had totally ignored the warnings and gone on about their business as usual, showing total disrespect to the complaints officer. Repercussion of this was humiliation for the charge nurse, but no repercussions for the staff member in question. Nursing staff upheld the ethos that complaints weren’t important. As has been evidenced clearly in several of the

transcripts psychiatric consumers are often not believed when they make complaints. Most shocking of these was the staff member who talked about the cavity search, saying that both he and the client knew that she would not be believed. The engrained automatic response to complaints is to deny them, even to say that the client is delusional and that staff would never behave that way.

There are also complaints made by staff against each other. In the transcripts one doctor said that

> 'they don't act on it so what do you do…you have to be confident that there is a system in place to deal with the complaints that you make and that you won't be perceived as being difficult which is easier for this system".

The engrained response to complaints is to deny them, pay lip service back to the person complaining and essentially no change to come from the process. I learned my lesson well in regard to making complaints about other staff members. Nurses almost never make formal complaints about doctors above them on the hierarchy, but I felt the need to when a young female patient was shackled to a trolley in the emergency department for 48 hours, with an emergency code called on her every 4 hours to give her a sedative via an injection. I made a complaint that this was against human rights, against the ethos of the emergency department and that other consumers in the emergency department were also being traumatised by watching this person being injected every four hours. Within seven days of my complaint the same doctor had made a complaint in writing to the charge nurse of the hospital saying that my assessments of consumers and his were totally opposite to each others, so therefore mine were wrong and I should be re-educated, saying that after I assessed a client he had to start all over again and reassess them with a different diagnosis. He was not able to give any examples that I could learn

from, but more general feedback. These unfounded allegations were payback for the complaint the week before. I was once labeled a ‘loose cannon’ because I would step out of these engrained patterns and try to develop new ways of doing things.

New graduates are socialised into these engrained automatic responses quickly diminishing the hope of new patterns taught at university. Identifying engrained automatic responses within the organisation and developing ways of laying down new neural pathways should be the focus of future research.

CHAPTER 9

CONCLUSIONS

The chapter draws together my final conclusions regarding this thesis. In line with reflective topical autobiography, it begins with a personal reflection of my own journey through this thesis and the understanding I have gained for myself. This is followed by the understandings gained in regard to consumer consultants and recommendations for the role of consumer consultants. The next section presents the understandings gained in regard to staff relationships and the power plays within the unit: horizontal violence and hierarchical violence. Conclusions and recommendations in regard to the unit as a whole are then presented. To assist in the flow of the thesis and for continuity, the recommendations for each theme are stated at the end of the conclusions in each section, rather than later in a separate section at the end.

The next section begins with conclusions in regard to the theoretical component of this thesis, that is Ego-state theory and Organisational ego-state theory. This is followed by limitations of this study and suggestions for future research.

Personal Reflection

My interest in mental illness was triggered by being born to a mother who had periods of mental instability and a father who reacted to her hysteria with naivety and a volatility. This led me to becoming more interested in people and how they think. As a student nurse I was certainly better at helping people cope with their illnesses than assisting in the sterile environments of the surgical theatres. The psychiatric unit had been my favourite placement during my training, so rather than the normal Post Graduate studies of Midwifery, I went into psychiatry in 1976 when I was a post graduate student at Royal Park Psychiatric Hospital. It was there, that this thesis

conceptually really began. The shocking treatment of people with mental illness horrified me and although it is likely that I took on some of the attributes of the staff members, I could see the discrepancies between humane and inhumane treatment of people with mental illness and I wanted to do something about it. The questions began for me as early as 1976, How could human beings treat other human beings with such contempt and control? What can I do to change it?

The problem in 1976 was that I was just 21 years old, had very little personal power, was fearful of being in trouble and yet tormented by the images I was seeing. I was a junior staff member and as such I had to hold people down while they had electroconvulsive therapy. I watched people who were curled up in into balls crying on the floor of locked rooms, and I listened while staff with delusions of grandeur, sometimes with religious or sexual overtones, manipulated people.,

During tea breaks, some staff members would sit out under the beautiful trees and smoke marijuana, whilst others tried to goad the young female nurses into having sex with them. I gave people injections whilst they were being held down by five or six nurses, because I was coerced, but I never personally accepted it. My complaints to staff and management went on deaf ears and I was seen as the general nurse who is ‘up herself, a troublemaker, a whistleblower’. It was not long until I was literally muscled out, threatened by two burley men to back off or be physically harmed by them. I soon resigned from the psychiatric hospital, but the questions remained with me for three decades.

It seemed that no matter where I worked, I saw discrepancies in the treatment of patients and I felt alienated from most of the staff and aligned to one or two staff

members who held similar beliefs. I never really felt totally comfortable in any medical organisational culture.

When I began this research, I was a full time university student, attending university 3 days a week and working in a full-time position at the hospital. Sometimes, I would go to university during the day and work at the psychiatric unit in the evening or visa-versa. For the first time in my life, my self esteem was strong, having attended many personal growth programs. I was in my honors year at university and had achieved mainly high distinctions over the four years of my university degree. I had a strong circle of friends, and both long term and short term university friends. My marriage was strong and my three daughters were all at secondary school. I entered this psychiatric culture feeling positive and believing that I could really make a difference.

The charge nurse was a personal friend and I believed her work practices were of a high standard, so being invited to work there by her, I expected to be held in high esteem. I was a general nurse, psychiatric nurse, naturopath and psychologist-in-training and I believed that I would be generally well accepted. I never expected that trouble would start for me on the first day of my employment there.

Problems began on the first day, when I started allocating an hour to each client and seeing them in a private room. I was seen as too much of a patient (consumer) advocate, and there was a continued friction between my attempts to treat patients respectfully and the desire by institutionalised staff to continue with past procedures. It was my impression that I was disliked because I rocked the boat. I was promoted to a more senior job in the emergency department, where optimal work practices were held in high esteem. I got on really well here, they liked me and I like them. But still, when I had to interact with the psychiatric ward (something I had to do on a daily basis) my life

was difficult. Practically every week the manager would get a complaint about me from a staff member in the psychiatric unit. He would say to me, 'I know it is unfounded Robyn, but I have to investigate it'. He never resolved anything.

What happened to me was that I became a victim to the people of this culture and this led me to wonder why? Other staff members who disliked the culture just left and went elsewhere looking for a more congenial place of work. But I stayed and endured the culture because I needed to understand why so that I could break the cycle for myself. I had run away from this culture once before and this time I wanted completion. In light of this, it is really a miracle that this research ever got off the ground and that I got to spend almost a decade trying to unravel myself and the culture.

What does it mean to be a victim and why was I such a good victim, why didn't I just leave like the others? Ego-state theory helped me a great deal, understanding myself as parts made it much easier to process. Firstly, because of my childhood abuses, I had developed sensitivity to criticisms, my family were good at put-downs, and being the youngest (along with my twin) I was often targeted. My parents never swore, and readily gave a slap across the face if I said 'hell' or 'shit', yet they so easily called us stupid. They would say, 'Don't you have a brain between your ears'. I was always 'in trouble' and my twin brother and I were affectionately called 'double trouble'.

Often being *in trouble* meant being threatened with going to bed without dinner or at least being yelled at severely. I had two distinct ways of reacting to criticism. If the hurt was deep enough I would put up a brick wall and close myself in and cut that person off. The other way was to be filled with guilt and remorse and be consumed by whatever the issue at hand was. In understanding myself from an Ego-state perspective,

I developed two ways of responding to criticism. When criticised I would enter into either a withdrawn ego state or a remorseful ego state.

I developed a radar for criticisms and for unjust treatment of people and I attracted lessons in this regard throughout my teenage and adult life. I spent many years attending personal development seminars endeavouring to heal my past, and eventually felt that I had surpassed much of the pain of my childhood and had become more compassionate for myself and others.

In working in this psychiatric unit, I was attacked on emotional levels by the staff within the unit. When the new strategies I had learned in life failed to assist me to cope, I returned to old patterns and became a victim to the culture of the unit. My transition through this thesis gave me the opportunity to better heal the wounds of the past by illuminating the best and worst aspects of me. Had I left the unit like many others had, I would have felt guilt for not trying to make a change to the culture.

I started this research from a point of wanting to expose the abhorrent work practices that I had observed. I ended this research understanding that if it was not this group of people it would be another group of people at another time and another place. What was far more important than retaliation was to understand how a culture such as this could perpetuate such poor practices over fifty years, and how even today with university training and equal opportunity that these archaic practices are still pervasive. I believe I have achieved an understanding of how that culture perpetuated poor practice. For myself, through immersion, incubation and illumination, I have learned a great deal about the way I operate through Ego-state therapy, and how I contributed to the culture. Personally, I have been lucky enough to spend almost a decade immersing

myself in this thesis and in understanding how I became a victim and how I changed that pattern for myself.

Conclusions in Regard to Consumer Consultants

The incorporation of consumer consultants was a major step forward in the care of mental health inpatients. The four consumer consultants in this research project were eager to meet with staff from the very beginning, at a time when no nursing staff members were willing to meet with them. Towards the end of the research when the group meetings began, I had to introduce the consumer consultants because the staff working in the unit had not met them, even though the consumer consultants had been employed at the hospital for over three years. In trying to understand this, it became evident that the consumer consultants' employment was confined to non-clinical contact, their focus being to inform policies.

Restricted from the nurses station and nursing handovers

This research has found that the two consumer consultants in this project, who were employees of the hospital, had been socialised into roles that minimised their potential for effecting the daily treatment afforded to inpatients. Their restriction from being in the nurse's station and nursing handovers had a two-fold effect on their work practices. Firstly, it prevented consumer consultants from being recognised as staff members by the nurses. Not having this status in the nurses station reduced the impact that they can have on influencing the nurses' practices and assisting staff with reflective feedback.

Secondly, this research has found that the nurses' station is one of the places where patients are rejected by nursing staff and where inappropriate language can be heard in relation to patients. These behaviours were so entrenched in the nursing staff of

this unit that it appeared to have become second nature to them. I believe that if consumer consultants were permitted to be in the nurse's station that they would be able to see the discrepancies regarding language and interactions with the staff members and give appropriate feedback to the nurses on behalf of the patients.

In this unit, consumer consultants were also prevented from being in nursing handovers as they are not allowed in areas where patient cases are discussed. Again, it is in this environment that the language some nurses use in relation to consumers could be changed. I believe that a change in language, could have the effect of changing the internal schemas of the staff, and that this, in turn, may influence work practices. Restricting access to certain areas of consumer consultant staff members, merely maintains the great divide between consumers and staff members and is just another way of maintaining the hierarchy and the status quo of the medical model. For change this must be urgently addressed.

Their Influence on Policies

Although having the consumer consultants as key stakeholders in the development of policies is extremely important, it was revealed in this research that the doctors and nurses interviewed had not read the policy in regard to the Extra Care Unit. So the potential of the influence of the consumer consultants was lost in this instance. I propose that if had they viewed the work practices of the staff and been given a safe forum to reflect their views back to the staff, then the potential for change and indeed staff adherence to the policy could be enormous.

Differences in Consumer Consultants Suggests Socialisation into the Unit

There were differences in regard to the two consumer consultants who were not employed by the hospital and the two consumer consultants who had been employed at

the hospital for several years. The consumer consultants employed by the hospital expressed their support of the nursing staff and the good quality of practice on several occasions and were less likely to raise discrepancies. The consumer consultants read each transcript from the staff, one including secluding a woman naked and another talking about a cavity search. The hospital employed consumer consultants did not comment on these things until I questioned them directly about them. In contrast, the non-employed consumer consultants were horrified that people with mental illness were treated that way and they were more vigilant in raising the discrepancies in the quality of the nurses' practice. This has led me to draw the conclusion that, overtime, the consumer consultants are socialised into the environment and are less likely to acknowledge poor practices.

If most of the interactions with staff are with management and in meetings to create policies, then the consumer consultants would not be able to have a true sense of the quality of practices in the unit. The consumer consultants would then be likely to get a false sense of the true nature of the work practices within the unit. This unit has received national awards for the quality of its policies, but the chasm between its policies and practices are enormous. I conclude that consumer consultants should not be restricted from being involved in work practices of psychiatric health practitioners.

The group meetings where staff and consumers talked together about work practices were highly successful and this has demonstrated the value of facilitating consumer consultants to be involved at this level. All consumer consultants expressed that they really enjoyed the group meetings and felt that they participated well, were heard and were able to make a difference. The consumer consultant employed for this research was particularly forthright and clear in her opinions in regard to new work

practices within the unit. In light of the excellent feedback from the consumer consultants I have made the following recommendations:

Recommendations in Regard to Consumer Consultants

1. It is recommended that the consumer consultants be utilised in areas where they have the potential for more impact on staff practices in relation to inpatients. Particularly, they should have full access to the nurse's station and to the nursing handovers and to all areas where the treatment of consumers is discussed.
2. It is recommended that there are regular education sessions on each policy regarding patient care in the unit and that consumer consultants participate in those education sessions to assist with the policies being interpreted through the consumer standpoint.
3. It is recommended that consumer consultants be encouraged to observe staff practices and to assist staff in the process of reflexive practice, taking in the consumers' perspective.
4. It is recommended that consumer consultants and staff develop new work practices together in weekly group meetings which are based on achieving an outcome of an improvement in work practices of the staff.
5. It is recommended that consumer consultants become mentors to staff members, in a supervisory role, to facilitate change and to assist in the push for consumer-driven practices.

Conclusions and Recommendations in regard to the treatment of Koori patients.

The following recommendations and conclusions are given in line with the suggestions initiated by the Koori Consumer Consultant and upheld by the staff/Consumer group:

1. Aboriginal patients should not placed into seclusion. If under an extreme circumstance this happens, that the aboriginal person be given a time that they will be reviewed and that family and elders are given the freedom to support the person. In preference to ECU an quiet room should be set aside for aboriginal people to have silence in natural surroundings. This room should include plants and paintings.
2. That traditional healers be allowed access to the unit. Further to this that complimentary (alternative) health practices be made available to the aboriginal inpatients to allow choices of treatment, including massage, reiki, reflexology, acupuncture and spiritual healing.
3. Staff members build relationships with the aboriginal community to build trust and to educate staff members in the aboriginal culture. It is recommended that the Koori nurse Liaison spend more time at the Victorian Aboriginal Health Service (VAHS) and introduce as many nurses as possible to the staff and consumers there. The idea being that if nurses could build respect and a sense of community prior to admission, then the Koori Consumers would feel safer, having been introduced to some of the staff members prior to admission. It was noted that to go to the VAHS and meet Aboriginal people in their own space was quite a respectful thing to do and respect is paramount.
4. Continuity of care be upheld and that if an aboriginal person relates well to a staff member that they continue to have that person care for them during their inpatient stay.

5. Finally, to develop a sense of community where respect and cultural understandings lead to a sense of being respected. The trust built within this community will assist in facilitating mental health.

Conclusions in relation to Staff Relationships

The Influence of Power plays within the Unit

A further finding within this research was the difference between the nurses and the psychiatric registrars in power within the unit. Nurses were influenced in a negative way by *Horizontal Violence*, whilst Psychiatric Registrars were influenced more by *Hierarchical Violence*. The psychiatric registrars felt unsupported by their supervisors and the consultant psychiatrists above them on the hierarchy, and they felt unsupported at times from the nurses below them. Yet, the psychiatric registrars experienced comradeship and they supported each other, while the nurses experienced more Horizontal Violence from power plays with each other.

The Impact of Horizontal Violence

One of the most influential power plays within this psychiatric unit is the use of Horizontal Violence. The use of Horizontal Violence has been a major negative influence in the work practices of the nursing staff. Horizontal Violence has emerged as the mechanism that has been used to socialise new staff members and new graduates into the work practices already established by the core group of nurses within the unit. Even though the behaviours of the core group were unacceptable and unpalatable by the new staff, their fears of reprisals influenced them to give up their own ideals and values.

There were several mechanisms that stood out amongst the rest as more potent in breaking down the nurses personal values:

1. Staff members who were not aligned to the core group felt that they were being given the worst jobs in the unit. For example, they were given the most difficult, dangerous, manipulative or draining patients to look after.
2. Staff members felt that they were undermined by false allegations about them to management if they raised issues about the quality of the work practices in the unit.
3. Staff also reported that they were alienated and treated as social isolates at work if they did not 'knuckle down' and behave like the other staff members.
4. The roster was used as a weapon of Horizontal Violence, and there was also the potential of the loss of income and status within the unit.
5. Staff who did raise issues in regard to work practices felt that they were not promoted due to being labelled a whinger.
6. Staff members in this thesis have said that their need to belong to the group was greater than their need to uphold their personal values.
7. Horizontal Violence was used to protect engrained automatic responses within the organisation.

The use of Horizontal Violence must be made totally unacceptable and be replaced with collaboration involving service users.

Recommendations in Regard to Horizontal Violence

1. It is recommended a zero tolerance to Horizontal Violence, although I would suggest caution in the way new procedures are introduced to the unit. Suddenly taking a zero tolerance in a dysfunctional organisation

may create another weapon of Horizontal violence, making false accusations against colleagues.

2. It is recommended that personal growth programs be developed for staff within the unit to facilitate a sense of personal empowerment. Specifically, these programs would need to focus on staff taking personal accountability for their behaviours and decisions; developing respect for fellow staff members and extinguishing 'power over others' mentality.
3. The aforementioned personal growth programs should be linked to team building programs where staff members work together to achieve goals and which gives each person in the team an equal voice. Consumers should be involved in driving these programs.
4. The team building programs should contain scenarios of poor practice, where staff members would then be asked to identify the errors and antecedents to the unacceptable practice and develop alternative practices.
5. I also recommend that the team building programs contain role plays where staff members are trained to ***say no*** to work practices that go against their personal values, the core values of the hospital and that of the Mental Health Act. Likewise, staff should be trained in being able to accept feedback from each other and to brainstorm new possibilities for the particular work practice in question.
6. Too much time and energy is expended on horizontal violence. It is recommended that a program be developed to extinguish horizontal violence. Staff should be asked to keep a diary of the interactions they

have with staff members and reflect on how they could improve their own interactions. It would be important for this to be a self-reflection rather than a criticism of others.

The Influence of Hierarchical Violence

The most powerful influence in regard to the work practices of psychiatric registrars was that of their supervisor and the psychiatrists (psychiatric consultants) that they worked under on the unit. They described a hierarchical violence where the supervisor's influence of recommending them to the medical board for full registration as a psychiatrist was a powerful influence on their work practices. It was identified that some of these psychiatric registrars practiced against their own value system to comply with that of the consultant psychiatrist out of fear of retribution. The recent formation of the multidisciplinary team and the promise of equal voices in that team has not become a reality. The psychiatrist still rules the team and in the end makes his or her own decision about treatment and the subordinate staff members under carry out those orders regardless of whether or not they agree with them. This is another bottleneck where the promises of change to mental services have been blocked.

Recommendations

1. It is recommended group meetings including the psychiatric registrars, the psychiatrists and an external mediator to assist them in developing processes for change. It is my opinion that the person who recommends registrars to the board for registration should not be the same person who controls their daily activities. However, within the scope of this research, I have not fully explored the registrars plight, and therefore this recommendation should be viewed judiciously. .

2. Psychiatric registrars need to be given the right to say no when treatment decisions go against their value systems without fear of retribution.

Hierarchical violence represents an archaic, mechanistic and reductionist model of ancient psychiatry and should not have a place in a modern consumer-driven therapeutic community.

Conclusions in regard to the Extra Care Unit

The intention of the Extra Care Unit was to provide an area of low stimulus where clients could be placed when they were agitated or distressed in the unit. It is a misnomer, being a place of confinement and torment rather than a place of caring. It rapidly became an area of high stimulus with sometimes 6 patients in an area built to accommodate 3 to 5. The area was claustrophobic and when five agitated patients were in there together the area was more frightening than relaxing.

This area became an area that was used as a punishment for consumers and staff who did not 'tow the line'. The behaviour of staff in relation to secluding people naked and locking people up for punishment is unacceptable. The use of seclusion to lock people in a single room when they are suicidal is illogical.

Recommendations in Regard to the Extra Care Unit

1. The seclusion of people who are suicidal is inappropriate and should in most instances be replaced by what is termed special nurse care, that is one nurse to one patient at critical times. Patient safety and wellbeing should not be jeopardised.
2. Nurses need to be re-educated to understand that secluding a patient naked is an illegal practice and that if patients are so desperate that they

may harm themselves with their clothing, then appropriate attire be found and a more appropriate treatment should be engaged.

3. Nurses should be educated through personal growth programs to be empowered and be able to say to no to practices which are against the Mental Health Act and human rights.
4. All staff should be familiar with the Mental Health Act and its Amendments, and its underlying premise of 'least restrictive environment'.
5. Debriefing should occur for patients on exiting the locked areas, particularly the seclusion room.
6. Staff should debrief together after secluding someone and trace back the steps that brought about the seclusion to determine if it could have been prevented.
7. It is recommended that nurses and consumers brainstorm new work practices monthly that would prevent seclusions.
8. In line with psychiatric hospitals in other countries, the Extra Care Unit should become an open, quiet area where people go for quiet time, and is not a locked area. Therefore, it has been demonstrated that no locked area is required.

In a therapeutic environment which is consumer-driven there would be no need for a locked area. This type of confinement is archaic and barbaric.

Conclusions Regarding Critical Incidents

This research has found that although there was a critical incident stress debriefing team within the hospital it was underutilised by staff within the psychiatric

unit. I concluded that this is because the psychiatric staff members believed that they were better trained than the debriefing team members who could have been from anywhere on the hierarchy and from any department in the hospital.

Further to this, the debriefing critical incident stress management team of the hospital is mandated not to focus on the issues that caused the critical incident or to attribute accountability, but rather for people to state how they were feeling. What is lacking is the involvement of the nursing and medical staff who are directly involved in the incident to fully explore the antecedents to the critical incident.

There were no provisions for identification of changes to work practices as a response to the critical incident. It was clear from this research that nursing staff changed their behaviours to be more controlling and restrictive, and less in line with human rights following a critical incident. The hospital in question has failed to use past critical incidents to make changes which would prevent critical incidents in the future. The self-protection of the organisation and the staff members within it prevents the truth being heard following critical incidents.

Recommendations in Regard to Critical Incidents

1. When there is a critical incident, staff and patients should be debriefed together about the incident wherever possible.
2. The staff involved in the critical incident should be asked to go back over the incident, attempt to identify the antecedents to the incident with a view to finding where the incident could have been everted.
3. Six weeks following a critical incident, staff members should brainstorm how the critical incident has affected them and if they have changed their work practices because of the incident.

4. Not only should the patient who was involved in the critical incident be debriefed, but the patients in the unit that either observed the incident or heard about it from out patients should also be debriefed.
5. There is urgent need for a forum where the people involved can tell the truth about a critical incident to afford urgent changes.

General Conclusions in Regard to the Psychiatric Unit.

I conclude that the psychiatric unit in question did not function as a team, but rather as groups of staff members against other staff members, each competing non-cooperatively for power. Nursing staff behaved as though power was a finite resource that needed to be taken from someone else, particularly from other nursing staff. This ideology must be addressed if there is going to be positive changes within the culture of the psychiatric unit.

I further conclude that relationships between the nurses and patients were often from a stance of 'them-against-us', with the nurses controlling the patients in a domineering and demeaning manner. The consumer's voices were not only, not heard, but were silenced through the use of the extra care unit or seclusion rooms, and through withholding privileges such as cigarettes. That patients are still being secluded naked, injured in rugby tackles, locked up against their will, are placed on community treatment orders, their relatives refused permission to visit them, that patients have management plans forced upon, whilst others are refused treatment seems incomprehensible in this era and must be addressed immediately.

Recommendations in Regard to the Unit as an Organisation

It is recommended that creating a sense of community should be a priority of this unit. In a community the members would interact on a more equal basis. This

would be achieved by involving all stakeholders in decisions that are made about the them and the functions of the unit. Participation in choices brings about equality and has the potential to give an equal voice to people who would otherwise not be heard. In this way the unit would mimic a small society. Rather than power being directed away to a chief psychiatrist who often has no relationship with the consumers, the therapeutic community would have the psychiatrist be a team voice with the consumers and other staff members. This sense of community could be established in the following ways:

1. Incorporate a unit meeting where all staff and patients attend. This would include the full spectrum of the hierarchy from psychiatrists to consumers.
2. Incorporate consumers in decisions about the daily running of the unit, creating more equality in the power structure, and providing consumers with the vision that the unit provides them a service, not merely an incarceration.
3. Break down the barriers between consumers and staff at the nursing station door by providing the consumers with the time they need to interact with the staff. This could begin with staff spending more time with consumers in the day room and the garden. This would reduce the need for consumers to be making their requests at the nursing station door, because the nurses would be more available because they are already in the same room. In this way, issues are more likely to be addressed rather than fester over time. The need for consumers to badger staff at the nursing station door to be heard would then not be a necessity and would therefore cease to exist.
4. Nursing staff are in need of high quality supervision, not just the sort of supervision where the nursing staff member brings an issue and it is talked about, but more in depth supervision where nurses are observed in clinical

interactions and given feedback about the way they do their job. This, of course, would mean that supervisors would also need to spend more time in the unit observing work practices.

5. Staff should be trained to speak openly and honestly to each other, not in a critical manner, but in a positive and empowering manner, to assist their colleagues in achieving the highest standard in care.
6. Unit policies should be discussed at meetings with open discussion between staff and consumers.
7. The unit should be consumer-driven.

Conclusions in Regard to Optimal Work Practices

I do not believe that it is possible for me to work to the standard of my own optimal work practices in a psychiatric unit as this one is currently managed. As psychiatry functions at this time, with the current Mental Health Act, the lack of appropriate funding, the shortage of beds, the lack of appropriate supervision and the lip service in regard to consumer-driven practices, there is little scope for optimal work practices. I believe these practices encompass being part of a team of equal players and this is not possible under the current conditions. Optimal work practices for me would need to be a therapeutic community, one that was consumer driven, one that encompassed a biopsychosocial philospophy, a place that honored individual's spirituality and that allowed me as a worker to work within my own spirituality and belief systems upholding basic human rights.

General Conclusions in regard to Organisational Ego-state Theory

A focus of this thesis has been the development of Organisational Ego-state theory as a framework to explore the psychiatric unit as a complex entity. The use of

Organisational Ego-state theory has enhanced an understanding of the psychiatric unit as an entity in a culture which is distinctive to other cultures because of its particular individual parts. Not only can Organisational Ego-state theory help explicate the individual staff member's roles within the unit, and their group alliances, it can also illuminated possible solutions to bring about change. It further provides a way of evaluating that change in the future. For example, the power of the core group is made possible by the level of the subordination displayed by the less powerful groups within the unit. Therefore, facilitating (empowering) these groups to create their work practices in line with their own values could bring about informed change. This could then be evaluated by observing the changes in practices within the unit.

Contributions of the current research

Horizontal Violence

This thesis has offered data and theory to the body of literature already available on Horizontal Violence. One of the most important findings is that research participants consciously chose to renounce their own high standards of work practices to belong to a group of individuals with less preferred work practices. This devolution of acceptable work practice appears to be a self-serving, defensive mechanism to protect the individuals from being victimised by the core group. It is an important finding that some of the members consciously chose to behave inappropriately to consumers to prevent their own lives from being made uncomfortable in the work place. This extends the body of knowledge in relation to horizontal violence, which has previously focused on how staff members harm each other and not how horizontal violence directly affects consumers through their work practices. Previous research had not identified the direct affects of horizontal violence on the patients.

Ego-state Individual Practices

This thesis has extended the body of knowledge in relation to the use of Ego-state theory to explore the underlying beliefs of individuals in relation to their work practices within a psychiatric unit. Understanding that people have different parts to them provides the potential to explore the triggers in the environment that facilitate negative and inappropriate reactions. This is the first time that Ego-state therapy has been used as a theory to explore a person's work practices. When staff members became scared for their own safety they resorted to practices that they would normally have found reprehensible to them.

Using Ego-state theory to understand the decision making process of the individual staff also opens the possibility of using it as a supervision tool to assist further understanding and growth in relation to work practices in the future. It could also be used as a way of mediating between individuals in the unit who are in conflict with each other. Ego-state theory has been an excellent tool to illuminate the underlying psychology that underpins work practices.

Ego-state theory helped me understand my own work practices within the unit. It facilitated me to understand why I was able to be warm and friendly to the clients and a victim to some of the staff members. I was able to trace the antecedents to my own reactions and strengthen ego-states that became resilient, thus, enabling me to experience less victim consciousness.

Organisational Ego-state Theory

I have developed Organisational Ego-state theory to better understand and documente the functions of the organisation as an entity capable of learning, responding and change. I have coined the phrase *engrained automatic response* of the organisation

to understand how the staff respond to triggers in the environment and react in automatic ways with old work practices. It is at this juncture that practices can be changed.

Firstly, the engrained automatic responses of the organisation need to be identified using Organisational Ego-state theory and then changes to the engrained automatic responses can be invoked. To explain this further, I propose that each unacceptable work practice scenario be fully analysed to reveal how each staff member and patient reacted and participated in the incident. This would include looking at the antecedents to the events and the way each stakeholder processed the incident as it was occurring.

> For example, a patient begins to escalate and yells at a staff member. The old engrained neural response may be an aggressive one ‘speak to me like that again and I will put you in the lockup’. Other staff members listening may come running to the area to support their colleague who might be perceived to be in danger. They reinforce the first staff member’s stance by telling the client to ‘back off’. The patient by then would be feeling even more frustrated and may react back to the group of nurses that ‘they should all get lost’. Staff members already triggered to control situations may now choose to march the person into seclusion.

This engrained automatic response is one of control and confinement. To break this cycle one of the steps that led to seclusion needs to be eliminated. In this case, the staff member has acted inappropriately. He or she has not tried other mechanisms for settling a client down, but have gone straight for the locked area as a solution. In terms of my Organisational Ego-state theory, the antecedents to the incident need to be

identified (maybe the patient wanted cigarettes and was refused by the staff member). Why was the patient upset? No-one had attempted to find this out. Why did the staff member over react? Had they been in many critical incidents? Once these things have been unravelled new processes can be implemented.

Assessing if there are new engrained automatic responses with the new behaviours can also be determined through the same process. I have found that Organisational Ego-state Theory is invaluable in understanding the culture of this psychiatric unit, has the potential to illuminate change and then be a tool to evaluate that change. Organisational Ego-state theory should be further investigated in future research.

Limitations of this Study

1. My experiences over the year I worked in the psychiatric unit had been so dramatic, that this influenced my role within this research. Although I have tried to be as transparent as possible there may be unconscious personal agendas that have not been disclosed.
2. Management in this study were also a stakeholder. However, when they were asked questions in relation to the poor work practices they denied any knowledge of them. I was not able to ascertain if they were taking a self-serving stance, or if they were naïve to the practices. The managers' stance raised fears within me that I would be seen as a whistleblower and therefore may have influenced this study.
3. I began this research by being disliked by the culture and I have no doubt that this has influenced this study. However, the depth of the experiences that I had because of being disliked gave me the impetus to design and implement this study and without it I would have left like many others before me. Staying helped me

illuminate my own practices and influence in the culture giving me the opportunity to effect change in the future.

4. This study was also limited by the fact that the research was a ‘work in progress’ over many years. This research started out with the intentions of having a relatively short time frame to collect the data. However, the data collection process was complicated by the initial reluctance of staff to attend group meetings with consumers to discuss their work practices. In response to this, the next two years were spent collecting forty individual interviews with staff members and sending those transcripts to consumers to read. It was not until the staff members had disclosed their personal stories in the individual interviews, that there were enough staff members who were willing to join consumers in group meetings to discuss work practices. Further to this, in line with the Participatory Action Research methodology, the dissemination of the results was also incorporated in this research, extending the project for another two years. Confining the data collection to a lesser degree with more definitive boundaries would have made this thesis easier to complete and simpler to replicate in the future, however the methodology used requires the researcher to respond in an iterative manner to the information collected in the data.

Future Research

1. Future research should assess how consumer consultants are socialised into their roles within their unit and how some accept the status quo, while others remain mindful and able to clearly see discrepancies between good and bad practice.

2. Future research should develop strategies for staff to be able to say no to work practices that are not in alignment to their values and should develop strategies to assist staff to negotiate new practices.
3. Strategies should be developed to use Ego-state theory and therapy as a strategy in supervision. This should include assisting people to understand their inner selves and which parts trigger certain reactions in their relationships with staff and consumers alike. Underlying patterns of behaviours and reactions could be understood in great depth with the use of Ego-state theory.
4. Organisational Ego-state theory should be used as an organizational tool in other disciplines and cultures to evaluate other organizations to assist the change process.
5. Future research is needed to explore the concept of engrained automatic responses of the organisation. The most important factor in this exploration would be the development of multiple strategies to shift these established responses from negative to positive reactions. Organisational ego-state theory seems the most appropriate theory to bring about change at this time.
6. Future research would be valuable in evaluating the use of the nomenculature of psychiatry. Particularly the terms ‘mental illness, patient, consumer’ and power plays that they generate in regard to the treatment of people with mental illness.

Final Conclusion

Psychiatry has established automatic responses that have been present for decades. These practices are archaic and reprehensible. The community, through its changes to the Mental Health Act and the voices of human rights movements, have said that inhumane work practices are no longer tolerable. In my exploration of work practices in

an acute psychiatric unit, I have found that inhumane and unacceptable work practices do exist and are common place. Staff members in this unit hold a large balance of power, they are able to keep people in the unit against their will, medicate them, seclude them naked, refuse family permission to visit, withhold cigarettes and lock patients in single rooms for days on end. This treatment of people with mental illness is appauling. I have discovered patterns that underlie these poor practices, the most important one being the use of horizontal violence to socialise new staff members into the established work practices.

The use of Ego-state therapy to understand the underlying thought processes in regard to work practices of the individual has the potential to assist staff to make positive personal changes. Organisational Ego-state therapy has the potential to transform the culture of psychiatry through identifying engrained automatic responses and laying down new preferred pathways for positive change.

In this last decade consumers of mental health services have been given a voice and are being consulted to give feedback to psychiatric services about consumers' needs and treatment. In this research the consumer's voice has been heard through stories, that is, through reporting examples of their experiences within the mental health service. Initially, staff were resistant to meet face to face with consumer consultants, but through hearing their stories this resistance was extinguished and after many months and multiple attempts staff and consumers met together to develop new work practices and forged new pathways together. It is my hope that in telling my own stories and the stories of the consumers and staff members of this psychiatric unit, and by using these stories to base new theory and recommendations, that there will be a positive change to

the culture of psychiatry and that this research will make a difference to the lived experience of staff and consumers of mental health services.

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APPENDIX 1

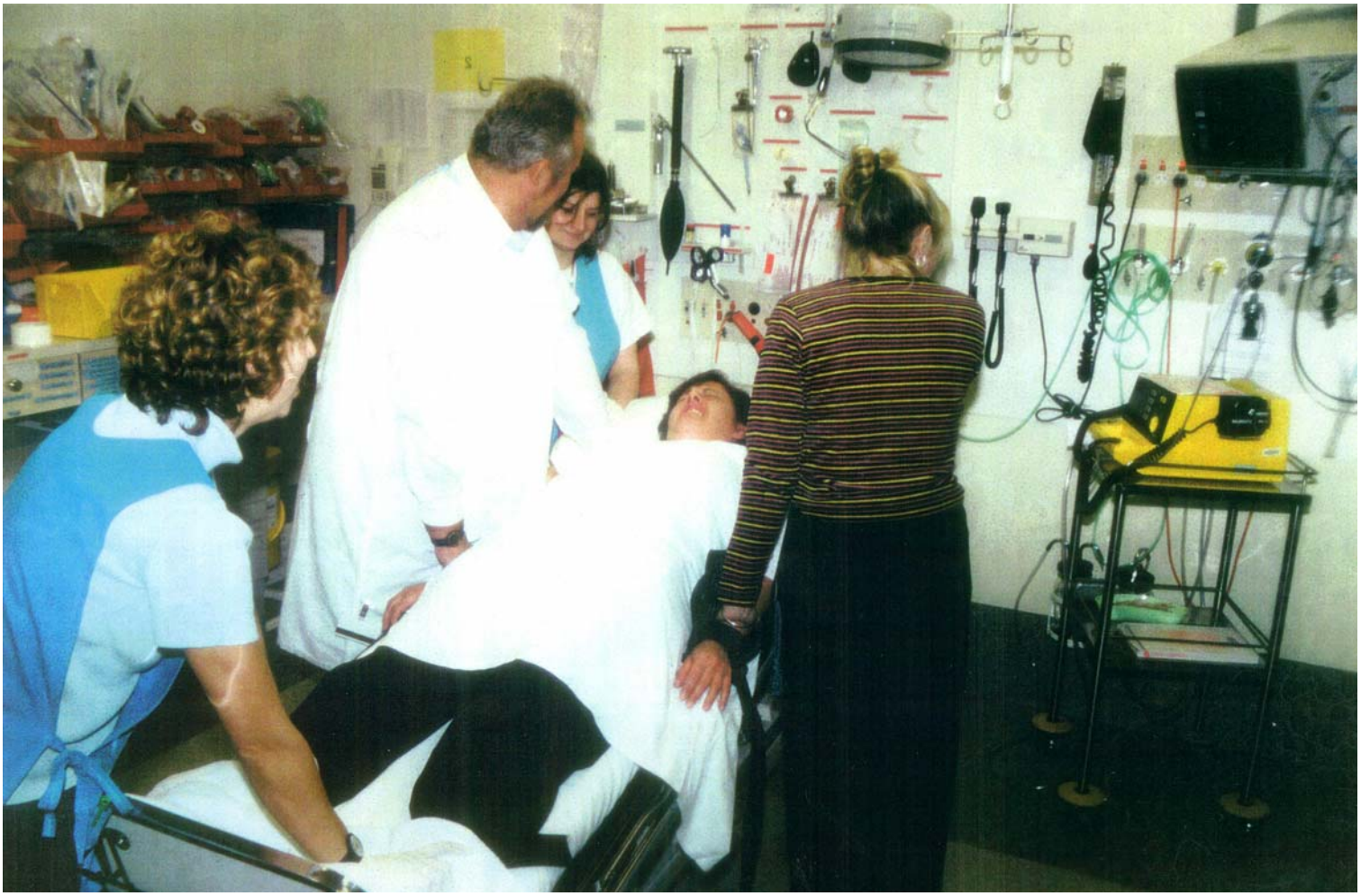
PHOTO OF A SECLUSION ROOM

The following photo is of a seclusion room in a major public hospital in Melbourne. It is similar to most public hospital seclusion rooms. The only window is the small window in the door that staff view consumers through. The walls are bland with no pictures on them and the sheets are stark white.

APPENDIX 2

PHOTO OF THE NURSES STATION

looked into the Extra Care Unit or locked area. The nurses station is effectively called the fish bowl. The area in front of the nurses station can house up to five consumers at any given time.



APPENDIX 3

A CONSUMER BEING SHACKLED IN THE EMERGENCY DEPARTMENT

This photo has been included to demonstrate the changes since mainstreaming. Consumers wishing psychiatric help now must to present to emergency departments requesting assistance. Often consumers are shackled to trolleys in resuscitation rooms because they are the only room big enough for people to stand around a trolley to hold someone down while they are being shackled. This image shows the inhumanity of such actions and the dangerous environment

.

APPENDIX 4

OPERATIONALISED DEFINITIONS

Consumer or Patient / Consumer Consultants

Within this research project the terms 'consumer' and 'patient' have been used interchangeably. Traditionally the term patient is almost always used to describe people who are hospitalised. In this case, of the people admitted to the psychiatric unit in question, are admitted to hospital and are called patients by the staff involved. Ex-patients who are employed by the hospital as consultants regarding the care of the patients are called 'consumer consultants'. Consumer (of mental health services) is one of the words that the consumer movement uses in an effort to bring about change to mental health services. Being a consumer of something denotes that there is a service that one is being provided, whereas being a patient denotes a strict hierarchical system where doctors and nurses have power over the patient.

I have chosen to use these terms interchangeably to indicate my own beliefs in regard to changing the nomenclature of psychiatry to fit with a language that is more likely to promote equality to people using mental health services. The word patient is how the staff members have described the inpatients that they work with. Therefore it has been necessary to use both words.

Mental Illness

I acknowledge that the word mental illness is a very power laden term. It signifies that there are those who are well and those who are sick. This label gives mental health

workers the power to control individuals diagnosed with mental illness and take away their freedom and treat them against their will. I will use this term throughout the research, not because I agree with it, but because it is the nomenclature of the culture that I am investigating.

Optimal Work Practices

I chose the term ‘optimal practices’ to the very best practices that a person can achieve. It is the opposite of poor practice. In this research ‘optimal practices’ is a value based term. Optimal practices are not the best choice for the staff member, but rather the best possible practice for and with the consumer. Optimal practice connotes equality and quality in practice. I chose optimal practice to mean practices that staff members can feel good about, be proud of and can make a difference to the quality of care for consumers.

Less than Optimal Work Practices

A less than optimal work practice is one where a staff member walked away feeling that they could have done a better job. At one end of the continuum practices might be not in line with the staff members idea of optimal practice. At the other end of the continuum this might mean practices that are against human rights, the dignity of the patient and or is neglect of duty of care of the staff member.

APPENDIX 5

INTERVIEW SCHEDULE

The interview questions used an open ended format designed specifically to encourage participants to explore their own experiences within the psychiatric unit. The interview followed a conversational format allowing the interviewer to follow any leads the person being interviewed held.

The questions began with asking participants what led them to psychiatry, how long they had worked in psychiatry for and if they had job satisfaction. Questions were focused around five central points:

1. **Culture of the ward**
    - ¬ What sort of culture do you believe we have in the ward?
    - ¬ What are your thoughts about the different diagnostic labels of psychiatry and whether or not you believe people's chance of recovery is worse than another's depending on that label.
    - ¬ Do you have job satisfaction
2. **High Dependency/Seclusion**
    - ¬ How do you feel about working in the extra care unit?
    - ¬ What do you believe about the extra care unit?
    - ¬ What criteria do you think patients should have to be taken into the high dependency unit?
    - ¬ How do you feel about seclusion?
    - ¬ How do you think seclusion is used in this ward?
    - ¬ Have you ever been in a seclusion room by yourself with the door closed?
    - ¬ What does the Mental Health Act say about seclusion?
3. **Good and Bad work practices**
    - ¬ I'd like you to think of two incidents of your work practice. One where you felt really good and thought that your work practice worked for you and perhaps you thought that you would do it the

same way again. The second work practice I would like you to tell me about is one that things went wrong when you thought that you would not do it the same way again the future.

In line with the theory of optimism and pessimism participants were then asked three further questions in relation to those work practices

a. Where responsibility for the outcome of the event should lay.
b. If they though the influence from the event would have a permanent of temporary effect on the patients life
c. Whether they though the influence was specific just to the event or would have permeated other aspects of the patients life.

4. Consumers voice

- Do you believe consumers have a voice in this unit?
- How is that voice heard within the unit?
- How much time do you spend with consumers each day?
- If a consumer disagrees with their treatment how would their voice be heard?

5. Staff relations

- How are your relationships with your peers?
- How would you rate your voice in the multidisciplinary team?
- If you opinion differed from another member of the team how would you rate your opinion being acted on?

6. Completion Questions

- Is there anything else you would like to say about the psychiatric ward or about your experience in it?
- If you have a magic wand and could change one thing in the culture of our ward what would it be?

APPENDIX 6

TIME LINE OF RESEARCH

Time Line For Thesis												
	Jan	**Feb**	**Mar**	**April**	**May**	**June**	**July**	**August**	**Sept**	**October**	**Nov**	**Dec**
1997	Application for Enrolment as a PhD Student		Background writing and reading				New Supervisor	Extension to Candidature	Ethics applications to Hospital and University			Ethics Approval University
1998	Hospital Ethics Applications Continued		Hospital Ethics approval			Candidature approval		Invitations to staff to join groups	Proposed first meeting	First Individual Interview	Individual Interviews	
1999	Individual Interviews								Presented ALARPM world Congress	Individual interviews		
2000	Developed a Video regarding work practices		Final individual Interview					Presented at THEMES conference	First Staff and Consumer Group Meeting		Final staff and consumer group meeting	
2001												
2002									Presented at Atlanta SCRA			Supervisor moves overseas
2003												
2004												
2005											Thesis to Examiners	
2006			Thesis returned with recommended changes		Thesis finally submitted							