A qualitative study
of the ethical practice of newly
graduated nurses working in mental
health

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ABSTRACT

Despite nurses having legitimate ethical rights and responsibilities, they are often constrained in practice from acting in ways they believe to be morally correct. This thesis presents a qualitative exploration of factors that influenced eight newly graduated nurses as they endeavoured to practice ethical mental health nursing in New Zealand. Data was gathered from in depth interviews with the participants and analysed using a thematic analysis method. A critical lens was employed to view the data so as to make visible aspects of the social and political context within which the participants were situated.

The participants' moral practice was profoundly influenced by a number of relational experiences they had. These relationships were then determinants in their moral development, professional socialization and their ability to practice in accordance to their moral beliefs. Key aspects of these relationships were their experiences with nursing education and the influence of the organisations where they worked. Recommendations are made to both areas to enable and support moral nursing practice for new graduate mental health nurses.

New graduate nurses inherently desire to practice in a way that honours the client and is therefore inherently ethical. Moral nursing practice is an everyday occurrence that must be situated in a culture of respect and regard for both clients and nurses. New graduate nurses have much to offer the profession and the tangata whaiora of the mental health services. They must be valued and supported to act in accordance to their moral ideals.

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<div align="center">Tēna koto tēna koto tēna koto katoa.</div>

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CHAPTER ONE

Introduction and overview

He aha te mea nui o te ao?
He tangata, he tangata, he tangata, he tangata.
What is our greatest treasure?
It is people, it is people, it is people.
(Traditional Māori proverb)

1.0   Background to the study

My interest in the study is multifaceted. I have been a mental health nurse for the last fourteen years and my passion for the area has never dissipated. The complexity of the human mind and spirit, and the interpersonal aspects of mental health nursing continue to inspire and challenge me. To work alongside someone as they journey toward their potential is infinitely rewarding. Latterly in my career I have worked as a nurse educator, teaching undergraduate baccalaureate students the art of mental health nursing. As my role expanded I was also asked to teach 'ethics', a subject that I myself had no formal educative preparation in. My own experience of ethical decision making within the mental health services was an instinctual knowing of what was 'right' from the client's perspective and then 'going into battle' for them.

To teach formal ethical theory, to nursing students was a steep learning curve. I read extensively and the more I learnt, the more fascinating the subject was to become. I hadn't realised on an intellectual level the considerable power and relational aspects that constrained nurses in making ethical decision and the effects that this has on them. My own thinking and learning then begged the question as to how I could best prepare undergraduate nurses to enter their first working environment, and manage all of the conflict and complexity that is associated with ethical decision making.

Thus, the idea of the study in particular to my own specialty as a mental health nurse was conceived.

During the second year of the project I returned to clinical practice and was sharply reminded of the difficulties that everyday mental health nurses encounter every day. The reality of how hard it was to work in the public health sector was a powerful check for me, even as an experienced and confident nurse. The research became very 'real life' for me as new graduates gave mirror accounts of the participants' stories and the literature I was reading. I now worked alongside new graduates as they often struggled to be the kind of nurse they wanted to be with difficult clients, impatient and tired senior staff, and organisational constraints. It seemed to me that to be an ethical new graduate nurse was far more difficult than it should be.

As the project evolved it became clear to me that the essence of what the participants' described wasn't as narrow or as linear as to being just the 'process of making ethical decisions'. In retrospect, this process seemed to be a more abstract and contained part of ethical practice, rather than a reflection of the relational, emotional and messy encounters that are involved in any human interaction. The participants told stories that unfolded what it meant to be an 'ethical mental health nurse', and then subsequently the aspects that influenced positively or negatively on their ability to practice in accordance with that goal. The 'ethical decision making' that I had anticipated as the foundation of the research, became the broader 'ethical practice' of new graduate mental health nurses.

The finished project encapsulates what it is like for these participants to work in the New Zealand mental health services and to endeavour to provide the best possible (and therefore ethical nursing) care to clients.

Without doubt mental health clients deserve ethical care. Equally nursing has an ethical obligation to ensure that it supports and develops new graduate nurses in a way that enables them to meet their potential, provide the best possible care they can to clients and maintain their moral positions. The future of mental health nursing is dependent on how we value and nurture our next generation of nurses. This research is timely then, as the influences on new graduates' ethical practice must be highlighted and addressed, so that they can be prepared and supported in ways that maintain their moral integrity.

1.0.1 Relevance to nursing

Nurses have a clear ethical component to their knowledge and practice, with Watson (1990) arguing that nursing is fundamentally a moral endeavour. The public perceive that it is most likely that doctors and nurses will be the key providers of health care (Botes, 2000b), and they rate nurses as the most trustworthy of all professional groups (Beaumont, 2004; Williams, 2001). Indeed in order to meet the criteria to be considered a profession, nursing must demonstrate ethical behaviour and regulation by its own code of ethics (Rutty, 1998).

Even though nurses are now prepared with more formal undergraduate ethics education than ever before (Woods, 2005), they are frequently unable to act in the way that they believe to be morally right (Diaski, 2004; Dodd, Jansson, Brown-Saltzman, Shirk, & Wunch, 2003; Yarling & McElmurry, 1986). Student and new graduate nurses are a vulnerable and powerless group within the ethical domain as they try to reconcile moral ideals within the complex realities of practice (Cameron, Schaffer, & Park, 2001; Kelly, 1998; Vallance, 2003). If nurses are unable to behave in ways that they believe to be ethical, it can result in their becoming morally distressed (Corley, Minick, Elswick, & Jacobs, 2005; Pendry, 2007; Woods, 1997). Ethical constraint and moral distress has a profound effect on the nurse, the profession and the client that they care for.

This study will contribute in part to the journey for mental health nurses in New Zealand to gain collective understanding and voice within the ethical domain. To be understood, first the new graduate nurse's experiences must be described, so that their particular moral perspectives are heard and respected. Following that, factors that support and/or impede novice nurses in acting in a way that they believe to be morally right can be identified and responded to.

1.0.2   Relevance to health

Mental health consumers are a particularly vulnerable population (Lakeman, 2003), with the mental health arena having its own particular ethical difficulties (Ewashen & Lane, 2007; Godin, 2000; Leung, 2002).

Client autonomy is often compromised, consumers are often stigmatised and discriminated against, and may have power and self esteem issues that impact on their ability to have their needs met (Leung, 2002; O'Brien & Golding, 2003; O'Brien, Maude, & Muir-Cochrane, 2005; Severinsson & Hummelvoll, 2001). With rates of mental illness increasing in New Zealand (Oakley-Browne, Wells, & Scott, 2006), it is imperative that every effort be made to protect the moral entitlement of this group (Johnstone, 2004a; Lakeman, 2003) With an ethico-legal environment that has historically had a mandate to constrain and control psychiatric clients (Evans, 2005; Holmes, Kennedy, & Perron, 2004; O'Brien, 2001), considerable work remains to provide the ethical care that clients who live with mental illness are entitled to.

Nurses are the most numerous mental health care providers in this country (Hamer, Finlayson, Thom, Hughes, & Tomkins, 2006; Hercus et al., 1998), and have the greatest proximity to the client (Craig, 1999; Dodd et al., 2003; Peter, Macfarlane, & O'Brien-Pallas, 2004). There is a clear moral and social expectation for nurses to advocate for and provide ethical care for clients (New Zealand Nurses Organisation, 2001) and research confirms that quality nursing care positively impacts on health care delivery and client outcomes (Hercus et al., 1998; McCloughen & O'Brien, 2005; Severinsson & Hummelvoll, 2001). Nurses are strongly positioned to ensure that ethically appropriate care is provided to clients to support their recovery.

If nurses are constrained in their ability to be involved in ethical dialogue, make ethical decisions and act in accordance with them, it can be argued that this will negatively affect their own professional development, client outcomes, the nursing profession and the quality of mental health care delivery.

More information is required to establish how best to prepare and support nurses to deliberate and act upon ethical issues in a way that is congruent with the profession's philosophical and moral ideals. There is a clear paucity of research in the area (Leino-Kilpi, 2004; Vallance, 2003; Woods, 1997, 2005), and even more so in mental health nursing ethics (Leino-Kilpi, 2004). Indeed, Johnstone (1995) states that ethics research in the mental health area is 'scandalously neglected'.

1.0.3   Previous New Zealand research

There have been few studies conducted in New Zealand that relate to the ethical practice of nurses. Martin Woods (1997) conducted a grounded theory study which sought to explore the moral decision making of eight experienced general nurses. He found their moral competence began with early moral experiences, was further developed through their nursing training and modified and refined in practice to establish 'a nursing ethic'. He described a moral nurse as, one who would attempt to behave ethically despite contextual difficulties. Recommendations from his study included the imperative need for nurses to develop a nursing ethic, to be able to act on moral decisions and to be involved in ethical debate within the healthcare setting. Implications for nursing education were to include real world situations as well as traditional ethical theories when teaching ethics to nursing students.

Esther Vallance (2003) also conducted a grounded theory study of nine new graduate nurses to investigate how they learnt ethics and whether their undergraduate education prepared them for practice.

As nursing students they learnt ethical concepts in the classroom, from role modelling, clinical educators, by reflection and, by trial and error. In their practice placements she found that as undergraduates they struggled to hold onto their ethical ideals. In the real world setting they endured powerlessness, passive acceptance and compromise as they endeavoured to 'navigate' through a number of contextual obstacles. Her work indicated the need for increased ethics and conflict resolution education and the use of guided reflection on practice and further research in the area.

Woods (1997, 2005) argues that nursing ethics research provides the opportunity to discover and explain the moral nature of nursing knowledge and practice. Research is required in New Zealand specific to ethical practice of new graduate nurses within the mental health environment which is a clinical context that has its own particular, and often occurring ethical issues. The deliberation of ethical issues in health care is founded on theoretical perspectives informed from Western moral philosophy and is discussed in brief below.

1.1   Theoretical constructs of ethics

The study and consideration of ethics has its genesis in ancient Greece where influential philosophers' such as Socrates, Plato and especially Aristotle, sought a rational understanding of what was held to be morally acceptable and unacceptable behaviour (Johnstone, 2004a).

The goal of such endeavour was the virtuous aspiration of living 'a good life'. Johnstone (2004a) describes ethics as a way of examining and understanding the moral world and morally correct behaviour.

Traditional or formal ethics briefly described tend most commonly to be understood as: ethical principlism underpinned by a predominantly justice based approach; deontological ethics; and teleological ethics (Beauchamp & Childress, 2001).

Ethical principlism is an often utilised framework for identifying and resolving moral problems in the health care context (Beauchamp & Childress, 2001) and acts as a guide for behaviour by setting the general standards for ethically correct conduct (Johnstone, 2004a). Ethical principlism holds that clinicians have duties and clients have rights, and the principles serve to inform ethical behaviour in order to ensure both are met. The most frequently applied and utilised principles are: *autonomy,* allow the individual freedom to choose; *beneficence,* do good; *non maleficence,* do no harm; *veracity,* tell the truth and *justice,* people should be treated fairly and given equal access to resources.

In any given morally problematic situation principles may compete with each other. For example telling the truth may actually cause the client harm. The principles are then also considered in relation to ethical theory. *Deontology* is the theoretical perspective whereby principles are applied irrespective of consequence and outcome, but rather as moral imperatives. *Teleology* is the perspective whereby action is considered in terms of outcome with a view to achieving a utilitarian 'greatest good for the greatest number' (Johnstone, 2004a).

However, although objective principles and codes attend to the cognitive reasoning of moral decisions, there is criticism that they do not adequately address the humanistic or emotive aspects inherent in the business of ethical decision making in the biological sciences (Doane, Pauly, Brown, & McPherson, 2004).

1.1.1 Bio-ethics

Bioethics is the study of the moral dimension of the life or biological sciences (Reich, 1995). Central to the focus and funding of mainstream bioethics are the 'big issues' of, abortion, transplants, genetic engineering and research ethics with Western bioethics remaining medico-centric (Johnstone, 2004a). Increasingly there is argument that bioethics should not only be about solving crisis dilemmas, but also be about the everyday moral work involved in healthcare (Peter et al., 2004). There has also been argument and legitimacy for a nursing ethic distinct from a medical ethic, gaining credibility since the 1970's (Fry & Veatch, 2006; Thompson, Melia, & Boyd, 2000; Woods, 1997), and current recognition that it represents a justified domain of study in its own right (Thompson et al., 2000)

1.2 Nursing ethics

Nursing ethics most simply understood, is the examination of the moral or ethical domain, from a perspective of nursing theory and practice (Johnstone, 2004a). Unlike other ethical discourses, central to nursing ethics is the distinct experiences and voices of nurses, underpinned by the values and beliefs of the profession.

Subsequently, it is argued that any nursing ethic must focus on human wellbeing as its central moral good and should emphasise caring as a moral obligation (Bowden, 2000; S. Fry & Johnston, 2002; Tong, 1998; Watson, 1990). Benner (1991) holds the dominant nursing ethic is care and responsibility, which is realised through the moral art of knowing a patient and their family through the context of narrative and relationship.

Fundamental to professional nursing ethics is a humanistic regard for the client realised through a caring relationship. Dodd et al. (2003) describe a caring approach as based on the relationship with the client and their significant others and acknowledges their central part in ethical deliberation. As with other professional groups there is an expectation of ethical behaviour and a moral contract and responsibility with society to do good (Cronqvist, Theorell, Burns, & Lutzen, 2004; Mohr & Horton-Deutsch, 2001).

Nurses are expected to behave with exemplary ethical behaviour, greater than that would be expected of an 'ordinary person' (Johnstone, 2004a). Nursing identity is inseparable from nursing ethics, and, in justifying a public trust, nurses must demonstrate the ability to self regulate and behave as ethical practitioners (Akerjordet & Severinsson, 2004; New Zealand Nurses Organisation, 2001; Nursing Council of New Zealand, 2006; O'Brien et al., 2005). Nurses must be able to consider moral problems and articulate and justify their ethical decisions and responses (Bowman, 1995; Duckett et al., 1997; Parsons, Barker, & Armstrong, 2001; Woods, 1999, 2005).

Nursing's historical alignment with medicine has seen the profession utilise a predominantly justice approach to ethical decision making characterised by the use of principles (Lipp, 1998). Childress (1998) holds that a principle based approach remains the most influential in the bioethical realm, but furthers that a caring perspective offers a corrective influence for a principle based approach, by attending to context, narrative and compassion.

There is now a large amount of literature now that promotes that the traditional (principles based) approach should be utilised in combination with a caring perspective to ensure ethical nursing practice (Benner, 1991; Botes, 2000a; Carper, 1978; Childress, 1998; Lipp, 1998; Tong, 1998); or even, that a relational ethic of care is the most appropriate approach for nurses (Bowden, 2000; Bradshaw, 1996; Brannelly, 2007; Manning, 1998; Tong, 1998). Likewise argument is made that a feminist ethical approach allows for nurses to improve their ability to be morally assertive and effective by addressing hierarchical social systems that constrain or ignore their moral values and views (Bjorklund, 2004; Liashenko, 1995; Schreiber & Lutzen, 2000).

There is a clear ethical component to both nursing knowledge and practice and nurses as a professional group are bound by a code conduct and ethics. The New Zealand Code of Conduct is based on four principles; the nurse complies with legislated requirements, acts ethically and maintains standards of practice, respects the rights of clients, and justifies a public trust (Nursing Council of New Zealand, [NCNZ], 2006).

The NCNZ (n.d.) describes the RN scope of practice as utilising nursing knowledge and complex nursing judgment to assess and provide care, both independently and in collaboration with others. The Code of Ethics for nurses in New Zealand is based philosophically on a moral foundation of caring and holds that New Zealand has unique cultural issues for nurses (New Zealand Nurses Organisation, [NZNO], 2001). The Code encompasses professional values that include compassion, commitment, competence, confidence, conscience, culture, collaboration, communication and consultation (NZNO, 2001). The code of ethics along with the scope of practice for the registered nurse demonstrate not only nursing's ethical aspect and responsibility, but also the RNs mandate to function as a legitimate and autonomous health practitioner in health care practice.

1.2.1   Moral issues for mental health nurses

Nurses are frequently confronted with complex ethical dilemmas and problems in practice (Corely, Elswick, Gorman, & Clor, 2001; Johnstone, 2004b; Severinsson & Hummelvoll, 2001; Woods, 2005). Although sometimes these moral problems are related to the big ethical issues of euthanasia, abortion and resuscitation, more often they are everyday ethical issues of client choice, dignity and care (Benner, 1991; Doane, Pauly, Brown, & McPherson, 2004). In general, ethical issues for nurses centre around client wellbeing, the quality of care provided to them and any organisational constraint that impact on their ability to act in ways they believe to be moral (Corley et al., 2005; Pendry, 2007; Peter et al., 2004; Schreiber & Lutzen, 2000).

Mental health nurses identify that organisational culture and structure effect ethical practice and the quality of care provided to clients (Lutzen & Schreiber, 1998; Mohr & Horton-Deutsch, 2001; Severinsson & Hummelvoll, 2001).

Issues of compulsory treatment, reduced autonomy, force, coercion, restraint and seclusion are amongst the most frequently cited moral problems for mental health nurses (Corley et al., 2005; Lutzen, 1998; O'Brien & Golding, 2003; Severinsson & Hummelvoll, 2001). Mental health clients are amongst the most vulnerable of our population and rely on nurses to provide ethical care and advocate for them (Johnstone, 1995; Lakeman, 2003). The nature of mental health intervention has its own unique and complex ethical issues for nurses to contend with.

Neil Pugmire is an example of an experienced nurse who made a highly publicised ethical decision that would highlight the difficulties of nursing ethics within the mental health services (McErland, 1995). Pugmire, a charge nurse at Lake Alice Hospital was unheard within the institution as warned against the release of a known paedophile back to the community. He faced a clear ethical dilemma, i.e. his moral responsibility toward the patient and his privacy, and a responsibility to minimise harm to the public at large. He strongly believed the client was a dangerous risk to the community and would reoffend if discharged, and wrote to the then minister of health regarding his concerns, without effect. The client was released and reoffended, attacking a small child within days of his discharge.

Incensed by this act, Pugmire sent a copy of the original letter to Phil Goff, member of the opposition, with his continued concerns. Goff related the contents of letter, which included the patients name in Parliament, and Pugmire was held in breach of patient confidentiality. He was suspended, and then demoted before finally being reinstated after taking Good Health Wanganui Ltd to court. Subsequently changes were made to the Mental Health Act (1992), and greater legal protection afforded to 'whistleblowers'. Although Pugmire's view was that he was compelled to act in the way he did, the cost in terms of stress, and professional ramifications to him and his family was very high. Accordingly McErland proposed that the Pugmire incident sent a clear message that it was just not worth speaking out.

The incident arguably demonstrates the notion that nurses have the greatest access to the patient's life world, thus rendering them in a very strong position to assume a central role in the provision of safe and ethical care. The Pugmire incident also illustrates the serious consequences of nursing perspectives going unheard, and paradoxically the ramifications of nurses speaking up. Yet the degree of involvement that nurses have with clients means that their perspectives and contributions to ethical decision making are of considerable value.

1.2.2   The value of including nurses in ethical decision making

There are significant benefits in ensuring that nurses are included in ethical decision making and moral problems. Nurses have the closest professional proximity to the client which allows a greater understanding of their perspectives and wishes (Holmes et al., 2004; Peter et al., 2004).

Spending more time with clients than physicians, nurses are in a privileged position that renders them the primary source of information relating to the clients' life world (Bailey, 2006; Dodd et al., 2003; Rodgers & Niven, 2003). Nurses are often also charged with being in the strongest position to advocate on behalf of the client (Lutzen & Schreiber, 1998; Mohr & Horton-Deutsch, 2001). Nurses themselves believe that they have valuable contributions to make (Bailey, 2006) and point to the benefits of collaborative decision making with medical colleagues (Botes, 2000b; Dodd et al., 2003). Organisations that value and include the work and voices of nurses in ethical decision making are able to claim improved client out comes, and improved job satisfaction and retention of nurses (Allen, Benner, & Diekelmann, 1986; Laschinger, Finegan, Shamian, & Wilk, 2001; Pendry, 2007; Severinsson & Hummelvoll, 2001)

It is essential that nurses are involved in ethical discourse, that they deliberate moral problems and articulate the reasoned decisions that they then act upon. This is not only imperative for the profession, but also for the client population they work alongside. It is integral that nurses are free to provide morally sound and clinically competent care for their clients. Yet, despite nurses being in a central position to intervene in moral matters as they relate to the client, they are often constrained in practicing as they believe they should (Mohr & Horton-Deutsch, 2001; Peter et al., 2004; Schreiber & Lutzen, 2000; Severinsson & Hummelvoll, 2001). In particular, newly graduated nurses are a group who often struggle to act in accordance with their moral beliefs (Kelly, 1998; Vallance, 2003; Woods, 2005).

In order to support and develop the professional and moral practice of new graduate mental health nurses, a greater understanding of their experiences of ethical practice is required. In New Zealand this has not yet occurred in sufficient depth. Such description and exploration will allow for identification of factors that support or impede ethical practice, and to inform nursing education on how to best prepare them to maintain ethical integrity within the practice environment.

1.3   Research question and aims

The question that underpins this study is: What influences the ethical practice of new graduate nurses in the mental health arena?

The primary aim is to describe the experiences of ethical practice by new graduates in mental health, with secondary outcomes to: identify institutional influences on ethical practice and; inform educators on how best to prepare nurses to enter the mental health system and maintain ethical integrity.

1.3.1   A reference to terminology

As it is commonly understood within the philosophical realm of ethics and related literature, that the words 'ethic' and 'moral' are used interchangeably and are deemed to have the same meaning (Johnstone, 2004a). The nurses referred to in the project are registered nurses (RNs); this by no means minimises the contributions that other regulated nurses make, but it is beyond the scope of this work to explore the experiences of such groups. For the purpose of the study new graduate nurses were those nurses with up to two years post registration clinical experience.

'Working in mental health' constituted being employed within the mental health services of a New Zealand District Health Board. All of the participants were women so nurses are described in the work in language that describes the female gender. The new graduates interviewed for this study are described throughout the work as participants. The term 'client' or 'tangata whaiora' is used to describe consumers of mental health services; family is on occasion referred to in its Māori translation of 'whānau'.

1.4   Organisation of the thesis

In chapter one, I have overviewed my own interest in the research and the relevance of the study to nursing and health. The major contextual concepts related to ethics, its theoretical constructs, nursing ethics, ethics in mental health and then the value of nurses being involved in ethical decision making have also been considered. The research question and aims have been established, along with an explanation of terminology and the way the thesis is laid out.

Chapter two explores the literature surrounding ethical practice in mental health nursing. Contemporary research studies related to ethics education, nursing involvement in ethical deliberation and discourse, new graduates and ethical issues in mental health are examined and discussed. The literature pertaining to ethics is predominantly from the United Kingdom and America, although there are a number of studies from Australia exploring the experiences of new graduate nurses working in mental health, with an increasing amount of research regarding the topic being published in New Zealand.

The literature conclusively agrees that nurses should be able to act in accordance to their moral beliefs, however it also attests to nurses frequently being constrained in doing so. New graduates are found to have particular difficulty in acting as they believe they should.

Chapter three outlines the qualitative interpretive research design and justifies the utilisation of such methodology. The method of sampling, interviewing and use of thematic analysis is discussed, along with the rationale for approaching the study with a critical perspective. Ethical considerations are identified and the validity of the research proposed.

Chapter four and five presents and explores the data from the participant interviews and introduces the two major themes and subsequent ten sub themes that describe aspects of the participants' experiences that make up the major themes.

Chapter seven presents the discussion, recommendations, limitations of the study, implications for future research and the concluding remarks.

1.5   Summary

This chapter serves as an introduction and overview of the study which sought to describe and interpret the experience of ethical practice of new graduate nurses working in mental health. The background, importance and relevance for the study have been proposed, as have the aims and outcomes. Terminology has been explained and the organisation of the thesis presented. The major concepts surrounding ethics have been discussed so as to provide the foundational understanding of ethics in relation to nursing. In the next chapter the literature surrounding the central aspects of the ethical practice of newly graduated nurses working in mental health will be presented and explored.

CHAPTER TWO

Nursing ethics: A review of the literature

"The ultimate lesson, though, is that it is people who matter, not things, and it is the love of people that directs moral life, not the love of abstract and decontextualised principles"
(Johnstone, 1999, p.131).

2.0. Introduction

In this chapter current understandings and literature surrounding ethical nursing practice in mental health are reviewed and examined. Key search terms from nursing journal databases Medline, Psycinfo and Cumulative Index to Nursing and Allied Health Literature (CINAHL) were: graduate mental health nursing; nursing ethics education; ethics and nursing; ethical decision making and nursing; ethics and mental health nursing, nursing and oppression, horizontal violence and clinical supervision.

The literature review covers a broad range of subjects, as ethical nursing practice cannot be separated from the complex factors that it is influenced by, and the contexts that it is situated in. Key areas that will be discussed in relation to the current literature are: moral development and ethics education for nursing; moral agency and ethical decision making; nursing autonomy and oppression; constraints on ethical practice; moral distress; the mental health arena; ethical issues in mental health; mental health nursing and; the ethical experiences of new graduate nurses.

2.1. Moral development and nursing ethics education

Although nurses have historically been taught 'etiquette' rather than ethics (Johnstone, 2004a), there is currently a clear and purposeful intent to develop and produce ethically sensitive and capable practitioners, (Duckett et al., 1997; Parsons, Barker, Armstrong, 2001). Formal ethics preparation is an integral aspect to nursing education to ensure that nurses can identify and respond to moral problems in a competent way (Johnstone, 2004a; Parsons et al., 2001; Woods, 2005). Nursing students learn ethics not just through traditional moral theory but also, and importantly through the experiences and narratives of the real world of nursing (Benner, 1991; Bowman, 1995; Parker, 1990; Woods, 2005). Woods (2005) proposes a pluralistic and pragmatic approach to teaching nurses ethics that includes traditional theories, an ethic of care that holds the nurse-patient relationship as central and real life clinical issues for examination. Other literature clearly indicates that formal educative preparation is beneficial to nurses in their practice.

For instance, in Parsons et al.'s (2001) quantitative study on teaching ethics to undergraduate nurses in the United Kingdom, the entire sample of nursing educators and leaders felt that the teaching of health care ethics was 'vital' to nursing education. They proposed the rationale for this was: "to enable and facilitate critical reasoning of practical ethical tensions; to provide students with a degree of 'formal' ethical knowledge; to provide a framework of values for clarification of conflicts" (p.48). Research indicates a positive correlation between formal ethical education and the moral development of nurses (Duckett et al., 1997; Johnstone, 2004a; Parsons et al., 2001; Woods, 2005)

Duckett et al. (1997) utilised a qualitative descriptive longitudinal survey method to study the development of moral reasoning from entry to exit in an American baccalaureate nursing programme. They found that all of the cohorts' moral reasoning scores were higher on exiting the programme. Nevertheless, Vallance (2003) found that despite formal ethics preparation, new graduates struggled with the 'real versus ideal' dichotomy of the health care system when it came to ethical decision making in practice. It is repeatedly argued in the literature that clinical practice and the health care system have a profound influence on the ethical learning, identity and behaviour of nurses (Dodd et al., 2003; Mohr & Horton-Deutsch, 2001; Peter et al., 2004; Severinsson & Hummelvoll, 2001).

Doane et al. (2004) explored the meaning of ethics for nurses and found that three aspects profoundly impacted on the nurses' sense of moral identity. These were the way they reconciled their personal and professional selves, the context and role expectation in the workplace, and the educative experiences that supported them and gave them confidence to engage in moral decision making. Student nurses found the most value in learning that enabled them to: balance their integrity within the 'messiness' of the workplace context; to develop their nursing identity; to become aware of their qualities and limitations; to develop experientially what it means to do good in practice; and to learn to identify and understand ethical issues in their work. Dodd et al. (2003) identified factors that affected nurses' ability to be ethically active and assertive. They found that there was no significant link between ethical assertion and work experience; it was rather cumulative nursing ethics education that significantly impacted on nurses' ethical actions.

The way that nurses are taught ethics however, remains a variable and potentially problematic issue.

Within academic realms tensions remain as to the content and extent that ethics should be taught, and who should teach it. Parsons et al. (2001) found that 72.8% of the nurse leader or educator sample felt that insufficient time was allocated within the curriculum for ethics education. Woods (1997) identified the lack of postgraduate education for those teaching ethics, as potentially problematic, as clearly the educational preparation of those teaching the subject would be vital to its delivery. The quality and quantity of undergraduate ethics education certainly impacts on the moral development of nurses. Further moral and professional socialisation takes place experientially in clinical practice

Stockhausen (2005) argues that not all elements of learning to be a nurse can be truly taught or explicated in the classroom, but must rather be experienced, in practice. Clinical practice provides students with exposure to RN role models. Some of these are positive experiences whilst others demonstrate to them the type of nurse they don't want to be. Greenwood (1993) warns that student nurses can become desensitised from humanistic issues if they are repeatedly exposed to poor practice in the clinical environment. Vallance (2003) found that student nurses learnt ethics by resolving to do the opposite to what they witnessed some registered nurses doing in the clinical environment. Yarling and McElmurry (1986) propose that whilst education teaches the ideology that the client comes first, in the reality of the practice context, powerful socialisation contradicts this.

The conclusion of these ideas is that neophyte nurses are inculcated by a health care system that renders them often unable to act as self determining moral agents.

2.1.1.   Moral agency, ethical decision making and moral values.

Moral agency is the ability to consider and act upon a moral problem. Rodgers and Niven (2003) hold that moral agency is linked to moral responsibility, which is in turn linked to moral action. They warn however that there must be the freedom to exercise moral agency and act upon it.

Ethical decision making can be described as the making of a judgment about what constitutes 'right' or 'wrong' behaviour (Johnstone, 2004a). Callahan (1988) argues that reason, intuition, emotion and life experience collaboratively guide moral decision making and that these aspects are mutually correcting resources in ethical deliberation and reflection. Callahan (1988) proposes that although intuition and emotion are not sufficient on their own as the basis of moral consideration, they are essential components within the process of ethical deliberation.

Woods (1997) proposes that nurses use both knowledge and human experience in the process of moral choice. The nurse must acquire the means whereby she perceives (sensitivity), considers (cognition, reasoning) and acts (response) upon each ethical situation that she confronts and will do this based on previously learned experiences that have formulated her moral values. Moral values can be described as the basis from which the importance or worth of something is established (Thompson et al., 2000).

Both personal and professional values will be a central aspect to the way a practitioner will approach resolving ethical issues in practice (Thompson & Thompson, 1992). Professional values are developed throughout the period of socialisation as an undergraduate nurse and then continue in practice (Brandon, 1991). Professional values are shared with other members of the nursing community (Johnstone, 2004a). These however, are heavily influenced by organisational environments (Mohr & Horton-Deutsch, 2001), with Brandon (1991) arguing that practice socialisation is more powerful than any education that has preceded it and new staff will conform to norms and values of the institution. Moral agency and ethical decision making not only based upon value systems but also relies on the ability for the person to act upon their beliefs and decisions, and their ability to behave autonomously.

2.1.2. Nursing autonomy and oppression

Moral agency and action relies on professional autonomy. Autonomy can be described as freedom from conscious or unconscious restraints (Matheson & Bobay, 2007). Professional autonomy is associated with accountability, authority and responsibility and feelings of empowerment (Kopp, 2001; Mrayyan, 2006). Mrayyan (2006) associates nursing autonomy with self direction and control over one's work and proposes that when nurses are able to make autonomous decisions it impacts positively on the quality of nursing care, client outcomes, job satisfaction and retention. However Pendry (2007) argues that nurses have more responsibility than authority. Issues of power, status and gender impact on the ability of nurses to practice freely and apply legitimate autonomy.

Systemic power and relational issues for the profession continue to oppress autonomous nursing practice which then impacts on ethical decision making (Peter et al., 2004).

Some notable authors identify nurses as an oppressed group, with likely causative factors being a predominantly female membership and nurses' status within a healthcare environment where patriarchal models dominate (McCall, 1996; Roberts, 1983). With nurses demonstrating the salient features of oppressed behaviour which include hierarchical relationships, low self esteem, submissiveness and violence displayed horizontally within the group (Cox, 1991; Roberts, 1983). This manifests in a tendency 'to eat our young', reject and resist new ideas and oppress those whose status is lower than ours (Diaski, 2004). Despite considerable literature and understanding of the subject, many nurses are unaware of their oppressed status (Matheson & Bobay, 2007) and the part that they play in perpetuating oppressive behaviours and hierarchical systems.

Walker (1998) proposes a feminist view that moral knowledge is inseparable from social knowledge and is constructed within social hierarchies. These hierarchies ascribe inferior positions to some members in relation to their social status and power, holding that what people can know and do in a social and moral sense is determined by their social position within a stratified hierarchical system. Schreiber and Lutzen (2000) argue that nurses must not just pursue moral justice for their clients, but also for themselves as well, particularly when institutional restraints limit their power and autonomy.

They propose that a critical feminist ethic should be employed to deal with conflict and constraint explicitly, therefore meeting the clients and the nurses' moral needs.

Despite rightful moral agency, nurses continue to be constrained in acting in accordance to their moral beliefs and indeed moral responsibilities (Vallance, 2003; Woods, 1997; Yarling & McElmurry, 1986). Peter et al. (2004) propose a possible relationship between nurses being powerless and their ethical compromise in practice. The degree of autonomy that nurses have directly impacts on their ability to be effective moral agents.

2.1.3.   Constraints on the ethical practice of nurses

Although nurses have both the ability and responsibility to act on their ethical beliefs and responsibilities, it is appears that they often lack the autonomy and authority to do so. The reasons for this are complex and multi-factorial and are situated in the broader socio-political context of nursing with issues of power, position and gender, which remain omnipresent for the profession (Liaschenko & Peter, 2003; Peter et al., 2004). The literature finds similar repeating themes when describing the constraints nurses face and the resulting behavioural responses employed, as they endeavour to resolve ethical dilemmas whilst maintaining their moral integrity. Nursing's lateness to the table for ethical discourse, and lack of legitimised nursing ethic or formal moral code (until 1953), along with their perceived role in health care delivery, all provide distinctions from medicine which has resulted in nurses' perspectives being largely unheard or suppressed or even 'invisible' (Peter et al., 2004; Rodgers & Niven, 2003).

It is argued that patriarchal medical dominance and institutional obstacles continue to marginalise nurses' moral involvement (Cronqvist et al., 2004; Dodd et al., 2003; Johnstone, 1999; Kelly, 1998; Vallance, 2003; Woods, 2005). Roberts (1983) proposes that nursing has been dominated by the medical model which is viewed as having the 'right' values and norms within the health care system.

Nurses' continued difficulties with their medical colleagues are well reported in the literature. Nurses cite hierarchical, patriarchal and disempowering relationships with doctors as considerably limiting factors in their ability to act on their moral agency and ethical beliefs (Daiski, 2004; Dodd et al., 2003; Kelly, 1998; Lipp, 1998; Woods, 1997). Yet it is strongly argued in the nursing literature that nurses and doctors must collaborate in ethical deliberation in a mutually respectful manner that acknowledges the difference and value in each perspective (Bailey, 2006; Botes, 2000b; Cameron et al., 2001; Dodd et al., 2003; Lipp, 1998).

Faced with medical resistance, even experienced registered nurses often feel constrained in ethical decision making. Woods (1997) argued that nurses often respond within a spectrum of possible choices, either by doing nothing; submitting to the decisions of others; pragmatically compromising; demanding inclusion; employing covert and/or overt subversion and (for a few at least) using more overt or radical actions such as formally protesting within the institute or even whistle blowing.

Institutional structure is identified as impacting on nurses' inclusion in moral decisions making with Dodd et al. (2003) work finding that the 'organisational receptivity' significantly influenced nurses' ability to be ethically active and assertive. When institutional structures included nurses in clinical ethical deliberations, discussion at a policy level and provided interdisciplinary ethics education, nurses reported positively on their ability to confidently act in accordance with their ethical ideals and advocate for clients (Dodd et al., 2003).

McDaniel (1997) describes an ethical environment as one wherein: ethical values guide moral behaviour; the ethical treatment of patients is prioritised; and professional nursing practice is supported in the organisation. When organisational values are in opposition to nursing values, and nurses lack sufficient power to be assertively involved in ethical collaboration and decision making, there is a strong relationship with low job satisfaction and burn out (Severinsson & Hummelvoll, 2001). Organisations that privileged medical bioethics and therefore constrained nurses became 'morally uninhabitable', causing oppression, exploitation, marginalisation and moral distress (Peter et al., 2004; Yarling & McElmurry, 1986).

Yarling and McElmurry propose that if the client's interests are in conflict with the hospital's interest, then nurses are forced to choose between the wellbeing of the client and their professional wellbeing. Corley (2005) warns that if nurses do not advocate for patients because of institutional constraint they will feel morally distressed.

2.1.4. Moral distress

If nurses are not able to act in the way that they believe is ethically right it results in professional compromise and conflict, and will often lead to the nurse being morally distressed. Moral distress has been defined by Jameton (1984) as "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p.6). Corely, Elswick, Gorman, and Clor, (2001) expanded the definition to "the painful psychological disequilibrium that results from recognising the ethically appropriate action, but not taking it, because of such obstacles as lack of time, supervisory reluctance, an inhibiting medical power structure, institution policy or legal considerations" (p.2590). Wilkinson's (1988) qualitative study on moral distress verified the presence of the phenomena amongst nurses. Nurses reported feelings associated with moral distress as frustration, anger and guilt that often led nurses to exit the profession or avoid patient contact. Pendry (2007) proposes that nurses are often unaware of being morally distressed, and that frequently reported feelings of stress, burnout, emotional exhaustion and job dissatisfaction may actually be caused by the phenomena. Corley et al. (2001) found that 15% of nurses reported resigning from their posts due to experiencing moral distress. Corley et al.'s (2005) later work identified that the highest frequency and intensity of reported moral distress was associated with short or incompetent staffing. Hamric (2000) found that the nurses were morally distressed by the multitude of implications staffing shortages had on them. Factors such as; decreased communication and collaboration between staff, nurses being less able to know their patients; an increase in turnover resulting in less experienced staff and problems prioritising patient care.

A relationship between the ratios of RNs has an effect on the quality of care with greater RN numbers being associated with reduced errors (Blegen & Vaughn, 1998). With increasing reliance on utilising an unregulated workforce (Jenkins & Elliot, 2004), problems with recruitment and retention of registered nurses, and a rationalised practice environment all caused nurses significant moral stress (Corley et al., 2005). The nature and complexity of providing mental health care renders unique ethical issues within the arena.

2.2. The mental health arena

The incidence of people experiencing mental illness and disturbances to their mental health is increasing, with depression expected to be the greatest worldwide health related disability by 2020 (Murray & Lopaz, 1996). New Zealand statistics (Powell, 2002) indicate that 20% of the adult population will experience some sort of mental illness throughout their lifetime, and vast amounts of the health budget is used in response (there was an annual budget of $687 million for the primary and tertiary mental health sectors in the year 2001). Key political priorities for the New Zealand government are to implement a recovery focused National Mental Health Strategy with an aim to decrease the prevalence and impact of mental illness; to promote a greater understanding of mental illness, eliminate discrimination; and to strengthen the mental health workforce (Mental Health Commission, 1998; Ministry of Health, 2003b).

In New Zealand mental health care is philosophically based on a recovery focus (Mental Health Commission, 1998; Ministry of Health, 2003a, 2003b) and acknowledges the importance of a holistic approach including physical, emotional, spiritual, familial and cultural aspects in the client's life.

New Zealand is a bicultural society with a multiethnic population (Wood, Bradley, & De Souza, 2005), and subsequently there is a clear professional expectation that nurses in New Zealand provide culturally safe and holistic care to tangata whaiora and their whānau within the mental health services (Nursing Council of New Zealand, 2004; Te Pou, 2008). Cultural safety education has been a compulsory aspect to undergraduate nursing education since the 1990s (Ramsden, 2002). Culturally safe practitioners can be described as providing services that 'recognises, respects and acknowledges' the rights and individuality of others whereas unsafe practitioners can 'diminish, demean, and disempower' those with cultural practices different than their own (Cooney, 1994).

Cultural safety is not just limited to ethnicity, but rather encompasses any aspect of the client that may be different from the nurse. This includes socio economic status, age, ethnic origin gender, sexual orientation, religious belief or any sort of disability (Ramsden, 1997). This recognises the complexity of life and cultural experiences, with the person seen in the contexts of their relationship with others and society, and regarded from a strengths, rather than a deficit perspective (Jackson & O'Brien, 2005). Respecting and acknowledging difference, and an approach that favours holism rather than dualism, is the current philosophical approach to mental health practice in New Zealand (Jackson & O'Brien, 2005).

Mental health care delivery has been reformed philosophically and systemically with significant shifts having been made in the way services are delivered internationally and in New Zealand. Worldwide health care reforms have seen a heavy emphasis on cost containment, with limited access to services and people having considerably shorter hospital stays (Cleary, 2003; Lowery, 1992; Stockmann, 2005).

In the last 20 years large psychiatric hospitals have been closed in the deinstitutionalization movement with a move to provide care in the community or in small inpatient units (Fourie, McDonald, Connor, & Bartlett, 2005; Stockmann, 2005), with overcrowding, poor conditions and cost containment as some of the reasons for the movement (Trow, 1999). At the time of this shift in thinking and provision there were often inadequate community resources to effectively support those living with mental illness resulting in a reliance to manage community clients as they had been in the institutions, with chemical control (Godin, 2000; Stockmann, 2005).

Psychiatric health services in New Zealand are based on a Western medical model approach whereby people are given a diagnosis of a mental disorder, with an interventionist focus on the use of medication to reduce signs and symptoms of mental illness (Muir-Cochrane, 1996; O'Brien & Golding, 2003; Tapsell & Mellsop, 2007). Inpatient care in New Zealand has a focus of rapid assessment, stabilisation and discharge from units, whereby there is high demand for available beds for clients with high acuity and complex health care requirements (Cleary, 2003; Fourie et al., 2005).

Clients are admitted to psychiatric units as either voluntarily clients or, under the Mental Health (Compulsory Assessment and Treatment) Act (1992), for compulsory treatment (Farrow, McKenna, & O'Brien, 2002). For clients treated under the Mental Health Act, treatment can be enforced and restrictive environments utilised to protect the person or others from risk of harm (Farrow et al., 2002; New Zealand Government, 1992). Despite a practice environment which is based on utilising the least restrictive environment in the New Zealand mental health services, control and containment remain complex and unresolved problems in current health provision (O'Hagan, Divis, & Long, 2008). The 'care versus control' dichotomy is therefore ethically problematic for mental health nurses (Muir-Cochrane, 1996).

Mental health nurses make up the greatest number of professional providers in the mental health services (Hamer et al., 2006; Munro & Baker, 2007). However there is a worldwide shortage of nurses (Department of Human Services, 2001), and few nurses being attracted to the mental health environment (Hayman-White, Happell, & Charleston, 2007; Humpel & Caputi, 2001; McCloughen & O'Brien, 2005),sees New Zealand following international trends with registered mental health nurse levels in crisis (Clinton & Hazelton, 2000; McCloughen & O'Brien, 2005; Parliament of Australia Senate, 2002).

With an increasing reliance on utilising an unregulated staff and a significant overtime burden (Corley et al., 2005), mental health nurses themselves report they are less able to be involved in therapeutic engagement with the client citing factors such as increasing administrative tasks, understaffing and a medical model treatment approach (Fourie et al., 2005; Munro & Baker, 2007). All of these factors seem to impact on nurses' ability to provide a quality standard of ethical care to mental health consumers.

2.3. Ethical issues in mental health

People living with mental illness are amongst the most marginalised group in society, who are often not afforded basic human rights (World Health Organisation, 2001). Consumers of the mental health services often have diminished power and have historically been poorly served by a society that excludes, stigmatises and discriminates against them, with a mandate for control rather than care (Farrow et al., 2002; Lakeman, 2003; O'Brien & Golding, 2003). In an environment that may restrict and limit the clients' autonomy, mental health nurses face unique and complex ethical dilemmas that they must be able to respond to in a morally fit and prepared way. Failure to provide just and ethical care to clients is a frequently reported moral issue that causes distress to mental health nurses (Corley et al., 2005; Lutzen & Schreiber, 1998; Severinsson & Hummelvoll, 2001). Literature attests to compromised autonomy and the use of force as being the most considerable and frequently occurring ethical concern for mental health nurses.

For instance, Lutzen and Schreiber (1998) conducted a grounded theory study of ethical decision making by mental health nurses in Canada and found that many moral conflicts were associated with medication, restraint and seclusion, all activities that reduced client autonomy. A core variable from the study was 'moral survival in non-therapeutic environments', whereby nurses attempted to manage their moral distress in environments that did not well serve the clients' needs and moral entitlements. The types of survival strategies depended on how supportive or oppressive the work contexts were found to be.

In oppressive contexts the nurses identified that they were less able to 'keep sight of the patient' as they focused on non therapeutic activities such as managing power struggles and avoiding legal consequences. Nurses employed a number of strategies to sustain moral survival including perpetuating the doctor – nurse game, 'covering your backside', 'scape-goating' and 'glossing over' (Lutzen & Schreiber, 1998). When nurses were involved in survival strategies, as they experienced moral conflict with medical colleagues and the hospital system, the consequences to the client were held to be negative and dysfunctional.

The use of coercion and force is one aspect of a negative ethical consequence for mental health clients. In further work, Lutzen (1998) found that mental health nurses identify such coercion to be ethically problematic. O'Brien and Golding's (2003) work gives examples of coercive practice as; physical force, non recognition of refusal of treatment, compulsory treatment, manipulation through not telling the truth, restricting choices and utilising persuasive arguments to alter clients choices, restraint and seclusion.

They recommend that ethical nursing care should always utilise the principle of least coercive care.

Compulsory treatment makes provision for the use of restraint and seclusion if the client's safety or the safety of others is of significant risk (New Zealand Government, 1992). Restraint can be described as the use of an intervention that intentionally removes a client's normal right to freedom (Bell, 2008). Seclusion is a type of restraint whereby clients are placed in a room by themselves, from which they cannot freely exit; it involves isolation, containment and a reduction in sensory input (Mental Health Commission, 2004).

There is a national directive to reduce the use of seclusion with a view to eventually eradicating it (Mental Health Commission, 2004). Best practice indicators to reduce the use of seclusion include: a national commitment to its reduction; service user involvement; organisational cultural changes; effective clinical leadership; workforce development; implementation of practical alternatives to seclusion; data collection and analysis on the usage of seclusion (O'Hagan et al., 2008). Despite moves to reduce the use of restraint and seclusion the practice remains established in New Zealand which develops ethically problematic occurrences for mental health nurses and mental health clients.

Muir Cochrane (1996) conducted a grounded theory study into nurses' perception of seclusion in a closed acute psychiatric ward in Australia. She found that all of the interviewed nurses perceived that seclusion was a therapeutic intervention in order to maintain a safe environment.

Participants indicated that seclusion was utilised when staffing levels were low and held the belief that hospital administration sanctioned the use of controlling methods to fulfil the need to provide a safe environment, even at the expense of the client. The two core categories that emerged were 'watching out for' and 'watching over the client'. Muir-Cochrane (1996) identified that the use of seclusion is exercised within a framework of power and control. She recommended that these aspects must be considered in relation to the historical mandate for custodial psychiatric nursing care which is now at odds with contemporary nursing philosophy. Seclusion is a controversial and morally dubious practice still frequently utilised within mainstream mental health services.

Nursing and organisational culture are clear determinants in the frequency and use of seclusion, with nurses holding that the use of seclusion is of therapeutic value and essential for safety (Meehan, Bergen, & Fjeldsoe, 2004; Meehan, Vermeer, & Windsor, 2000; Muir-Cochrane, 1996). This is in sharp contradiction with the views of clients who report seclusion often being used as a punitive practice (Brown & Tooke, 1992), with clients in Meehan et al. (2004) work perceiving that nurses enjoyed a sense of power and satisfaction when clients were secluded. A further dichotomy of perception was evident in the work whereby 93% of nurses believed that seclusion made the client feel better, whilst only 35% of clients indicated this was the case. The relevance of seclusion as a therapeutic measure and ethical intervention is therefore, at best, doubtful.

Severinsson and Hummelvoll's (2001) quantitative study identified stressful ethical situations for mental health nurses in acute psychiatric settings.

These included compromised autonomy for the client, care provided against their will and nurses having high workloads and time constraints, which they perceived impacted on the care the clients received. Adequacy of staffing is repeatedly attested to in the literature as a factor as to the amount of control versus therapeutic care that can be delivered by nurses (Breeze & Repper, 1998; Cleary, Edwards, & Meehan, 1999; Meehan et al., 2004; Muir-Cochrane, 1996). Inadequate staffing, high workloads and poor leadership have been found to have a high correlation with ethical conflicts in mental health units (Severinsson & Hummelvoll, 2001).

Hewitt and Edwards (2006) hold that suicidal clients can pose ethically challenging issues for nurses.
They propose therapeutic intervention in response to the suicidal client is best responded to from an ethic of care, rather than a principle approach. Interventions such as instilling hope, addressing losses, reconnecting relationships and social networks is part of the actual concrete context of many mental health clients lives, and should be attended to from a caring and humanistic framework. That is, emotional, cognitive and behavioural aspects must be addressed in the actual context of the person's life and needs, rather than by the application of abstract principles.

A number of studies indicate that the principle of justice is not well applied in mental health settings. Unexplained differential decisions are imposed on compulsory psychiatric care and appear to be dependent on ethnic and socio-economic qualities. Owens, Harrison, and Boot (1991), found that in England and Wales compulsory admissions was greater for Afro-Caribbean clients than Caucasian patients.

Rayburn and Stonecypher's (1996) American study found that African-American patients were more likely to be diagnosed with a psychotic disorder, whereas Caucasian patients were more likely to be given an affective diagnosis. In Germany men with lower occupational status were more likely to be compulsorily detained than their counterparts with higher status (Riecher, Rossler, Loffler, & Fatkenheuer, 1991).

Similarly in New Zealand higher rates of seclusion are used for people from ethnic minorities such as Māori and Pacific Islanders (Mental Health Commission, 2004; Ministry of Health, 2007a). It is therefore questionable whether people are being treated equally and fairly, with the possibility that assumed values and a lack of cultural safety may be perpetuating discrimination and ethical injustice in the New Zealand mental health services.

The nature and complexity of the relationships, politic and power and the inherent vulnerability of the client render the mental health context an 'ethical landmine'. Johnstone (1995) proposes that the field of mental health care ethics is the most neglected although paradoxically, the most promising, as it has the potential to make visible the position of the mentally ill. Nurses have a responsibility to act on their rightful moral agency to improve the situations of mental health clients, and there is perhaps no better chance of reinforcing this idea than when neophyte RNs enter the mental health care arena.

2.4. Entering the system (mental health nursing)

To enter the mental health nursing workforce in New Zealand, a student nurse must complete an undergraduate bachelor degree of nursing which incorporates a theoretical and practical mental health aspect (Finlayson, O'Brien, McKenna, Hamer, & Thom, 2005). Nurses cite reasons for entering the area as: believing that it has less of a technical and task orientated approach; that there is more autonomy for nurses and less of a hierarchical structure; and that there is a value and focus on the client as a person rather than a disease process (Ferguson & Hope, 1999; Moir & Abraham, 1996; Pye & Whyte, 1996). Despite this, attracting and retaining new nurses to the mental health service is an internationally problematic issue (McCloughen & O'Brien, 2005; Robinson & Mirrells, 1998; Valente & Wright, 2007). To be a mental health nurse in a rationalised healthcare context is not easy, with nurses attempting to fulfil a myriad of roles from counsellor to jailer with often complex and highly distressed clients (Stickley, 2002).

Mental health nursing is acknowledged as being a very high stress field that is particularly difficult for new graduate nurses (Jenkins & Elliot, 2004; Rees & Smith, 1991). New graduate nurses entering the workforce are often shocked and stressed with the working conditions and expectations placed upon them (McCloughen & O'Brien, 2005), finding themselves unable to meet the demands of the organisation and overwhelmed by workload issues (Charnley, 1997).

Challenges for the novice nurse during the transition from student to registered nurse include: inadequate theoretical and clinical preparation in undergraduate education; a lack of confidence in knowledge and skills; unrealistic organisation demands; and inadequate support (Hayman-White et al., 2007). If new graduate nurses are insufficiently supported they are significantly at risk of exiting the profession within the first 12 months of qualifying (Evans, 2001).

Arguably new graduates entering the mental health field experience added stressors and difficulties (McCabe, 2000; Prebble & McDonald, 1997). This is not helped by the fact that the dilution of mental health content and a focus on general nursing in the undergraduate curriculum fails to attract nurses to the area, or adequately theoretically prepare them (Clinton & Hazelton, 2000; Happell, 2001; Parliament of Australia Senate, 2002).

Australian research indicates that mental health nursing is perceived as one of the least attractive practice areas (Happell, 2001). Mullen and Murray (2002) propose that a lack of adequate undergraduate preparation could have negative effects on client care and the development of the RN role.

Much of the nursing literature attests to the difficulty new graduate nurses in mental health have in assimilating into their new role as registered nurses and in managing organisational conflict and constraint. For instance, Waite's (2004) qualitative exploration of the transition from student to beginning RN found four major themes in the nurses' experience. The 'emotional experience' was often a combination of fear, anger, confusion, shock, happiness and disillusionment.

'Role identification' related to the difficulty that the novices experienced as they attempted to assimilate into their new role. 'Workload issues' involved nurses assuming responsibility for a wide range of nursing skills including prioritizing client care and delegation. 'Interpersonal / organisational supports' highlighted the dynamics in the team and preceptor support as crucial to their experience.

Prebble and McDonald (1997) found two major themes in their investigation of new graduates adapting to acute psychiatric settings, namely: 'The importance of adequate orientation' and 'formal support in order to be safe practitioners'. Graduates wanted orientation to policy and procedures and feedback and support from preceptors. Risk assessment and aggression management training including negotiating and other appropriate skills in relation to client care are also identified as important aspect of the graduates' orientation.

Rungapadiachy, Madilla and Gough (2006) found that new graduate nurses after six months of entering the mental health workforce still felt unprepared for the transition to registered nurse citing a theory to practice gap from their undergraduate education. The graduates experienced role ambiguity describing their role as a mental health nurse as; conflictingly an advocate or a bouncer; an agent of psychological intervention, a teacher; a drug administrator; and a manager for the day to day activity within the ward. Organisational culture was of significance to their transition and participants gave an account of feeling unsupported and working in a 'blame culture'.

Preceptorship or mentorship is a central and imperative means for organisations to support graduate transition (Hayman-White et al., 2007; McCloughen & O'Brien, 2005; Waite, 2004). Ensuring that well suited preceptors are selected, trained and then in turn supported by the organisation is crucial to the success of the relationship and outcomes for the graduate (Hayman-White et al., 2007).

Clinical supervision is also identified as an important organisational support for graduates as they reflect and develop practice (Prebble & McDonald, 1997). Supervision is a formal process whereby clinicians can reflect on clinical issues and relationships in order to develop and improve practice (Finlayson et al., 2005; Magnusson, Lutzen, & Severinsson, 2002). Clinical supervision is associated with improved staff morale and job satisfaction, and reduced stress, sickness and burnout (Berg & Hallberg, 1999). All mental health nurses in New Zealand are recommended to have clinical supervision (Hamer et al., 2006) and it is further recognised as a means of supporting and retaining new graduate nurses in the field (Te Pou, 2008).

2.4.1.   Graduate mental health nurses

Graduate programmes have also been established as a development, recruitment and retention strategy (Hamer et al., 2006). New graduate programmes incorporate the use of preceptors, mentors, clinical supervision, structured orientation opportunities, theoretical and clinical knowledge, and practice development (Cherry, 2002; Hayman-White et al., 2007; Prebble & McDonald, 1997; Waite, 2004).

In New Zealand a review of post entry to clinical training programmes (PECT) that included nursing has been undertaken (Finlayson et al., 2005).

The findings indicate that PECT programmes were considered effective recruitment and retention interventions that resulted in lower turnover of staff. DHBs reported graduates of PECT demonstrated increased confidence, clinical knowledge and flexibility (Finlayson et al., 2005). Some of the recommendations from the study included; increased undergraduate mental health education for nurses; increased funding for CT to develop and purchase PECT programmes; trialling a pilot study of graduates working a 0.6 clinical workload; and the funding of release time for clinical mentors.

There is clear recognition that the mental health arena requires specialist knowledge which is inadequately addressed in a general undergraduate programme (Hamer et al., 2006; Hayman-White et al., 2007).

Graduates require ongoing education and support to apply theory to practice and develop the confidence and skills of effective ethical practitioners.

2.4.2.   New graduate nurses and their ethical experiences

Woods (2005) holds that it is of great concern to the profession that despite more ethics education than ever before new graduate nurses lack ethical confidence. Student nurses and new graduates appear to be a particularly vulnerable and powerless group as they endeavour to find their way in an increasingly complex and often hostile hospital environment (Cameron et al., 2001; Kelly, 1998; Vallance, 2003). Despite being taught what is right, they feel unable to assert themselves when faced with moral problems, and respond by managing their own distress and moral survival (Kelly, 1998; Vallance, 2003). Vallance's (2003) New Zealand grounded theory

study of the ethical practice of undergraduate nurses found a core category of 'navigating through' the contextual obstacles of the 'ideal versus real' world of ethical nursing. Participants 'endured powerlessness' to impact ethically on their environments as they balanced their own need to successfully graduate. Passive acceptance and compromise were behaviours they identified as utilising as they struggled to hold onto their ethical ideals. Vallance (2003) recommended increased ethics education in undergraduate programmes, instilling professional ethical values, the use of reflective journaling and the strengthening of communication skills, in order to support ethical integrity and practice.

Kelly's (1998) grounded theory exploration of graduate nurses adaptation to the hospital, identified their attempt to maintain moral integrity.

Core psychosocial processes that they utilised to do this included: coping with moral distress; lost ideals; alienation from the self and developing a new self concept. The graduates reported feeling morally distressed self critical and blaming as they struggled to do what a 'good nurse' would do. Again alarmingly, giving accounts of nursing's own cultural tendency to intimidate and victimise students and graduate nurses was identified. Cameron et al. (2001) found that student nurses often experienced dilemmas in the way nursing staff provided client care, particularly in regard to not following policy and procedure. They felt however powerless to challenge these practices and instead participated passively.

New graduate mental health nurses are undoubtedly a group who require professional and organisational support as they enter nursing practice environments.

They are also arguably a pivotal group for the continued development and indeed moral survival of the profession and must be valued and supported to realise their nursing potential, and be retained in the workforce.

2.5. Summary

In this chapter current the literature has been reviewed as it pertains to this study. The literature explored covered a range of aspects related to the ethical practice of newly graduated mental health nurses. The literature indicates clearly that nurses have an ethical component and responsibility, but that they are often constrained from acting in ways they believe to be morally correct. New graduates are a particularly vulnerable group in ethically asserting themselves.

Furthermore the context of mental health services proves to be a complex and ethically challenging field, with nurses facing unique moral issues. In order to establish influences on the ethical practice of the participants in this study a suitable methodology and method was required to conduct the project. In the next chapter the methodology, method, ethical considerations, rationale to utilise a critical lens and the validity of the research will be discussed.

CHAPTER THREE

Research design and method

"Stories illuminate meaning, meaning stimulates interpretation, and interpretation can change outcome" (Krasner, 2001, p. 70).

3.0 Introduction

This study was designed to investigate and describe newly graduated nurses' ethical experiences in mental health care settings, so that their particular moral perspectives and responses could be heard and more thoroughly understood. Such an inquiry suggested a qualitative-interpretive methodology, subsequently, a number of suitable research methods were considered before finally settling on a thematic analysis approach.

In this chapter I explore the theoretical and philosophical assumptions underpinning the research approach and outline the chosen methodology and method. The overall aim was to describe and interpret the participants' experiences whilst at the same time recording the possible commonalities and shared experiences that influenced their ethical decision making. Thus, a method was sought that offered both rich description and adequate depth in analysis; a method that would take into account the relational and contextual factors which impacted on the nurses' ethical practice. Finally, a method that would best reflect the extensive literature and existing research on relational and structural power issues in nursing. The decided method was a modified thematic analysis approach (i.e. one that utilised a critical lens where appropriate) to analyse the data and in the findings discussion. Hence, this chapter discusses both the methodology and method chosen for the research, the processes for participant selection, ethical considerations and the credibility and trustworthiness of the project.

3.0.1   Methodology

Research is a systematic inquiry that intends to generate new knowledge or verify and refine existing knowledge (Denzin & Lincoln, 2005; Gerber & Moyle, 2004). Brink and Wood (1983) however, contend that research will only be as good as the methodology chosen, and that it must best fit the topic being explored. Methodology provides the structure as to how the research will be designed, who or what will be selected in the sample, how the data is to be collected and analysed and how the reliability of the study can be confirmed (Polit & Beck, 2004). Methodology incorporates the entire process of how the knowledge is obtained (Polit, Beck, & Hungler, 2001) and must be congruent with the chosen epistemology, theoretical perspective and method (Crotty, 1998) to enable a creditable and dependable interpretation of the research data.

3.0.2   Epistemological assumptions

Epistemology is a branch of philosophy that concerns itself with the nature of knowledge. Epistemology examines what is known about the world and how that knowing came about (Cohen, 2006; Munhall, 2007a). In regard to nursing's epistemological assumptions, Carper (1978) proposes that there are four patterns and ways of knowing i.e. *empirical knowing,* which aligns itself with the biological sciences, and pursues knowledge empirically through a positivist tradition; *aesthetic knowledge*, which is the art of nursing and the appreciation of subjective experience and involves the development of nursing care that is respectfully created for the individual in their lived world;

personal knowing which is the knowledge of self and the understanding of what the nurse brings to the relationship with the client; and finally *moral knowing* which relates to the ethical sphere and as with aesthetic knowledge, it is more abstract. Moral knowing requires an understanding of what is right and wrong, knowledge of ethical theoretical constructs, and the ability to deliberate and act upon moral problems. These later three epistemological understandings are often best constructed from the qualitative paradigm. They are irreducible and complex patterns of knowing that are contextually, historically and individually situated. Therefore, the ethical experiences and perceptions of newly graduate nurses can be successfully related from a qualitative (descriptive-interpretive) approach.

3.0.3   Theoretical perspectives: qualitative methodology

From a theoretical perspective, inquiry from the qualitative paradigm is considered to be the most useful guide for a study that examines the philosophical and moral elements within human activities (Denzin & Lincoln, 2005; Munhall, 2007b; Streubert Speziale, 2007a). Denzin and Lincoln (2005) hold that qualitative researchers have a commitment to naturalistic viewpoints and interpretation of human experience. Qualitative interpretive research also places a strong emphasis on examining subjective narrative as a way to understand the individual or group experience (Poirier & Ayres, 1997; Sandleowski, 1991). Such an approach seeks to understand the holistic, dynamic, contextual and complex individual human experience and denotes the 'perceived view' of the participant (Polit& Beck, 2004). Therefore the participants decide was is 'right' and 'true' for them, with no single truth is presumed (Guba & Lincoln, 1994).

Through an inductive process researchers utilise the rich, in depth data they have collected, in order to develop a description with which to elucidate the multiple 'truths' of the phenomena studied (Gerber & Moyle, 2004; Polit & Beck, 2004). Qualitative interpretation allows for description and interpretation as to how people feel, what they know, their concerns, perceptions and understanding as they exist in a moment of time (Thorne, Kirkham, & MacDonald-Emes, 1997).

The interpretive paradigm theorises through examination of socially constructed action. It is held that people create and maintain their social world through the construction of relationships (Davidson & Tolich, 2003; Denzin & Lincoln, 1994), and knowledge and understanding are embedded in the context of such social relationships (Habermas, 1972). The aim of qualitative interpretation is to describe and understand the complexities of the individual's subjective experiences within a socially, historically and culturally constructed world (Parahoo, 1997).

Qualitative description, whilst frequently used by many researches is poorly described in the literature (Sandleowski, 2000). Historically, description has been held within the traditional scientific domains, as the crudest form of enquiry (Thorne et al., 1997), with early nursing researchers seeking creditability by distancing themselves from description and employing traditional approaches such as phenomenology, grounded theory and ethnography (Thorne, 1991). Within a current academic climate that is more eclectic and flexible, Thorne et al. (1997) hold that interpretive description aligns itself well to nursing's practice based questions that are not in essence, purely theoretical.

They propose further, that interpretive description sits well with answering the questions particular to the type of phenomena that nurses study, and reflects nursing's unique epistemological and philosophical foundations.

3.0.4   Qualitative interpretation in nursing research

Qualitative research has gained creditability and popularity with nursing researchers with a general acceptance that understandings are gained that explicate the experiential nature of human beings, and add to the professions body of artistic and scientific knowledge (Appleton & King, 1997; Munhall, 2007b; Sandleowski, 1991; Thorne et al., 1997). It is not reductionist in its intent, but rather seeks to understand the human experience wherein the person is part of a whole set of experiences and relationships engaged in a world with others (Munhall, 2007b). Benoliel (1984) proposes that qualitative interpretive nursing research lends itself well to understand the unique, dynamic perception of human beings who are actively constructing their own realties. There is a commitment to understanding the multiplicity of the participants' views and reporting findings in a style that is rich with the participants' narratives.

Thorne, Kirkham and Macdonald-Emes (1997) propose that interpretative description from the qualitative paradigm reflects nursing's unique epistemological foundations and is a very credible methodology to add to the professions practice science. The methodology is well suited to, and often used to answer questions in mental health research (Fossy, Harvey, McDermott, & Davidson, 2002).

Subsequently, the chosen research methodology for this study was philosophically informed by the qualitative paradigm, with an epistemological position that all knowledge and meaning are acts of interpretation. Further to this philosophical position is the belief that all endeavours that seek to interpret human experience must be cognisant of the complex contextual relationships that such activity is situated in. Meanings are constructed within a social context that is influenced by power and politic and that subsequently ideology is legitimised though such construct. I wanted to consider such aspects of the relationships the participants had with themselves, others and the world. I therefore decided to approach the study with a view to critiquing and analysing the data with a critical lens.

3.0.5   Using a critical lens

Callejo–Perez (2007) argues that "ultimately, good qualitative research is political (and that) good qualitative researchers understand that their work is political" (p.579). My decision to approach the study from a critical perspective was because of a belief that nurses can be constrained in practice by politic, power and social constructs. It seemed that without acknowledging and exploring these aspects, findings and understanding would be superficial and not identify the complexity that surrounded the new graduate's experiences. Although not a formal critical theory piece of work, I wanted to make visible and explore the aspects of power within the context and relationships that the graduates were positioned in. I suspected that they knew how they wanted to act in a moral sense but may have felt unable to do so due to external constraints. I felt further that this restraint affected the way they felt about themselves and impacted on the clients that they cared for.

To call the research emancipatory in intent would be bold, but by way of examining and highlighting power and relationships within the social and political realm as they occurred for the participants I hoped that in some way the project would strengthen and support the voice of graduates in mental health. Thus allowing them to feel more confident and empowered to act in a way they believed to be ethically right. I also have a strong sense that the participants were aware of injustices and power inequities which in turn moved them to come forward and offer their stories of ethical decision practice. Furthermore I believe they were motivated to make things better for themselves, for other graduates and for clients.

Thompson (1987) urges that the use of a critical perspective makes visible the power relations that allow for continued domination over nursing. That without such critical reflection there is a risk that oppression will remain unchallenged and dominant groups will maintain power. Many nurses are unaware of our oppressed group status and until such awareness comes about little can be done to change this. Carryer (2002) attests to the 'victim' status of the profession in New Zealand and calls for nurses to assume their central position in health care provision by claiming power through political activity. Nurses have legitimate power that can be used for societal betterment and therefore must collectively take responsibility and make changes to ensure we are free to act in accordance with our philosophical, ideological and moral convictions and the mandate we have with society.

Hence, in the study I have attempted to remain critically aware of where the participants sat in relationship to social construction and the influence relational power had on their ethical practice.

The nurses' stories of their experiences involving ethics within mental health care nursing settings needed to be of central importance to the authenticity of the work. The 'data' would be their own view of the world, a perspective that is 'true' for them. From this data would emerge the contextual and relational influences on their ethical practice.

3.0.6 Studying newly graduated nurses' ethical experiences

I wanted to give the participants the opportunity to tell their stories, and then to be able to make sense of relational and contextual factors that influenced their ethical practice. To interpret their experiences within the context of New Zealand mental health systems and to further illuminate any issues of power that arose. My intention was not to be able to generalise or predict any findings but present an interpretive description that was a true and accurate contextual account for these participants at this time. I also needed to be cognizant of my own personal and professional ideologies and consider how they would affect the way I conducted the study and made sense of the data.

I required a clear framework with which to position myself in as a neophyte researcher to hold the process of the study and ensure it was a credible piece of work, a suitable flexible but structured method with which to collect data and manage the analysis. Braun and Clarke (2006) propose that thematic analysis is a foundational method in its own right within the qualitative tradition, and that it can provide rich, detailed and complex accounts of data.

3.1   Thematic analysis method

Thematic analysis is the analytical process whereby the researcher gains understanding of what the data conveys by way of identifying themes or patterns (Boyatzis, 1998; Braun & Clarke, 2006; Burnard, 1991). The raw data is scrutinised and similar ideas are clustered together to form broad categories. These are then further examined and reduced to establish the dominant themes and sub themes within the participants' stories. Themes are collective and reoccurring concepts that emerge from the data bringing to life understandings of the experiential phenomena occurring for the group. A theme captures important reoccurring patterns of responses within the data that relate to the research question (Braun & Clarke, 2006).

Thematic analysis can be inductive or deductive (Braun & Clarke, 2006). Inductive thematic analysis infers to collection of data specifically for the research (often through interviews, or focus groups), with identified themes strongly linked to the data emerging from the 'bottom up'. Deductive thematic analysis is a 'top down' approach with the coding of themes driven by the researcher's theoretical interest in the topic being explored. Inductive coding does not attempt to fit codes into any preconceived theoretical perspective but rather allows the data to drive the formation of themes. This project would utilise an inductive approach whereby themes would 'emerge' from data gathered in interviews. Braun and Clarke (2006) hold that it is a flexible and easily learnt method well suited to novice researches.

3.1.1 Using thematic analysis in nursing research

Research questions from a number of recent nursing research studies (including some specific to the New Zealand and Australian mental health arena) have successfully been answered by utilising such a thematic analysis method employed from a qualitative interpretive paradigm.

Fourie, McDonald, Connor and Bartlett (2005) employed a qualitative descriptive exploratory study with thematic analysis used to establish what registered nurses believed their role to be whilst working in acute mental health units in New Zealand. Similarly O'Brien (1999) used a qualitative thematic approach to explore what New Zealand mental health nurses perceived as expertise in relation to their practice.

Cleary, Edwards and Meehan (1999) utilised a qualitative exploratory approach and thematic content analysis method, to identify factors that influenced the nurse patient relationship in acute mental health units in Australia. Breeze and Repper (1998), likewise conducted a qualitative exploration of the care experiences of 'difficult' mental health patients utilising a thematic method.

In a similar fashion, an interpretive qualitative methodology and a thematic analysis method, with data being viewed through a critical lens, were chosen for this study to answer the study's question of; what influences the ethical practice of new graduate nurses in mental health?

3.2   Method and procedure

Method relates not just to the analysis of the data, but also the procedures surrounding who will be selected in the research sample and how the data will be collected. Davidson and Tolich (2003) describe choosing the correct method as choosing the right toolbox and subsequently tools, for the purpose of answering the research question. The first part of such decision is to choose who will make up the participant sample.

3.2.1   Sampling

Sampling is the decision making that surrounds who will participate in the study. In qualitative studies participants are selected because of their first hand experience of the social process or phenomenon to be studied (Streubert Speziale, 2007a). This is known as purposive sampling whereby participants are deliberately chosen with an experiential fit and a willingness to talk (Morse, 2007). In purposive sampling an inclusion criteria delineates information rich participants who offer the opportunity to learn about the topic central to the research. The inclusion criteria for this study was: To be a working RN in the mental health services with no more than two years experience following graduation from a baccalaureate nursing programme.

The study aimed to recruit between eight – twelve participants who met the inclusion criteria. Initially two New Zealand District Health Boards (DHBs) were approached and gave permission for recruitment from their organisations. However recruitment from these two hospitals failed to generate sufficient numbers of participants to meet the minimum number required for the project.

A minor amendment was made to the Central Ethics Committee who then approved a further three DHBs to be included. These further DHBs gave permission to recruit and then finally eight participants from four DHBs made up the sample group.

3.2.2 The participants

The eight participants had varied life and professional experiences. All of the graduates were over thirty years of age and three had long standing careers as enrolled nurses prior to embarking on their Bachelor degree. The other five had worked in health as health care assistants (HCA) or psychiatric assistants (PA) prior to registration (see Table 1 below).

Table 1: Characteristics of the participants

Violet	Francis	Shilo	Olivia	Zoë	Megan	Dixie	Angel
EN 19 yrs	HCA 18months	HCA 11 yrs	5 yrs HCA prior to RN	6 months HCA & PA	24 yrs EN 15yrs mental health	25yrs EN	2 yrs PA

The areas that the participants worked in included: acute inpatient units; rehabilitation units; community mental health teams; secure units; and mental health care units for the older person.

3.3 Data collection

Initial information was given about the study by way of a recruitment poster (Appendix, I), and information sheet (Appendix, II), which were displayed in various settings within the DHBs or distributed by the nurse specialists or educators at the DHBs.

Nurses were invited to contact me by phone or email and given the opportunity to ask questions about the study.

Potential participants responded to me by way of email, and at this point a further copy of the information sheet and the semi structured interview questions were sent electronically to them. Following this, phone contact was made and the purpose of the study was broadly explained (so as to not potentially bias responses through preconceived ideas) with an opportunity for the nurse to ask any questions that they had. If verbal consent to participate was given, a mutually acceptable time and place for an interview was arranged. No interviews took place on DHB premises or in work time as specified by the Central Ethics Committee.

In the first year of the study I was employed as a nursing lecturer, but in the second year worked in a clinical position for a DHB. A minor amendment was sought and the Central Ethics Committee then subsequently approved that I could recruit from the DHB that I was employed at as long as I had no managerial or supervisory relationship with prospective participants.

Prior to the interviews the participants were informed of my role and interest in the research. I had previously had a lecturer–student relationship with four of the participants, but made it clear to them that I was not in any way judging their experiences, but rather allowing them to be told. I had not taught two of these students ethics, but had taught them all in a mental health capacity. The nature of the relationship between the participants and me was one of reciprocity, respect and collaboration within the research process.

Having met with the nurse a written copy of the information sheet, interview questions and consent form (Appendix, III) was given to her. There was further opportunity to ask questions and then written consent was sought. The participants then acknowledged that the study had been satisfactorily explained to them and that they had signed the consent form as the interview began.

A semi structured interview list of questions was prepared prior to interviewing (Appendix, IV). This question structure was used in each interview, allowing for a systematic and consistent frame to guide the process. Sandleowski (1991) reinforces the use of semi structured and open ended questions enquiring about the who, what and when in order to explore people's thoughts, feelings and experiences.

Each participant was interviewed for approximately 1-1½ hours in duration. One participant was interviewed twice because of the poor quality of taping that rendered the interview impossible to transcribe. Consent to participate also included the nurses understanding that they agreed to have the interview audio taped by me.

Tapes were transcribed verbatim by a transcriber or by me. If the interview was transcribed by the transcriber, I then listened to the entire interview again on tape and checked the accuracy of the transcription. Once completed, the transcription was returned to the participant to check the authenticity of the interview. The participant then was asked to sign a consent that the transcription was accurate and could be used for the purpose of the study (Appendix, V).

I kept field notes and 'memos' which were taken at each interview highlighting areas of interest and the thoughts and feelings that were evoked for me in the process. My research supervisors provided the opportunity to discuss and reflect upon ideas or difficulties that arose during the process of interviewing the nurses. I began to consider and analyse the data as soon as it was collected.

3.4 Data analysis

Data were analysed concurrently to collection and sampling continued until no new themes arose from the interviews. This concept is known as theoretical saturation, whereby the researcher continues to sample as widely as possible until they are confident that saturation has occurred (Streubert Speziale, 2007a). Morse (1995) describes saturation as the repetition and confirmation of previously collected data, however warns that saturation may only be a myth (Morse, 2007). Morse argues that qualitative research can only hope to saturate the information from the particular culture being studied at any given time. Having interviewed and collected the data I utilised Braun and Clarkes (2006) six phases of thematic analysis to analyse the data. These were:

Phase 1: Familiarizing with the data, which relates to immersion in the data by way of collecting, transcribing, reading and re reading the material gathered in an interactive way. The interviews were transcribed either by me or the transcriber. If they were completed by the transcriber I listened to the tape again and checked the accuracy of the transcription. All interviews were reviewed fully and transcriptions read several times.

Phase 2: Generating initial codes, this refers to collecting features of interest from the entire data set in a basic but systematic way. I worked on phase two by hand and cut out key quotes and pieces of data from the interviews that appeared to have significance and meaning.

Phase 3: Relates to searching for themes, whereby codes are then sorted and combined into potential overarching themes. Having captured the initial codes I then sought to put them into categories with similar codes. Again I did this by hand and pasted cut out data segments onto large sheets of paper under the relevant theme or category.

Phase 4: Reviewing themes, whereby all themes are checked to ensure that they accurately reflect the coded data, and then are refined and presented in a thematic map. Themes at this point should fit together and accurately tell the story from the data. Categories were reviewed first with my supervisors and then with one participant to ensure they accurately told the story of the data.

Phase 5: Defining and naming themes; whereby continued analysis generates clear definitions and names for each theme. Each theme will tell a story and may contain sub themes. Themes were named and renamed throughout the process, with themes being joined and collapsed together to become major themes. Subthemes were generated to tell the story within the major theme.

Phase 6: Producing the report, whereby the thematic analysis is written up telling the story of the data by way of examples and extracts of the participants' narratives.

Extracts are embedded in an analytic narrative and illustrate an argument that relates to the research question. This was the writing of the thesis, in a way that captured the experiences of the participants.

3.5   Ethical issues

The research project received ethical approval from the Central Ethics Committee (Appendix VI). In addition, each of the five DHB's gave approval to recruit new graduates from within their organisations. The Massey University Code of Ethical Conduct for Research and Teaching involving Human Subjects (Massey University, 2006) guided the process. The code sets out eight major principles with which to base ethical conduct within a research study, and is discussed below:

Respect for persons: Respecting persons relates to respecting choices, recognising individual beliefs and allow people to withdraw from the research. This principle was addressed by nurses self presenting and making their own decision to be part of the research. Attesting to this was that the participants made the initial contact to the researcher and signed a written consent to participate. No judgments were made about the nurses' recounts of their ethical practice and they were aware by way of the consent form that they could refuse to answer any questions or withdraw from the study up until the data had been analysed. Inherent to the intent of the study participants were respected as co collaborators in the research.

Minimisation of harm: Every effort was made to prevent harm to the participants, including their physical and emotional wellbeing.

Although registered nurses are not a particularly vulnerable population, it was likely that they would be discussing potentially difficult and possibly distressing ethical events. The participants were aware that the tape recorder could be turned off at any point during the interview and restarted when they felt ready. Each of the DHB's had an Employee Assistance Programme that would have allowed participants access to supportive counselling if they had required it and this was pointed out on the information sheet. The nurses were also able to refuse to answer any particular question should they choose to, however this did not occur.

There was the possibility of unsafe or illegal practice being disclosed in the interviews and this was managed by the statement in the consent form that such disclosures would need to be referred to the team leader or manager where the nurse worked. No unsafe or illegal practice that required intervention was disclosed by the participants.

Informed and voluntary consent: All of the nurses self presented in response to the recruitment posters and the information sheet which were displayed in visible areas of the mental health services or distributed by the organisations clinical educators and nurse specialists. The nurses then contacted me, usually by email and gave an indication that they were willing to be part of the study. The information sheet, consent form, and a copy of the interview questions were then made available to the nurses before they consented to be in the study. This allowed them to make an informed decision about their participation. A mutually agreeable interview time and venue was then established and any further questions answered.

Written consent was then sought and this was further confirmed at the commencement of each interview on the audio tape. Interviews were transcribed verbatim and checked by each nurse to ensure their own authentic story was told in a truthful and accurate way.

Respect for privacy: The location for chosen for each interview was quiet and private, with no interviews taking place on DHB property or in work time. All participants choose a pseudonym, known only to them and myself, to ensure confidentiality and anonymity. All information gathered was kept in the strictest confidence and safely stored. The transcribers, my supervisors and I were the only people who had access to the tapes and transcriptions and, and the transcriber signed a confidentiality agreement (Appendix, VII). Tapes, consent forms, transcriptions and field notes are stored in a secured manner and will be held for five years (2013), for audit purposes and then destroyed.

Avoidance of unnecessary deception: The study was in no way covert or deceiving. All aspects of the research were made transparent by way of information given to participants and the Central Ethics Committee, with copies of all relevant material kept for audit proposes. All communication with the participants was honest and truthful and obliged the informants with any information they required.

Avoidance of conflict of interest: There was no direct power inequity within the relationship between the nurses and myself. Although I had been in a lecturer – student relationship with four of the nurses, this was historic.

When I returned to clinical practice I had no managerial or supervisory relationship with any potential or actual participants as approved by the amendment from the Central Ethics Committee. My own thoughts and feelings prior to commencing the study were explicated in written form as memos. This allowed me to consciously examine any preconceptions or bias that I held that may have affected the data collection and analysis.

Social and cultural sensitivity: Sensitivity and respect was afforded to each nurse who participated. The study was not specifically a Māori piece of research although has relevance as Māori are over represented users of the mental health services and rely on nurses being able to act ethically for them. Māori nurses were free to participate and the manager of the local IWI health authority was consulted with in relation to any Māori Tikanga needs that arose, however this did not occur. Ethnicity of the nurses is not disclosed in the work so as to ensure anonymity and confidentiality.

The overriding principles of Te Tiriti o Waitangi were applied to the study. The researcher participant relationship was based upon a *partnership,* whereby the contributions of both were equally valued. *Participation* was available for all nurses who meet the inclusion criteria and they were given sufficient information about the study with which to decide if they wanted to participate. The graduates had their privacy, rights and their own beliefs *protected* throughout the process.

Justice: This principle considered justice as fairness and equal access, and was addressed by allowing whoever wanted to participate in the study, to do so.

By utilising five DHBs the sample group was reasonably varied and not just chosen for convenience, thus giving fair representation of graduate nurses. Consistency and fairness was maintained as all participants were given the same information about the study and asked the same questions from the semi structured interview list. The study was held to be ethically sound by being approved by the Central Ethics Committee.

3.6   Soundness of the research

Criticisms of naturalist inquiry relate to reliability, rigour and validity. Sandleowski (1993) argues that "rigor is less about adherence to the letter of rules and procedures than it is about fidelity to the spirit of qualitative work" (p.2). She holds that trustworthiness rests on the practice of making interpretive inquiry visible and therefore auditable (1993) and that credibility is about fittingness (1986). Lincoln and Guba (1985) suggest that reliability and trustworthiness can be achieved by maintaining field notes, debriefing, continuous scrutiny of data, triangulation and maintaining an audit trail. Triangulation includes feedback to participants to ensure authenticity and fit, field notes and memos. Authenticity is established by the 'emergent fit' with previously generated literature and the 'grab' it has with participants (Polit et al., 2001). According to Streubert Speziale (2007b), the goal of rigour in qualitative work is to authentically represent the participants' experiences.

A large part of the soundness of the work relates to the fidelity to the research process and to recounting the participants' stories with accuracy. The participants' narratives and the findings of this work resonate with the considerable amounts of nursing literature that was explored.

Of course, no piece of research can ever be the 'final word' on anything, rather it presents the participants realities as they exist in the context of the mental health services in New Zealand, and forms a platform for other research to build upon. This study has been written primarily for nurses in practice, nurse educators and those involved in service design and delivery within the mental health services.

Its usefulness will therefore in part, depend on how these nurses and providers perceive it, and how it informs their work. Hopefully it will have given the participants the opportunity to recount their experiences and increase understandings as to what it is like to be a new graduate working in mental health services in New Zealand at this time. The study is obviously a qualitative one, and thus subject to critique by qualitative means. Guba (1981) proposes utilising four objectives to assess rigor and transferability in qualitative research:

Firstly: *Credibility* was established in this work by returning transcriptions to participants to ensure the accuracy of their narratives. All participants confirmed the accuracy of their transcription by signing the consent for release and making no alterations to the verbatim script. Data is included to represent verbatim how the participants described their experiences. Findings clearly fit with the national and international regarding nurses and ethical decision making, and the experiences of being a new graduate in mental health settings.

Secondly: *Transferability* relates to the researcher providing sufficient information surrounding the context of the study to allow the reader to establish whether the work could be transferred to another practice context.

Details around the DHBs and the sample group have been described in as much detail as is possible whilst ensuring anonymity for participants. Again the fit with the literature gives the work validity.

Thirdly: *Dependability* is demonstrated with the use of audio taped interviews and all interviews being conducted by the researcher. Transcription was either conducted by myself or if completed by a transcriber, was checked entirely by myself for accuracy. Interviews were all based on the semi structured interview questions. Initial consent and subsequent amendments were approved by the Central Ethics Committee.

Lastly: *Conformability* is evidenced by all data being able to be traced to its source, and a logical structured framework employed to organise and interpret data. All of the project's data sources and consent information has been stored securely and will be held for five years for audit purposes. Braun and Clarke's (2006) six step framework for analysis, provides for logical interpretation of the data collected. Validity is enhanced by checking the generated categories with two colleagues and some of the participants (Burnard, 1991). Both of my supervisors reviewed two transcripts independently and identified the categories that thought were indicated. These were then contrasted with mine and were amended and collaboratively agreed upon. One of the participants reviewed the various themes to ensure that they fitted with her ethical experiences as a new graduate. Field notes were scribed during and after the interviews and provide further evidence of the decision making process.

3.7   Summary

In this chapter I have explored the theoretical and philosophical assumptions that underpin the research approach. The chosen methodology was qualitative interpretive description with a modified thematic analysis method utilising a critical lens to view the data. Justification for employing such method and methodology has been discussed. The thematic analysis method, procedures for sampling, data collection, the ethical considerations as well as the process for evaluating the soundness of the research has been presented.

In the next chapter I begin with the introduction of the participants' stories and analysis of the data. The data analysis and discussion that follows allows for the research question, aim and secondary outcome of the study to be in part addressed. The first major theme of the project is proposed along with discussion relating to the subthemes that illustrate the participants' experiences within the theme. The theme of 'learning the rules" describes how the graduates were socialised to assume their role as RNs and endeavour to practice ethical mental health nursing.

CHAPTER FOUR

Learning the rules

Whāia te iti kahurangi
ki te tūohu koe, me he maunga teitei
Pursue excellence should you stumble, let it be to a lofty mountain
(Traditional Māori proverb)

4.0   Introduction

In this chapter I begin with the introduction of the participants' stories and analysis of the data which relates to the first aim of this project: to describe and explore the participants' experience of ethical practice within a mental health setting. Chapter four also begins to address a secondary outcome by identifying institutional influences on the participants' practice. The discussion in this chapter is illustrated with the participants' narratives gathered in the interview process and supported by literature. In chapter four the thematic analysis of the participants allowed for the emergence of the first theme of **learning the rules.** This major theme from the data demonstrates how the participants' went about learning the rules of mental health nursing. Their experiences related to the powerful socialisation that they were exposed to on entering the practice environment. Learning the rules describes how the graduates defined ethical mental health nursing, their educative experiences, and how they were shaped by the relationships they had with clients, nursing colleagues and the organisation in which they worked. This chapter describes how the graduates learnt the rules of becoming a mental health nurse within the organisations in which their practice took place.

Within the first theme there are a series of sub-themes describing how the participants worked to develop ethical understanding of their mental health nursing practice.

The sub-themes discussed in this chapter include the components of what learning the rules entailed for the participants in this study. These sub-themes include: **being prepared; being new; fitting in; learning into practice; making sense; and recognising conflict with others**. The sub-themes highlight the influence of multiple relationships which affect the graduates' ability to be involved, understand and contribute to ethical practice within their developing professional roles as mental health nurses. The following discussion provides the foundation to address the research question: What influences the ethical practice of new graduate nurses in the mental health arena?

4.1   Learning the rules

Mental health nurses are at the front line of professional services accessed by people experiencing mental illness in New Zealand (Hamer et al., 2006). Mental illness as a generic term might be used to describe a continuum of difficulties, varying from temporary problems to ongoing trauma and disabling conditions. The incidence of people experiencing mental illness is increasing, and it is expected to be one of the greatest worldwide health burdens (Murray & Lopaz, 1996). In New Zealand 20% of the adult population will experience some disruption to their mental health during their life (Powell, 2002).

Historically, people with mental illness have been treated poorly by society (Lakeman, 2003), and as a result radical reform about what services should be available and how those professionals working within has led to dramatic change in policy and service provision (Cleary, 2003; Ministry of Health, 2003b).

As a direct result of consumer involvement in how services are run and what outcomes are expected of mental health nursing practice, nurses have been required to develop relational ability well beyond the traditional roles of institutionalised psychiatric nursing (O'Brien, 2001).

As the participants entered the practice environments for the first time as RNs they described being quickly socialised and influenced by the expectations of the organisation, the consumers of mental health services and nurses with whom they worked alongside. They described recognition that there were certain rules and expectations as to what nurses do and how they were expected to behave within the context of the hospital. Learning the rules impacted on their role development and all aspects of their practice as graduate RNs. Their responses were influenced by expectations that they had of themselves and those they worked alongside. The participants inherently defined what they believed it was to be an ethical mental health nurse and they then sought external supports to enact this role. Not all of the relationships the graduates were involved in were healthy or productive. However, examining multiple facets of the relationships and social structures was congruent with viewing the data from a critical perspective (Callejo Perez, 2007). The following discussion begins at their starting point of how they were prepared by their undergraduate education to enter the system of mental health services.

4.0.1   Being prepared

Being prepared is a sub-theme within the overarching theme of learning the rules which describes how the participants were prepared by their undergraduate education to enter the workforce.

Undergraduate nursing education provided the foundations of understanding as to what ethical mental health nursing was. The participants drew upon a range of educational experiences both theoretical and clinical in response to the ethical issues that they faced. Each of them studied in New Zealand tertiary organisations and was awarded a Bachelor of Nursing degree.

The Nursing Council of New Zealand (NCNZ) requires all educational institutions teaching nursing curriculum to deliver formal ethics education as well as theory and clinical experience specific to mental health nursing (Finlayson et al., 2005; White, Roberts, Berkett, Gleisner, & MacMahon, 2001). The quality of undergraduate mental health education is recognised as a pivotal influence on the recruitment of nurses to mental health, and on their preparedness for the workplace (Department of Human Services, 2001; Hamer et al., 2006; Hayman-White et al., 2007; Mullen & Murray, 2002). However, there is substantial criticism that undergraduate programmes have a focus on general nursing and fail to either attract or prepare graduates to work in the mental health setting (Clinton & Hazelton, 2000; Hamer et al., 2006; Happell, 2001; Prebble & McDonald, 1997). The professional and moral development of nurses is inextricably linked to their undergraduate education.

The participants were asked how their nursing education prepared them to think about and respond to the ethical issues that they faced. Responses were wide ranging and often contradictory.

There was however a general consensus that preparation for the realities and complexities of ethical issues in practice could not be entirely addressed in the classroom context. According to Shilo ethical education was not particularly helpful for her:

> No it didn't (help) because ...it's all theory, nothing practical (Shilo, p.10).

For Francis, her ethics preparation was described as a type of armchair philosophising:

> In the classroom it's controlled, you're just talking about a situation and coming up with all the ways that you would deal with it ideally. You run backwards and forwards to text books and get all the interventions ... in real life you don't have that opportunity usually (Francis, p.9).

Various authors suggest that nursing graduates feel inadequately prepared to enter the workforce with a problematic theory to practice gap (Hayman-White et al., 2007; Maben, Latter, & Macleod- Clark, 2006; Newton & McKenna, 2007; Waite, 2004). Yarling and McElmurry (1986) argue that ethics education teaches the belief that the client comes first, however a client centred approach is not necessarily a reality in practice. There is concern within the profession about how much formal ethics preparation occurs with undergraduate nursing students (Parsons et al., 2001) and the academic preparation of those teaching it (Woods, 1997).

There is little question, however, that formal ethics education for nurses is vital to their moral development (Johnstone, 2004a; Parsons et al., 2001) and their professional moral identity (Doane et al., 2004).

Ethical preparation is associated with nurses being more readily able to identify moral issues, competently deliberate and act upon them ethical issues with increased confidence and moral reasoning abilities (Dierckx-de-Casterle, Grypondck, Vuylsteke-Wauters, & Janssen, 1997; Duckett et al., 1997; Johnstone, 2004a). A well rounded preparation includes traditional moral theory of ethics as well as clinical issues for examination that recognise the importance of an ethic of care within the relationship between the nurse and client (Woods, 2005).

Brannelly (2007) argues that an ethic of care provides a basis from which mental health nurses can balance interpersonal involvement and care with clients. She proposes that an ethic of care acknowledges the interdependence of human relationships and encourages collaboration between clinicians, clients and families. Of further note her work indicates that the quality of care should be considered from the perspective of the service user. Nurses report particular value in ethics education that includes clinical issues that from the real world of nursing and service user involvement (Benner, 1991; Blegen & Vaughn, 1998; Bowman, 1995).

Despite some participants describing their ethical preparation being less than sufficient or too theoretically driven, all of the participants were able to describe their ethical issues utilising an understanding of the language of ethical principles. For example Violet shows the retention of ethical language learnt during her undergraduate education:

...the teaching itself helped me to think about it ...differently and break it down and put it into ... the autonomy box, the non maleficence and justice box ... rather than it being a jumbled mess.   I didn't know anything about ethics before I started the degree, they were just problems as far as I was concerned and you sorted them out, but the thinking about it helped me (Violet, p.13).

Whilst describing making sense of moral issues Dixie attested to the usefulness of understanding the language of ethics, although it was her own set of principles about what was right or wrong that alerted her to a dilemma:

 I think probably personally, you know in yourself its wrong, from an educational aspect, yes it highlighted all the ... terminology of beneficence and non maleficence and we should be doing good for our patients (Dixie p.11).

Furthermore, Olivia and Francis felt that their education not only helped them to identify ethical issues but a principle approach provided frameworks from which to consider and respond to a dilemma.   In describing how her education informed her practice Olivia stated:

There was an issue there, there were two sides, there was a reasonable argument for both sides and which principles were the main ones (Olivia, p.5).

For Francis however an understanding of the principles alone was insufficient preparation for her to act as she would have liked to:

I didn't know what ethics was before that (the education) and I think I got a good grounding in ethics ... I wouldn't have been able to weigh it up in my mind against those principles which are really simple but really helpful but the education didn't help me to be assertive in the situation (Francis,p.9).

Despite mixed reviews of their ethics education, the participants were able to identify ethical issues and respond to them in a way that indicated their education was clearly useful in assisting them to deliberate issues and respond to them. This is congruent with the literature that attests to formal ethics education being vital for the moral development and professional moral socialisation of nurses (Dodd et al., 2003; Duckett et al., 1997; Johnstone, 2004a; Parsons et al., 2001). Nursing ethics education had influenced the way the participants were able to understand the complex moral issues that they faced in practice.

Ethics education was not all the participants drew upon to help them practice in a way that they believed was moral. To be an ethical mental health nurse the participants described a process of integrating many facets of their undergraduate learning. The graduates discussed aspects of ethical practice in terms of maintaining professional behaviour and addressing the needs of the whole person. This included the emotional, spiritual, social, cultural and familial aspects of individuals. One such framework is that of the therapeutic relationship learnt and practiced by the graduates. For example, Violet had a clear theoretical understanding about therapeutic relationships and professional boundaries and how to behave as an ethical mental health nurse. This nursing knowledge underpinned her ability to identify and formulate a response to her dilemma:

> ... you've got all this stuff in your head about nursing practice and philosophy, just everything is in there, and ethics of course is there as well (and) I kind of think this has probably cost me $100,000 to do this degree, I might as well use what they've taught me" (Violet, p.19).

"I think the teaching and the degree has certainly made me pull back and there have been a few incidences in mental health where I have had to do that … (to avoid) the rescuing thing (Violet, p.20).

Angel was educated with a high degree of cultural content incorporated in her undergraduate programme and felt very confident that her academic preparation had equipped her with the knowledge and skills to attend to her clients cultural, spiritual and whānau needs. She described this as being central to ethical nursing practice:

They (the lecturers) taught us how pivotal cultural safety was to Māori and Pacific people (Angel, p.13).

Megan felt that the cultural safety component in her education in a mainstream provider, allowed her to see the bigger picture and to care for each person as an individual rather than looking primarily at the illness. She attributed a 'mind shift' in the way that she worked with clients to the cultural component of her education, despite finding it sometimes disagreeable as an undergraduate:

I think it's the years, probably the cultural safety stuff at tec I would say, I hate to admit it but I have got something out of it … and it has actually made me look at how I work (Megan, p.3).

Cultural safety education gave the participants an ability to consider the client in a holistic and respectful way and reflect on their own cultural views. Mental health services tend to represent a biomedical and eurocentric view of health and illness (Ramsden, 1990) and are cultural force that for the uninitiated, can be frightening and stressful (Wright, 1991). The participants gave accounts that indicated they were focused on providing holistic care that attended to the individual cultural requirements of the clients.

Cultural competency in mental health can be linked to improved client outcomes and recognition of culturally safe nursing care (Ramsden, 1990). Culturally safe mental health nurses must develop an understanding of their own culture and the environment in which they work (Campinha-Bacote, 1994; Craig, 1999).

There is a clear expectation that New Zealand mental health nurses should provide individualised, holistic and culturally safe care to clients (New Zealand Nurses Organisation, 2001; Nursing Council of New Zealand, 2004; Te Pou, 2008). The participants indicated that a number of collective educative experiences gave them a platform from which they integrated a range of theoretical ideas into ethical nursing practice.

Despite some of the nurses' criticism around their educative experiences all the graduates described a theoretical understanding and problem solving skills that would not be apparent without formal ethics education. The graduates were readily alerted to perceived moral injustices and were able to articulate their positions using ethical terminology, primarily that of the ethical principles. Education was certainly an influence that assisted the graduates to make sense of ethical issues in practice.

Having been prepared by their undergraduate education, the participants entered the practice environment and the world of mental health nursing. A further component of learning to be a mental health nurses was the participants' acute recognition of their newness. 'Being new' was a common idea that described the participant's development into their role as Registered Nurses and significantly influenced the way they were able to practice.

4.0.2   Being New

All of the participants identified with the idea of being new Registered Nurses and this impacted on their self perception and confidence in practice, to varying degrees. The initial question that I put to each of the participants at the commencement of the interview was "why did you choose to work in mental health?" This revealed the philosophical beliefs they held about being a mental health nurse and provided a picture of the new RN that they wanted to be.

The graduates discussed being a new mental health nurse and their perceptions of the differences of the speciality with general nursing. There was a collective view that mental health nursing afforded a different perspective than general nursing.

Most participants believed that being a mental health nurse meant there was a greater focus on meeting the needs of the whole person including, emotional, spiritual and cultural aspects. This took place within a foundational relationship between the nurse and the client as Francis suggests:

> ... I like the fact that the emphasis is on the therapeutic relationship, where you understand you clients in a broader sense, not just the physical sense ... nursing should be holistic no matter what area (you work, but) I think it is more encouraged in mental health (Francis, p.1).

Dixie perceived that in mental health settings that nurses had more time to spend with the client, with a less task orientated focus than they perceived their colleagues in general nursing to have:

> ... I'd been in (the) general side of nursing for some years ... and I saw a lot of that as task orientated work and it wasn't a lot of quality time with the patient ... (Dixie, p.1).

Megan felt that mental health nurses were afforded more respect and autonomy than their general nursing counterparts and that there were greater career development opportunities:

> I reckon it's the best kept secret in nursing actually (Megan, p.9).

Nurses cite the reasons they are attracted to working in mental health rather than other areas of nursing to be that they will be able to focus on the needs of the client rather than being task orientated, and disease focused (Ferguson & Hope, 1999; Moir & Abraham, 1996). There is a view that mental health nursing is more complex, but takes place in a less structured and less hierarchical environment which leads to nurses having greater autonomy and ability to practice holistically (Ferguson & Hope, 1999). The therapeutic nurse-client relationship is suggested to be the cornerstone of mental health nursing (Lauder, Reynolds, Smith, & Sharkey, 2002; O'Brien, 2001), which mental health nurses report is their most important and fulfilling role (Cleary et al., 1999; Ferguson & Hope, 1999; Fourie et al., 2005).

The participants discussed a variety of reasons to support why they chose a nursing pathway which held the therapeutic relationship as primary to their nursing practice. Some had more generalised views at the beginning of their career and were less specific about what exactly the therapeutic relationship involved. As Zoë points out in a general sense, her underlying reason and motivating factor in choosing mental health was:

> ... I knew I should be doing something ... you know helping people (Zoë, p.1).

Olivia described her attraction to mental health as a love of people, a desire to share their stories and an amazement of how resilient clients were often despite horrific life experiences. She described the belief that clients faced a number of social difficulties and injustices:

> ... mental health is the underdog and I think it needs as many people as possible to go in and challenge the discrimination which is out there (Olivia, p.1).

Angel wanted to work with Māori in the mental health setting, a population who are disproportionately represented as service users (Oakley-Browne et al., 2006).

> During my training general nursing just did not interest me what so ever and in my mental health placements it was a passion ... and I knew that's where I wanted to be and for me it's more of a challenge. There's a prevalence of mental health (illness) ... and I want to be able to be there to support Māori tangata whaiora in their recovery and their whānau (Angel, p.1).

A desire to being involved in the life world of the client and a commitment to helping and supporting them is a fundamental aspect of mental health nursing (O'Brien, 1999). Chambers (1998) proposes mental health nursing is about a partnership between nurse and client, one which is based on a humanistic regard and dialogue. In order to be helpful to clients, nurses need to understand the difference between professional and social relationships (Wilson, 2008). Social relationships involve interactions in which the needs of both persons are of equal importance. In contrast, professional relationships are those in which the needs of the client are paramount (Usher, Luck, & Foster, 2005). Although new to the role, the participants consistently discussed the needs of the client as of central importance and endeavoured to realise them through the relationships they had with them.

They were developing fundamental beliefs and philosophical ideas as to what the role and purpose of an ethical mental health nurse was.

Being new, captured a sense of the participant's developing and defining their new role as they commenced in the realities of practice and transitioned from student to RN. Francis' description of being new captured the mixed feelings and uncertainty which summarised the notion of newness with the participants in this study:

> Because when you are a nurse with your registration it's a different situation, you have responsibility you can't hide behind that 'I'm a student', if you do something wrong I'm a student, it's different when you are a nurse (Francis, p.9).

Building on this idea of role and responsibility she stated:

> I think that I had very idealistic ideals when I first came out of being perfect super nurse or wanting to be perfect super nurse ... I haven't been as perfect (a) nurse as I would have liked to have been ... But I also wonder if that is even achievable, to be the perfect ideal nurse that you have in mind when you graduate (Francis, p.1).

Development of the nursing role from student to RN is a stressful transitory time whereby knowledge and skill from the 'ideal world of education' must be integrated into 'the real' world of the clinical environment with all the complexities that that brings (McCloughen & O'Brien, 2005; Vallance, 2003). New graduates develop a sense of becoming practical as they revise their self perception and cope with lost ideals (Kelly, 1998). Workload issues, role ambiguity, the uptake of professional responsibility and delegation and direction are some of the challenges that graduates face as they enter the mental health services (Prebble & McDonald, 1997; Waite, 2004). The success of the transition year can determine whether graduates will continue to have a successful nursing career or abandon the profession (Heslop, Ives, & McIntyre, 2001; Te Pou, 2008).

As the graduates negotiated relationships and deliberated moral issues they described feelings of being insufficiently prepared for the workplace. There was a sense that being new meant having limited knowledge to deal with issues they faced, which in turn shaped their ability to recognise and act on moral issues. The participants suggested that their undergraduate preparation was insufficient to be able to navigate the procedural requirements of the organisations that they now worked in. Not feeling confident that they knew what hospital policy was, affected the participants' ability to intervene when they encountered morally dubious situations. Violet described a sense of being thrown in the deep end and also struggling to get on top of the procedural requirements expected of her:

> It's is a huge learning curve as soon as you get chucked in ... and you think OK, and you just battle in, but I haven't found it difficult at all working with clients or patients I haven't had any problems at all ... it's the policies and procedures that stump me the most, you know getting those things right, that keeps everybody happy (Violet, p.4).

Feeling unprepared and lacking confidence related to a belief that they did not have enough specific nursing or procedural knowledge comparative to their more senior nursing colleagues, as Zoë points out:

> Because it was my first seclusion ever to witness, if I was aware of the procedures and protocols I would have promoted my thoughts ... (Zoë, p.7).

Francis also felt that the seclusion of a client did not follow procedural requirements and doubted the necessity of the intervention, so she questioned this with the other nursing staff:

> I wasn't sure about the policies and procedures relevant in that area, but I believed it wasn't actually legal to put him there (p.4).

I felt guilty confronting senior staff members (p.6) ... because I'm just a new nurse and what do I know and this is the way we do things here (Francis, p.7).

Graduates are often expected to 'hit the ground running', however often they simply learn to cope rather than improving clinical competence (Charnley, 1997). According to Tradewell (1996), graduates need to know clearly what is expected of them in terms of practice requirements as they enter the field of registered nursing, with socialisation to the norms and expectations of any given organisation taking at least a year. In order to do this and reduce the associated levels of stress that impacts on them during their transition period it is imperative that graduates have a well supported formal orientation to the workplace (Godinez, Scheiger, Gruver, & Ryan, 1999; Hayman-White et al., 2007; Heslop et al., 2001; Prebble & McDonald, 1997; Te Pou, 2008). Orientation for graduates should include clear procedural expectations of the organisation (Prebble & McDonald, 1997) and the consideration of workload issues (Charnley, 1997). For many of the participants to feel sufficiently confident to speak up in ethical incidents it was important to them that they were aware of and doing the right thing by the organisations.

The difficulties described by the participants as they transitioned from student nurse to RN, are well documented in the current literature about the first year of practice for mental health nurses. Issues include: feeling under prepared and lacking in confidence, feelings of stress, anger and confusion as they attempt to identify in their new role and manage workload issues and responsibilities (Newton & McKenna, 2007; Rungapadiachy et al., 2006; Waite, 2004).

To transition into their new role, meet the expectations of the organisation and others around them, and apply theory to practice was a challenging journey. They looked to the other RNs as guides on how to behave, or not behave, as a registered nurse.

4.0.3   Learning in practice

Learning to be a mental health nurse was heavily influenced by the nursing role models the graduates were exposed to as undergraduates in their practice environments. Nursing lecturers and preceptors during both undergraduate mental health placements and entry to practice programmes proved to be both positive and negative role models. Zoë was clear from her second year mental health placement about the type of nurses she did not want to be, but her lecturer was a correcting role model for her:

> I never want to be a nurse like those ones I've worked with (in mental health placement), but my tutor in the third year was so inspirational that she had an enthusiasm for people in all walks of life as well as seeing the value in people who are mentally well or unwell, just seeing people for who they are … (Zoë, p.12).

Dixie suggested negative preceptor experiences put students off entire areas of practice:

> Who you are buddied up with when you are training, will make or break you as to whether you ever want to go back to the area (Dixie, p.14).

The quality of clinical experiences is recognised as being a crucial factor affecting where student nurses will choose to practice when they graduate (Clinton, 2001; Clinton & Hazelton, 2000; Ferguson & Hope, 1999; Hamer et al., 2006). If student nurses do not have positive clinical experiences in their mental health placements they are unlikely to choose to work in the area (Patzel, Ellinger, & Hamera, 2007).

Likewise the quality of the undergraduate lecturers is of key importance to development of appropriate, relevant and up to date clinical knowledge. Wynaden, Orb, McGowan, and Downie, (2000) found that students doubted the clinical creditability of undergraduate lecturers. Lecturers themselves attest to the value of clinical currency and activity in supporting their ability to teach clinical papers (Owen, Ferguson, & Baguley, 2005). Nursing lecturers are obviously of great significance to students not only through their theoretical and clinical knowledge but also as role models.

Angel had experiences of mainstream undergraduate lecturers paying 'lip service' to cultural safety:

> If you have got tutors who aren't practising cultural safety ... what sort of role modelling is that giving the people they are teaching? (Angel, p.10).

She believed this had negative moral consequences, not just for the clients but also for the Māori and Pacific nursing students as she stated:

> I don't know actually whether they want Pacific island and Māori (nurses) to succeed (Angel, p.27).

There is a clear strategic drive to recruit and retain Māori and Pacific Island people to nursing and to the mental health services (Finlayson et al., 2005). It is important for Māori that their world view is recognised with education by acknowledging and incorporating Māori health models and Tikanga (Curtis, 2004).

Key priorities are to develop Māori providers, attract Māori students, foster Māori values, enhance cultural identity and increase training in both clinical and cultural aspects of Māori mental health service delivery (Ponga, Maxwell-Crawford, Ihimaera, & Emery, 2004). Māori clients benefit from culturally competent care and Māori nurses have a vital role to play in that. However Māori nurses need to be adequately supported and validated and must have positive role models themselves.

Megan articulated clearly that a good role model was one of the most important factors in her learning to be a mental health nurse and that this was now lacking, as the role models had generally left the acute units:

> ... they (new grads) need really good role models because I think in mental health you do most of your nursing and your learning by watching people do it and you need to have skilled clinicians. I believe you've got to have the role models. (Megan, p.9).

Preceptors, role models and mentors are crucial aspects of a positive transition to graduate practice for nurses in mental health (Hayman-White et al., 2007; McCloughen & O'Brien, 2005; Waite, 2004) and are particularly effective if they demonstrate a positive attitude in clinical practice and offer graduates support and encouragement (Maben et al., 2006).

Mentors and preceptors must be adequately experienced, trained and supported by organisations if they are to provide effective support to graduates (Hayman-White et al., 2007). If graduates are repeatedly exposed to poor role models and poor practice it can lead to them being desensitised to moral issues with a lack of humanistic regard for the clients (Greenwood, 1993).

A difficult issue for some of the graduates was standing up to their RN 1 preceptor when they believed that he/she was behaving unethically.

A significant aspect of this was the power the preceptor had over the graduate to 'pass' their work and placement as Zoë and Francis described:

> I think I would have liked to have been more assertive in speaking up on behalf of this chap. But I think the power thing applied to me as well, being a new nurse and an RN1 (but) the senior nurse involved happened to be my preceptor at the time so that, there's a power imbalance in there like it or not there is a power imbalance on several different levels. They have more experience than me, they are responsible for filling out the paper work to say that I have achieved the goals I have to achieve in order to pass the course that I am on this year. So there is an immediate power imbalance (Francis, pp.6-7).

> I had to get a support person ... cause I was so fearful of her (the preceptor)... it was the most belittling experience I have ever had ... because the preceptors make or break you and pass or fail (you) so they have another power thing making you sweat it out (Zoë ,p.17).

The quality and educational experience of preceptors is significance to their effectiveness (Hayman-White et al., 2007; Waite, 2004; N. A. Watson, 1999). McCloughen and O'Brien (2005) recommend that only nurses who are sufficiently experienced and recognised by their colleagues as good role models should be selected for preceptoring. They argue that preceptors should then be engaged in specific formal mentor training workshops.

Marshall (2000) found that educative status of preceptors impacted on what they valued in relation to student's knowledge and practice. In particular was the perceived value of cultural safety.

This author also noted that in New Zealand preceptors were often responsible for preceptoring those with higher education than them.

Haitana (2007) found that many preceptors working with students in a New Zealand hospital had not completed any formal training for the role. Her work further noted the need for preceptors to have workload accommodated for whilst they were preceptoring. Haitana recognised the significance of a positive preceptor/student relationship as being pivotal to the success of the student learning experience.

Graduate socialisation in this study was influenced not just by the nursing practice that they were exposed to, but also their status within the hierarchy of the nursing group in which they worked. The next sub theme on how the participants learnt the rules describes how the graduates establish their place as a new mental health nurse and attempted to fit into the practice environment.

4.0.4 Fitting in

Part of learning the rules was about finding where the participants fitted within the organisational culture and structure. The participants described wanting to establish a sense of belonging and collective purpose, however in reality they were quickly made aware of their place within the organisational hierarchy often rendering their contribution and moral agency invisible.

Many of the participants described a lack of confidence in speaking out against what they perceived to be morally unacceptable incidences. Even those who did speak up found it difficult and stressful as Olivia describes:

> At one point I thought I wouldn't say anything because I'm just a new grad. Then I thought no I'm going to advocate for my client (Olivia, p.5).

Megan had worked in the mental health services for fifteen years and was able to stand up for her moral beliefs and her clients, although it took some persistence. She did not think it would be so easy for a new grad who had not had her experience in challenging her more senior colleague who wanted to seclude a client:

> ... if something needs to be challenged then I will challenge it and I don't think RN1s or new grads will challenge it... (p.1), (but) She got quite angry ... with me and you know; 'no, no, no he's just demanding and I'm not going to feed into that bullshit' " (p.4)... Well I just don't think they (the other new grads in her unit) would have had the confidence actually, because I mean, I think a lot of Mental Health nurses are quite staunch (Megan, p.7).

There was a belief that the role of the new nurse was to fit in and not to be too challenging towards the more experienced nurses as they encountered new and unfamiliar situations. Olivia discussed the invisibility of the new graduates suggesting that they had not necessarily earned the right to be listened to:

> A new grad should be seen and not heard too much because they have not had enough experience to have an opinion ... They rely on new ones that (they)won't interfere with the status quo sort of thing (Olivia, p.5).

Many of the graduates had a sense of their invisibility and needed to fit in, even when they thought the other nurses were wrong as Dixie suggests:

> Because I was still very green so to speak ... seniority on the ward just sort of railroaded me into it, I've got to follow suit because if you go against the grain or question you're basically going to make your life hell (Dixie, p.12).

In agreement Zoë felt that the more experienced staff were not interested in listening to her perspectives and this further stifled her ability to be heard or to practice in way which was different from the established norm:

> They are not prepared for new grads coming in with new ideas ... they just don't have a voice (Zoë, p.4).

The importance of being accepted by the group with a 'fit in' or 'get out' mentality is a powerful influence on new graduates' ethical behaviour (Kelly, 1998). Student nurses and new graduates are a particularly vulnerable group who feel powerless to influence ethical outcomes within the context of the group, choosing rather to attempt to manage their own distress and reconcile lost ethical ideals (Cameron et al., 2001; Vallance, 2003). The influence of the social group and hierarchical systems can be an influence on moral values and behaviour, with individuals needing to find ways to redefine their sense of moral integrity in order to preserve their professional self (Kelly, 1998).

The 'group think' controlled behaviour by the threat of negative consequences for those who strayed and did not fit in. This influenced the graduates' practice and they often described feelings of powerlessness to behave in the way that they believed was moral. Ethical practice that was different to the cultural norm was not encouraged and put graduates at risk of isolation from the group, as Shilo indicates:

> It's bizarre really, because it's more the staff you have to watch out for rather than the clients, and it is (Shilo, p.13).

Whether real or perceived there was a majority view that the graduates needed to moderate their behaviour to be accepted and safe within the nursing group as Zoë and Francis describe:

> They (the other nurses) don't want splitting they want team work and solidarity and you can't be a tall poppy when you work in a team (Zoë , p.4).

> ...if you are not seen as part of the team, questioning or confronting them about things ...it could result in horizontal violence ... you would have to be very careful (Francis, p.8).

The participants gave disturbing examples of their limited status and power:

> ... there is that tendency to eat the younger nurses, and you're a new grad ... (Olivia, p.5)... I think that it comes in that horizontal violence. I think there is a lot of frustration with new grads that they're easy targets (Olivia, p.6).

When asked why she thought this was she replied:

> Because they can, because it's a power thing, because someone has done it to them, the food chain maybe and new grads are at the bottom of the food chain (Olivia, p.5).

With Zoë recognising that new graduates had very little power:

> I know a lot of people would say you choose to give your power away, sometimes you never even owned it ... new graduates don't ... (Zoë, p.9).

Nurses often feel powerless to act in a way that they believe to be ethically right (Holly, 1993; Kelly, 1998; Peter et al., 2004). Despite having a professional responsibility and the moral agency to act nurses are often not free to be moral, with limited power and autonomy to intervene as they believe they should (Johnstone, 2004a; Liaschenko & Peter, 2003; Peter et al., 2004; Woods, 1997, 2005; Yarling & McElmurry, 1986).

In relation to this study the notion of reduced autonomy and power due to their new graduate status, impacted on the participants' ability to behave in ways they believed to be morally right, and lead them to recognise potential conflicts that occurred with others.

4.0.5   Recognising conflict with others

Learning the rules meant negotiating relationships with other mental health nurses and for many of the participants this meant recognising conflicting values and positions the other nurses held. Whilst the literature describes relationships and power issues with doctors as a significant issues effecting nurses ethical autonomy (Diaski, 2004; Dodd et al., 2003; Lipp, 1998), the participants in this study did not describe difficulties with medical colleagues but rather disempowering and difficult relationship problems with other nurses that affected their ethical practice. Such relationships with other nurses are described in literature which attests to the oppressed behaviours that nurses demonstrate, including hierarchical relationships, low self esteem, horizontal violence, the rejection of new ideas, and a 'tendency to eat our young' (Cox, 1991; Curtis, Bowen, & Reid, 2007; Diaski, 2004; Randle, 2003; Roberts, 1983; Vallance, 2003).

New graduates are clearly vulnerable as they enter the profession at the bottom of the pecking order. To be accepted by the other nurses whilst balancing a belief about what ethical nursing practice was, and the type of nurse they wanted to be was far more difficult than the participants had expected. Although the participants wanted to fit in to the nursing group, they often felt different from their colleagues.

Often the graduates perceived that their experienced peers were burnt out and detached from moral issues central to the client, as Angel describes:

... they are just there to work and get their money; they are not actually there to nurse for their tangata whaiora (Angel, p.19).

Dixie articulated conflicting feelings around her senior nurse colleagues whom she perceived to have a greater knowledge base than she did, but not necessarily having a client centred or caring attitude:

> I think there is also an understanding on the wards that you have respect for those who have been there longer, because they do have the knowledge and you do need to soak up that knowledge from them ... You don't want to soak up their attitudes which over time ... become quite hardened and almost numb to the actual issues in nursing, ... that this, [the client] is a person with feelings (Dixie, p.11).

She further identified that she thought the more senior nurses had 'switched off emotionally', but even more alarming was her assessment of the graduates that preceded her by only a year:

> Some of them look quite drained and I think oh my gosh it's already zapped out of you (Dixie, p.19).

Repeated exposure to occupational stressors can lead to burn out for nurses in acute mental health units, resulting in emotional exhaustion and depersonalisation from the client (Jenkins & Elliot, 2004). Mental health nurses are however; morally responsible for providing care that reflects a genuine empathetic connection and commitment to the client (Akerjordet & Severinsson, 2004). All of the participants had a clear sense of the importance in being involved in a therapeutic relationship and the value of such a partnership with the client. They saw themselves as moral agents with an ethical responsibility to ensure that the client's needs were met. They did not always see their nursing colleagues behaving in a way that they thought was ethical, and consciously articulated not wanting to be part of a nursing culture that did not respect the client.

All of the graduates were able to identify aspects of the 'nursing culture' that they did not want to become part of despite significant pressure by their colleagues to do so.

> It's really hard not to get, I think the word is assimilated, into that culture or practice of others (Francis, p.1).

Dixie had been pessimistically warned of the inevitable perils of 'inculturation' by a nursing lecturer.

> We were told by a lecturer that they expected it would only take us probably 12-18 months to become inculturated as the other staff on the wards would be, ... basically everybody starts following the same road and you either go with it or you go against the flow of it, but the majority of nurses will end up doing the same thing. Not so much as turn a blind eye, but perhaps not do battle the same as you might have done initially, to advocate for people (Dixie, p.7).

Nurses assimilate a set of values and expected professional standards during their education, however they are then expected to adhere to a quite different set of practice norms on entering the work environments. Brandon (1991) argues that this professional practice socialisation is more powerful than any training that has preceded, with new staff being 'brutalized' into assuming institutionally acceptable ways of behaving. He attests to mental health nurses being just as at risk of being institutionalised as clients within the powerful cultural force of practice environments.

Environmental influences formed in organizational contexts can significantly affect choices and determine practices of the professional groups working within them (Mohr & Horton-Deutsch, 2001; Peter et al., 2004). For the participants the undergraduate ideas they been socialised into valuing were at odds with the practice realities they were exposed to.

Each participant described a process of learning the rules of mental health nursing as they entered the practice environment, defined themselves as RNs, negotiated relationships with other nurses and attempted to provide ethical nursing care to clients within the cultural force of the mental health services.

4.1   Summary

This chapter has presented the introduction of the first theme 'learning the rules'. I have introduced the participants' stories which related to the first aim of this project to describe and explore new graduates experience of ethical practice in the mental health services. It also illustrates the subthemes, which collectively describe what it meant for participants in this study to learn the rules of being a mental health nurse. The participants were influenced by a number of relationships that they had intrinsically, with clients, nursing education and other nurses and the organisation that they worked in. As they reconciled expectations and began to practice, they were able to define what they believed to be ethical mental health nursing. They then negotiated complex relationships with others and the culture of the system as they attempted to practice in ways they thought were morally just.

The next chapter titled Justice and Care is a continued discussion of the themes which were developed through the process of thematic analysis in this project. In chapter five, I further explore the primary aim of the project and complete discussion to address the second aim: to identify institutional influence on the ethical practice of new graduate mental health nurses in their first year of practice. Justice and care describes the two fundamental elements that the participants recognised as being crucial to ethical nursing practice.

CHAPTER FIVE

Justice and care

Kaua e takahia te mana o te tangata
Do not trample the mana of the people
(Traditional Māori proverb)

5.0   Introduction

In this chapter I further explore and discuss the data which continues to answer the research question: what influences the ethical practice of new graduate nurses in the mental health arena? Further examples of participants' narratives address the primary aim of this research project: to describe and explore the participants' experiences of ethical practice and the secondary outcome of: identifying institutional influences on ethical practice.

In this chapter the participants' discussion on educative experiences that were of use to them are presented. This therefore provides the platform from which to respond to the other secondary outcome of: how to inform educators on how best to prepare undergraduate nurses to maintain ethical integrity within the mental health system. The second major theme to emerge from the data analysis is titled justice and care. Justice and care are the two fundamental elements that the participants recognised as being crucial to providing ethical mental health nursing care. In this chapter I continue discussion of literature and sub-themes describe how the participants experienced knowledge and understanding of ethical practice in mental health nursing. The sub-themes which constitute the overall theme of justice and care are: **stigma and silence; in whose best interest; cure versus care; and finding allies.**

Understanding these contextual issues which I discuss in the sub-themes, demonstrates how the participants have come to understand, describe and enact ethical nursing practice in mental health settings.

5.1   Justice and care

The two central tenets that the participants believed were fundamental to ethical mental health nursing practice were that of justice and care. They believed that the most important aspect of their role was to have a caring and respectful relationship with the client. Further to this, was an understanding that the client was deserving of care that respected them as people, their rights and their individual needs. Justice was done if the client received such care. If the participants thought justice wasn't done or that the client didn't receive the care that they were entitled to, and then they felt morally conflicted and sought ways to remedy this. Justice was often articulated by the participants in terms such as: 'if this was me or my family'. Justice was understood and described by the participants in terms of fairness, equity and entitlement. Justice in this major theme does not refer to principle of justice commonly understood in ethical theory. The second aspect of the theme was care.

Care was enacted through a respectful, professional, therapeutic relationship with the client. Sometimes, the participants were not able to influence outcomes for clients or intervene as they wished to. They found themselves stigmatised and silenced in their role as new graduate mental health nurses.

5.1.1 Stigma and silence

The word stigma literally means a mark of shame and historically, provided a way of distinguishing difference by indicating a sign of social disgrace (Johnstone, 2004a; Mohr & Horton-Deutsch, 2001). Stigmatization is a process of discrimination whereby people are socially excluded and disadvantaged. Stigma and discrimination has long been associated with the mentally ill and people who live with mental illness are amongst the most stigmatised, disadvantaged and marginalised group of people in society (World Health Organisation, 2001). People who live with mental illness experience discrimination in most aspects of their lives and in a society where social structures reinforce deeply ingrained attitudes of intolerance, ignorance and fear (Burdekin, Guilfoyle, & Hall, 1993). Discriminatory beliefs about mental illness and how those with mental illnesses are treated permeate mental health systems.

Ideologies are conscious and unconscious shared sets of assumptions that reflect a social reality (Horsfall & Stuhlmiller, 2000). The reality of stigma and discrimination within the mental health system is that it is situated in a cultural and historical context of fear and containment (Clarke, 1991) with a mandate for control rather than care (Lakeman, 2003). As Olivia described her belief that society lacks regard and value for mental health clients, this belief extended to mental health nurses as well:

> I think what would also help is if Mental Health itself wasn't given the stigma it is. ... 'oh you're not a real nurse because you're in mental health', or 'why'd you want to work in mental health'.... cause everybody's 'nuts' ... because society has got so much ignorance and fear around mental health and I don't think some organisations help that (Olivia, p.17).

In New Zealand negative media perception of those with mental illnesses is associated with recruitment difficulties (Hatcher et al., 2005). Mental health service workers are seen as an undervalued and marginalised group with little regard afforded to them or their contribution to improving the status and outcomes of those with mental illness (Ministry of Health, 2003a).

There is a worldwide acute shortage of mental health nurses (Humpel & Caputi, 2001; Prebble & McDonald, 1997; Robinson & Mirrells, 1998; Waite, 2004), with more mental health nurses leaving the field, than being recruited (McCloughen & O'Brien, 2005). It has been proposed that in many undergraduate programmes the content of the curriculum is biased towards general nursing (Clinton & Hazelton, 2000; Happell, 2001) with limited quality mental health placements available to students (Ferguson & Hope, 1999; Mullen & Murray, 2002). In support Hamer et al. (2006) argues that mainstream nursing education has marginalised mental health issues and mental health new graduates may experience more difficulties in their first year of practice than their general nursing counterparts (Hayman-White et al., 2007; Prebble & McDonald, 1997).

Despite mental health nursing being recognised as a high stress profession (Jenkins & Elliot, 2004; Rees & Smith, 1991), it appears that they remain a group who are undervalued and stigmatised, not only by the general public but also by the profession. If mental health nurses are marginalised, it limits their ability to effectively influence positive client outcomes. The status and value of nursing affected the participants' ethical practice and ability to advocate on behalf of their clients.

Even though clinical nurses have the greatest access to the client's life world and understandings of their goals (Craig, 1999; Dodd et al., 2003) they are not always heard within the organisational hierarchy (Peter et al., 2004). Dixie believed that a lack of primary nursing approaches and primary nurses not being included in decision making effected the ethical outcome of care provision for the client:

> Because they're not there on a daily basis, seeing this person, or working with this person, in everyday, thinking, well, where are we going? I mean to me, yes there's other nurses that visit at the desk and all discuss it, who are far higher up in the hierarchy, but ... I don't think they see the full extent of it because it's not affecting them (the plight of the client), and I think that's the difference, is those nurses working on the floor ... have it as an ongoing issue and it does affect them ... (Dixie, pp.9-10).

Dixie identified that the effect of being rendered invisible and ineffective within the hospital system had significant negative consequences on the morale of her nursing colleagues. Even those who had only graduated the year before her:

> I can see the change in them, I think some of them feel like they've hit a brick wall and you can see them starting to slip down (Dixie, p.18).

Mental health nurses perceive that the quality of the therapeutic involvement that they have with clients is strongly associated with providing ethical care (Lutzen & Schreiber, 1998) and job satisfaction (Roberston, Gilloran, McKee, Mckinley, & Wight, 1995; Severinsson & Hummelvoll, 2001). If organisations are not receptive to involving the perspectives of nurses in ethical dialogue and decisions about client care, it has a negative effect on client outcomes, and the morale of the nursing staff (Cronqvist et al., 2004; Dodd et al., 2003; Woods, 1999).

Organisations that constrain nurses' ethical involvement oppress and marginalise their perspectives and become morally uninhabitable for them (Peter et al., 2004; Yarling & McElmurry, 1986). If nurses lack sufficient power to be involved in ethical collaboration and decision making that relates to client wellbeing, there is a strong correlation with low job satisfaction and burnout (Severinsson & Hummelvoll, 2001).

When the participants were unable to advocate for their client's or intervene when they believed they were not receiving ethical or appropriate care, they felt morally distressed and ineffectual as Dixie and Zoë describe:

> I just find it distressing and disheartening to think, I don't feel that at the moment all is being done that could be done, and because I'm there, I'm participating in providing that care, then that makes me as guilty as them (Dixie, p.6).

> I'm very disappointed in myself, not (just) as a nurse but as a human being (Zoë, p.8).

When organisational structure constrains nurses from advocating for their clients it can result in them becoming morally distressed (Corley et al., 2005). In environments that oppress nurses and minimise client needs and moral entitlements nurses will attempt to manage their own distress. However, eventually they lose sight of the client themselves as they attempt to survive in environments with little therapeutic value to the client (Lutzen & Schreiber, 1998).

The graduates' ability to act as effective moral agents on their clients' behalf was strongly influenced by how much the organisation valued and supported the nursing staff. If the nurses were not valued, their perspectives went largely unheard and their ability to positively influence ethical outcomes for clients was reduced.

The participants were conscious that the clients' interests were not being well served. Therefore it became questionable as to whose needs were actually being met? The following discussion relates to the issues of in 'whose best interest'.

5.1.2   In who's best interest?

The ethical issues that the participant's raised were centred on their perceptions that how the client was being treated was not necessarily in their best interest. Although nursing as a profession claims to be client centred in its approach, in acute psychiatric units, this is may be more 'rhetoric than reality' (Happell, 2001). Patient centred care involves a partnership with the client whereby they define their needs (Watkins, 2001) and nurses work with them in a participatory way based on shared decision making (Allen, 2000). The experiences of the participant's indicated that client centred care was not necessarily a reality in the DHBs in which they worked (see Table 2, below).

Table 2: Ethical issues discussed by the participants

Zoë	Francis	Shilo	Violet
Seclusion	Seclusion	Over sedation	Boundary breach
Dixie	Megan	Angel	Olivia
Long term compulsory treatment in a restrictive environment	Seclusion	Not addressing cultural needs	Seclusion

Often, interventions seemed to be of benefit to the organisation, the smooth running of the units or the clients' family rather than the client themselves as Dixie and Shilo describe:

> We have the high needs unit ... I don't specifically think its therapeutic or any sort of nursing, sometimes it seems more like punishment ... there are some bizarre things that go on and your just left scratching your head and wondering what that was all about, what did you achieve and how on earth has it helped that person (Dixie, p.18).

> He is always saying that you are giving me too much medication ... to just keep plying him with pills, what's the good of it? It's no good to..... (client name deleted) (Shilo, p. 5).

Megan intervened and prevented the seclusion of a client that she thought was inappropriate and not clinically indicated as she recounts:

> It seems to me quite a stupid thing to seclude (him) its punitive ... seclusion wasn't indicated (p.2) ... to me it was seclusion over a cigarette (Megan p.4).

If the needs of the client were undermined, ignored or not well served the participants were alerted to a moral conflict. The participants recognised that the type of care the client's were receiving was not in their best interests and therefore did not address the value and moral principle of justice. Therefore when organisational values and priorities are in opposition to nursing values, graduates feel unable to influence outcomes. As a result they are likely to become distressed and disaffected (Severinsson & Hummelvoll, 2001). The participants repeatedly described examples of organisational constraint which prevented the provision of just, appropriate and ethical care.

There was concern from some of the participants that the needs of Māori were not well met within the institution with a lack of concern for cultural safety frequently experienced. Spiritual, emotional and cultural were suggested to be of less value than risk management and psychiatric interventions. Angel was disturbed by the lack of family inclusion as she describes:

> (In) our culture whānau is really important and having family involvement while someone is unwell is paramount to a lot of Māori (Angel. p.6).

Likewise Zoë felt that in the culture of the organisation that she worked there was insufficient recognition or regard for the spiritual, whānau, emotional and physical aspects to people's health:

> I base my framework of nursing by holding the 4 walls of the Māori mental health model and so you have got to consider all aspects of their life (Zoë, p.3).

Olivia felt that part of the decision to seclude her client by nurses who hadn't been working with him was because he was Māori and weighed 150kg. This was associated with a perception of high risk of violence to others:

> But the other nurses that had come in ... said 'oh maybe we'll have to restrain him, and we put him back in seclusion'. They had not worked with him; they were just going off what they saw then and there. 'Oh no he has to go back into seclusion, he's a big guy, he's a safety risk', but they hadn't worked with him and seen him (Olivia, p.2).

In New Zealand, there is disparity between Māori and Pakeha rates of mental illness, with Māori having not only a greater prevalence of psychiatric diagnosis but also a greater association with the severity of illness (Baxter et al., 2006). Furthermore, both Pacific and Māori are less likely to access mental health services than Pakeha (Oakley-Browne et al., 2006).

Services have a medical approach with interventions that often fail to include family or cultural issues in service delivery (Craig, 1999). Once again, the participants suggested that care was not appropriate for the client and therefore not just, with a focus primarily on cure and control rather than care and recovery.

5.1.3   Cure versus care

Despite a decade of 'deinstitutionalisation' (Fourie et al., 2005; Hamer et al., 2006; Lowery, 1992) with a greater focus on client recovery (Mental Health Commission, 1998; Ministry of Health, 2003b), the participants identified a systemic culture of 'control rather than care'. Mental health services in New Zealand are based on an approach to care that utilises a medically focused interventionist model, relying heavily on the use of medication to reduce symptoms of mental illness (Muir-Cochrane, 1996). With a historic mandate to contain and cure those with mental illness (Evans, 2005; Holmes et al., 2004; O'Brien & Golding, 2003), it seemed to the participants that little progress had been made in the way clients were cared for and treated in the current mental health systems.

The socially constructed notion to control the mentally ill was a frequently repeated idea that caused the graduates moral discomfort and distress. Zoë felt that although the big psychiatric institutions had closed, the pervasive cultures continued:

   Lake Alice has never closed it just relocated (Zoë, p.5).

With little respect or value afforded to the client and at times, an absence of hope and belief in the client's recovery:

The majority of them are treated pretty dreadful" (Zoë, p.9) ... (with) a very bleak future that in a way it's like long term death sentence in a way, you know that the future outlook is limited (Zoë, p. 1).

Despite hope and recovery being foundational philosophical tenets in New Zealand mental health services (Mental Health Commission, 1998), the medical model remained dominant. The participants believed that clients were quickly diagnosed, labelled and treated accordingly.

Violet felt disappointed that the holistic practice that she had anticipated was in fact more about 'boxing' people off into mental illness diagnosis. She had a sense that the person was being lost as the diagnosis took the priority for how 'treatment' would progress:

I don't know if I even want to get to that point where you can talk to people and get to know people a little bit, and they put them in a box (Violet, p.3).

Congruent to the approach of a medical model, psychiatric medication remains the first line of intervention and was something the graduates were repeatedly conflicted by. Zoë described the consequences of a client being secluded and medicated with intramuscular anti-psychotics:

What was really shocking ... when I went back in the morning the woman was like a zombie, she could hardly move, she was so drugged up to the eyeballs umm, you wouldn't have even thought it was the same woman. ... they (nurses and psychiatrist) had drugged her so much, and she didn't need those medications on board, she didn't need to be reduced to that (Zoë , p.7).

People who live with mental illness are amongst the most vulnerable and politically powerless people in society (Lakeman, 2003; World Health Organisation, 2001) who can be subjected to compulsory treatment within restrictive environments (Farrow et al., 2002; Mental Health Commission, 2004; New Zealand Government, 1992). Compromised autonomy, the use of force, coercion and restrictive environments are the most commonly cited ethical issues that disturb mental health nurses (Lutzen & Schreiber, 1998; Meehan et al., 2004; Severinsson & Hummelvoll, 2001).

Despite a New Zealand Ministry of Health directive to provide care in the least restrictive environment (Lutzen & Schreiber, 1998; Mental Health Commission, 2004; O'Hagan et al., 2008), misappropriated power, unnecessary use of force and restrictive interventions were the most common ethical dilemmas for the participants in the study. Dixie describes the conflicting roles she had to assume within a health care system with a social mandate to control the mentally unwell:

> Sometimes I struggle within the ward with, am I a nurse or am I a jailer? (Dixie, p.3)

In support Zoë articulated the absence of care and the focus of control as:

> I don't see a lot of these people I work with, my colleagues, as nurses, I think they are prison wardens (Zoë, p.9).

Care versus control is recognised as a moral issue for mental health nurses (Muir-Cochrane, 1996; Rungapadiachy et al., 2006; Schreiber & Lutzen, 2000). As such it produces a difficult dichotomy for nurses as they endeavour to balance a therapeutic relationship whilst also assuming a custodial role.

Nurses must assume a number of roles when providing mental health care which range from counsellor to jailer (Stickley, 2002). For new graduate nurses who have arguably had insufficient theoretical and clinical preparation specific to the mental health environment (Clinton & Hazelton, 2000; Happell, 2001; Hayman-White et al., 2007), role ambiguity is heightened as they are expected to advocate for clients as well as restrain and control them (Rungapadiachy et al., 2006).

The participants in this study gave alarming accounts of a culture that did not support clients but rather, employed the overzealous use of control and physical force which they described as being morally abhorrent to them. Zoë and Francis describe the restraint of clients that they did not believe were a risk of violence to others:

> It was the staff with the issue…and he was pretty much frog marched into the area outside seclusion which is a locked area (Francis, p.2).

> LA (Lake Alice) nurses came in with their hands, with their fists punching into their other hands, this is women I'm talking about, say (gesticulates: punch, punch) We'll nail her, well give her an injection well slam her down so that she's quiet ... (staff members name deleted) for the rest of the night (Zoë, p.5).

Both Francis and Olivia believed that mental health environments attracted staff who wanted to assert power over others, perhaps due to their own personal inadequacies:

> I think that that's part of the culture of that type of (locked) unit. I think people feel quite powerful when they get to ...open doors, with keys and dictate to their clients when they can go to the toilet, when they can eat, when they can get changed, when they can go to bed and get up. And that setting probably attracts people (who) like that kind of power (Francis, p.6).

> I suppose some people just think they'll go to work and have some power, if they don't have power in their own home or they have not had education in understanding about empowerment that power shift from them to the client. The client should have the power (Olivia, p.9).

Restraint in the mental health setting is described as controlling a client through bodily force and is generally a strategy utilised to manage risk associated with client aggression and violence (O'Hagan et al., 2008).

Mental health nurses, due to their proximity to the client, are often both expected to manage the violent behaviour (Shepherd & Lavender, 1999) and are the targets of aggression (Fry, O'Riordan, Turner, & Mills, 2002). Factors which reduce the incidence of aggression by clients include: ensuring staff are trained in de-escalation strategies; having an environment that offers people quiet spaces and meaningful activities that support recovery; and having an organisational culture whereby clients are respected, listened to and supported (O'Hagan et al., 2008). Misuse of power by the staff clearly represents immoral and unprofessional practice and a violation of the client's right to ethical treatment.

Megan attributed high rates of seclusion as being due to staffing issues, with shortages resulting in some staff working up to 120 hours per fortnight and relying on the intervention heavily as she describes:

> ... just burnt out and in for an easy time because it's easy when you put them in seclusion, you don't talk to them, ...just lock the doors look at them every 10 minutes and go in every few hours .... I think it's unethical because when you seclude somebody you take away all their personal power (Megan, p.3).

Short staffing is directly related to both a reduction in the therapeutic interaction with the client and an increase in the use of controlling measures such as seclusion (Breeze & Repper, 1998; Cleary et al., 1999; Muir-Cochrane, 1996). Seclusion and custodial care are reduced in organisations that have leaders who are committed to recovery and restraint reduction; a high ration of staff who are well trained; and an organisational culture of respect (O'Hagan et al., 2008).

In contradiction, poor nursing leadership, high client acuity and nursing workloads are positively correlated to an increase in ethical conflicts within metal health units (Severinsson & Hummelvoll, 2001). The participants recognised that restraint and seclusion were often overused and clearly not for the best interest of the clients. This created significant moral conflict for them. The participants did recognise that not everyone was controlling and found some nurses who cared for and supported clients and the graduates themselves. The next sub-theme describes the participants' experiences of finding allies.

5.1.4   Finding Allies

The participants were able to identify supportive influences in their ethical practice. Identifying supportive relationships with others also had a positive effect on their ability to act in accordance to their moral beliefs. If the participants felt that their contribution and knowledge were valued and respected by their colleagues, they were more likely to speak up on moral matters. Shilo described working in a supportive and respectful team who valued staff and clients. She believed that this allowed new graduates to discuss ideas with others and practice in ways they believed to be ethical:

I just think it's that we all work together as a team; we certainly bounce ideas off each other … we know why we are there, we know that we are there for the clients, and if you are not there for the clients then you shouldn't be there really (Shilo, p.8).

Olivia was able to effectively intervene in a way that she believed to be right by enlisting the support of a more senior colleague:

I don't know, if the other nurse had not been with me, whether I would have got the same outcome. If she hadn't been in agreement, I don't know if they would have taken my view as a new person (Olivia, p. 6).

The support of colleagues assisted the graduates to navigate their complex ethical problems. Primarily, this support was found with other nurses but if nurses were not forthcoming colleagues from other disciplines were able to assist the nurses to find solutions to their ethical issues. There was also a recognition that now as RNs the participants had a professional obligation to support other nurses and students as Dixie describes:

The whole think we're taught with nursing, is you know the horizontal violence, and when you have students, just to remember you were one once yourself, which I do, which is the reason why I actually want to work with students, because especially in Mental Health, you see someone come in and they look absolutely terrified and they are, they're so scared and I don't want them leaving like that (Dixie, p.14).

The transition from student nurse to RN can be a difficult time, particularly in the first three to six months when nurses need considerable amounts of support to assimilate into their new role (Hayman-White et al., 2007). If new graduates are not well supported in the transition year they are at risk of exiting the profession (Evans, 2001; Hamer et al., 2006; Te Pou, 2008). Interpersonal and organizational support is imperative to a successful transition and the development of nursing potential (Waite, 2004).

Graduates report that organizational support must include an adequate formal orientation (Prebble & McDonald, 1997), realistic expectations around workload issues (McCloughen & O'Brien, 2005) and positive workplace cultures (Rungapadiachy et al., 2006). Pivotal to the transition year is relational support from other nurses and in particular, the need for formalized and positive mentoring and preceptoring and constructive feedback (McCloughen & O'Brien, 2005; Prebble & McDonald, 1997; Waite, 2004). Preceptors and mentors must be suitably chosen, educated, and in turn, supported by the organization (Hayman-White et al., 2007).

Education was recognised as key to the development and maintenance of ethical nursing practice. The participants were able to recognise what had been helpful in an educative sense as undergraduates, and what they perceived would be helpful to them now as RNs. The participants recognized that their education had given them a degree of competence in understanding professional and ethical nursing practice and a belief in their entitlement to have their perspectives heard. The participants were readily able to identify what they perceived to be ethical dilemmas and ethical violations to client care. Both Olivia and Angel describe their educative experiences as supporting theme to be ethically assertive:

> It is very important to know that they can stand up and not be crucified for it, that they are valued in the organisation as having done ... their study and they have done placements, they have had some clinical experience. They certainly haven't had a lot of experience, but they have got the knowledge base there (Olivia, p. 7).

> If it's a cultural issue and if it's from a Māori tangata wahiora I don't really care whether they think … I would make sure I would tell them (Angel, p.16).

This fits with the literature that holds that ethics education enables nurses to more readily identify moral issues and be ethical assertive in response to them (Dodd et al., 2003; Duckett et al., 1997; Johnstone, 2004a). Nursing students learn ethics through not just traditional moral theory but also through the real life experiences and narratives of nurses (Benner, 1991; Bowman, 1995), and examination of clinical issues (Woods, 2005). Nursing students report the most valuable learning enables them to balance their ethical integrity with the messiness of the clinical environment (Doane et al., 2004).

The participants were all able to discuss educational opportunities that they thought supported, or would support their ability to maintain a professional and ethical standard of practice. They recognised the importance of ongoing education and had an expectation that the hospitals needed to provide them with opportunities to further develop their practice. Both Shilo and Olivia thought in-service education with other registered nurses discussing possible solutions to actual real life ethical dilemmas and clinical situations would be the most useful for ethical learning and practice:

> Probably scenarios. If this situation arose, how would you deal with it? What would you do? (Shilo, p.11).

> More around ethical issues and dealing with how things are around seclusion, how you deal with a truly psychotic person, the best course of action, the most benefit to them because it's not till you get to that environment until you either do it or see it done you think 'Oh I could do that, that's a good idea' ... Or (clinical) examples that you can sort of relate back to, if you've never seen some one so psychotic before and you don't know what to do but if you've been given examples (Olivia, p.8).

Three of the participants alluded to the importance of their cultural safety education and its benefit to the standard of nursing care they could deliver. Angel thought cultural safety education and the Treaty of Waitangi workshops should be compulsory for all nurses and hospital staff so that they could provide morally sound and culturally safe care:

> This Treaty of Waitangi course you are talking about is it offered to the staff?... and she goes the staff just have to e mail us and we can put them on the (voluntary) course but from my point of view that is not really good enough. I feel especially overseas nurses should have to do the course (Angel, p.21).

Zoë attested to the usefulness of the conflict resolution workshop that she attended.

She was clear that it had assisted in finding ways to manage interpersonal relationships with other staff and to be ethically assertive:

> What's helped me there is this time I've done conflict resolution training two day workshop and I wished we had done that in our orientation week, because that just gave us communication skills that would have really (needed) if I'd been equipped with them sooner, I would have had my voice more you know because I had the confidence. I just think that has been the most wonderful course I've ever done (Zoë, 12).

Ongoing education that was specific to care of the client in the mental health area, ethics, cultural safety and conflict resolution were identified as supportive factors for the graduates to maintain moral integrity and develop their clinical practice.

Preparation for mental health nursing is being criticised at an undergraduate level for failing to prepare nurses to be workforce ready (Clinton & Hazelton, 2000; Hamer et al., 2006; Happell, 2001), with clear indication that graduates require ongoing education to develop clinical competence (Hayman-White et al., 2007; Prebble & McDonald, 1997). Graduate nursing programmes are identified as a key strategy in the recruitment, retention and development of the mental health nursing workforce (Finlayson et al., 2005; Hayman-White et al., 2007).

All of the graduates had completed or were completing a one year graduate education programme, called a Post Entry Clinical Training Programme (PRCTP) Registered Nurse-Level 1 (RN1) course at a regional polytechnic. This is a programme specifically for newly qualified nurses who have chosen to practice in mental health.

On completion of the year long programme the nurse graduates with a graduate certificate in mental health nursing (Finlayson et al., 2005). The content of the programme is specific to the mental health area and includes development of ethical mental health nursing practice however, there were mixed reviews on whether the RN1 programme was useful to them in practice. Francis and Zoë found the programme of significant benefit to their professional development:

> ...I'm total advocate of it its fantastic, it's really really supportive, good programme and ... spend a lot of time looking at ourselves and developing, it really works on developing our practice I believe and understanding more about who we are (Francis, p.12):

Absolutely fantastic, the tutors who are the most beautiful people, they never want to see anyone not get through, and they bend over backwards it wasn't just bums on seats, it was we need you to all make it, you know, the country needs more mental health nurses, you have got to get through (Zoë, p.13).

Whereas Olivia felt the content had been covered her undergraduate education:

I'm not learning anything new in the RN1 programme from my undergraduate education. It's pretty much going over the same sort of thing. Probably not going into the same depth, just refreshing. So you're reflecting but it's in no more depth (Olivia, p.8).

Graduate nursing programmes have been identified as a key strategy for the recruitment, retention and development of the mental health nursing workforce (Department of Human Services, 2001; Hamer et al., 2006; Hayman-White et al., 2007). The goals of graduate programmes are to increase and consolidate mental health nursing knowledge and develop skills and attitudes that demonstrate nursing competence (Heslop et al., 2001).

Graduates have rotations in different mental health areas with structured learning requirements around theoretical aspects and development of clinical skills within context specific situations (Hayman-White et al., 2007).

In New Zealand, the Post Entry to Clinical Training Programme (PECT) have been evaluated with both the DHB's and graduates perceptions on the usefulness of the programme examined. Both parties reported that the programme was positive and helped graduates to develop speciality knowledge and professional practice within mental health organizations (Finlayson et al., 2005).

A further important organisational support that the participants identified was clinical supervision. Supervision is described as a reflective process whereby the preceptor meets with an experienced practitioner of their choice and has the opportunity to reflect on clinical experiences and relationships, with a goal of developing and improving practice (Finlayson et al., 2005; Magnusson et al., 2002). Supervision was repeatedly described as being helpful by the participants of this study, as Dixie illustrates:

> Supervision made a big difference for me. I mean it's definitely good going talking to somebody who is completely; well she's not completely neutral, but not working within your direct environment, and her experience and place to take ideas. It really helped me sort things out and I could be myself and be challenged about what I thought was going on (Dixie, p.14).

Olivia found individual supervision to be more value than group supervision as she felt better able to bring up issues that were difficult for her:

> I find my clinical supervision heaps more valuable to me …because I think one to one you can be given more room to be open and fair.
> I mean if there are six or seven people in your group, and you're thinking, confidentiality, well there's more chance of it slipping from them than your one supervisor who is not your peer. You know it's not likely to go anywhere (Olivia, p.7).

Confidentiality, the quality and approachability of the supervisor were important aspects of its usefulness in managing ethical issues as Shilo indicates:

> That (the quality) also depends on the supervisor. But you know, I find my supervisor really good. And I am glad that I have a supervisor that I can go to and discuss whatever (is occurring for me in practice) (Shilo, p. 13).

Professional supervision is necessary to maintain professional and clinical integrity and to develop therapeutic competence for mental health nurses (Finlayson et al., 2005). Clinical supervision is associated with increased job satisfaction, improved staff morale, reduced stress, sickness and burnout (Berg & Hallberg, 1999). Hamer et al, (2006) suggests all mental health nurses have formal supervision and that this should take place in work time, to ensure practice development and competence. The participants were able to recognize and discuss relational, educational and organizational supports that assisted them to maintain their moral integrity and work in a way with clients that demonstrated moral and just care.

5.2   Summary

Chapter five has presented the second major theme of 'justice and care', and explored the contextual subthemes the participants described by way of understanding what they believed their role to be in providing just and ethical care in the mental health services. In this chapter I have further presented and discussed the factors which affect and influence the ethical practice of new graduate mental health nurses. In chapter five I have presented the supportive educational factors that the participants raised as being useful to their preparation and maintenance ethical behaviour. That pertains to the secondary outcome of: informing educators on how best to prepare nurses to maintain their ethical integrity as they enter the mental health services.

In the next chapter I present discussion and recommendations in relation to the outcomes of this project. I also describe the strengths and limitations of the study, recommendations and suggest ideas for future research in this topic area.

CHAPTER SIX

Discussion and Recommendations

E hara te pae i te tawhiti rawa ki nga ma kei te reri
No horizon is too high for those properly prepared
(Traditional Māori proverb)

6.0. Introduction

In this the final chapter, discussion is presented in relation to the research question and aims. Recommendations which relate to the secondary outcomes are proposed for nursing education (undergraduate and graduate) and mental health organisations, to prepare and support new graduate nurses to develop and maintain their ethical integrity as practitioners in the mental health system. Finally, the strengths and limitations of the study are discussed and implications for future research in the area are proposed.

The participants in this study were inextricably influenced by a set of interconnected, dynamic and evolving relationships with other nurses, other health professionals, managers and with clients, all of which took place in the wider context of the health care system. The discussion chapter examines aspects of the two central influential relationships that affected the participants' ethical practice. These relationships include those concerning people involved in their therapeutic practice (clients, family and others) and those connected to their ability to work as an ethical mental health nurse (the organisation and workplace practices).

In this chapter I discuss relevant issues which stem from the data analysis and form the basis and justification of recommendations for potential use in undergraduate educative organisations and institutions providing practice environments for new graduate mental health nurses.

The broad headings include: **socialisation during the process of education and graduate clinical experiences; socialisation and undergraduate preparation of ethical and mental health practice; institutional influences on ethical practice of new graduate nurses in the mental health setting; ethical issues for new graduates; mentoring and support of graduates; safe staffing and learning the skills to deal with conflict.** I begin the discussion with the factors affecting the socialisation of new graduate mental health nurses during their first two years of practice and perhaps, beyond.

6.1. Socialisation during education and graduate clinical experiences

Nursing education and professional socialisation determined for the participants' what they valued and thought was morally worthy. It developed the idea of 'the kind of nurse they wanted to be'. The organisational context then influenced to what degree the graduates were able to enact that value system and maintain their professional sense of self. To become an ethical mental health nurse required the participants to integrate a variety of theoretical understandings and synthesise a number of learning experiences and not just specific to mental health nursing, in order to practice effectively. They were able to identify what their supportive educational experiences were alongside what was required further development.

They also discussed situations whereby cultural forces within the workplace created a sense of 'powerlessness and invisibility', and prevented them from acting in a way in which they believed was ethically right for them and their clients. All of the participants were able to identify from educational and the organisational experiences influences that supported or impeded their ability to practice as ethical mental health nurses.

6.1.1. Socialisation and undergraduate preparation of ethical practice

The development of a professional identity, assumption of moral and philosophical beliefs, theory to practice integration and sense of confidence, depended in part on the educational experiences the participants were exposed to. Overall the participants discussed their ethics education as being generally helpful. All of the participants were able to identify and respond to moral problems in a way that indicated their undergraduate education had prepared them to develop professional values and standards, to recognise moral problems and utilise (to varying degrees) formal ethical theory to respond to their issues, in a combination of both rationale and emotional ways. It appears that undergraduate ethics education was adequate in preparing the participants to utilise the language and frameworks of formal ethical theory.

During undergraduate education, the participants developed a sense of what an ethical mental health nurse was and how one would behave. There was a strong sense of moral commitment and responsibility to the client.

With a notion that the key purpose of being a mental health nurse was to be in a relationship with the client that offered partnership, protection and support to enable the clients' potential and quality of life. When these notions of the therapeutic relationship were compromised or threatened the graduates felt ethically compromised and in moral conflict.

The essence of what the graduates valued personally and professionally and pursued from a moral sense, was a humanistic respect and regard for the client. In terms of ethical theory, this fits best with the notion of a relational ethic of care and adds weight to the body of literature that recommends that this is a most suitable approach to guide nursing responses to moral problems (Hodge, 1993; Parker, 1990; Tong, 1998). However, caution must be considered in relation to an altruistic notion of care and the paradoxical realities of practice (Stockdale & Warelow, 2000), particularly if caring has negative costs for nurses.

Schreiber and Lutzen (2000) found countless instances whereby mental health nurses made decisions based on an ethic of care with actions that attempted to promote the interest of the client but which resulted in a negative professional consequence for the nurse. An ethic of care, whilst serving the client well may not always serve nurses well (Schreiber & Lutzen, 2000). If nurses feel the need to manipulate or subvert the system in regard to meeting the needs of the client through an ethic of care, they may be excluded from legitimate ethical decision making and continue their own oppression. Liashenko (1995) suggests that nurses are people who speak for others rather than themselves.

This suggests as long as nursing is regarded as inferior to medicine within the hospital and nursing ethics lesser to bioethics, nurses may find their moral visions and values silenced (Bjorklund, 2004). Moreover, the nature of undergraduate ethical education cannot be an abstract, idealised theoretically driven bioethical approach that is removed from the realities of nursing practice.

Yarling and McElmurry (1986) rightly warn of the dissonance between ethical education and the ethical realities of practice with the resultant problem this represents for nurses. As previous studies have confirmed, undergraduate nurses need to be prepared not only by way of theoretical education, but also in ways which are pragmatically situated in the real life messiness that is nursing practice (Doane et al., 2004; Woods, 2005). The literature confirms the usefulness of deconstructing real clinical issues and utilising the stories of nurses to learn about ethical practice (Benner, 1991; Bowman, 1995; Woods, 2005), the usefulness of exploring real clinical dilemmas was also indicated by the participants in this study. Ethics is not limited to theoretical abstraction or crisis resolution rather; it is the business of everyday 'practice' ethics in health care (Peter et al., 2004). Brannelly (2007) proposes that a relational ethic of care ensures that care provided by practitioners allows for negotiation and inclusion of clients and families who otherwise may potentially have their perspectives marginalised. Woods (2005) argues that nurses must be prepared in a way that supports them to behave ethically despite organisational constraint, utilising both traditional ethical theories and a relational ethic of care.

Student nurses require a blend of ethical learning opportunities, traditional and relational which are situated in nursing practice.

They must also consider issues of power, context and reflect on whose interests are really being served (Freshwater, 2007). Traditional ethics education however needs to be clearly focused on practice ethics, that is, the moral art of everyday ethical nursing practice. It would be of benefit if ethics education was integrated into all practice aspects of the curriculum rather than being a standalone paper. Ethics is not an isolated theoretical abstraction, but rather an integral part of being a nurse and of practicing nursing. With criticism that there is not enough time allocated to ethics education (Parsons et al., 2001), there is argument for a foundation ethics paper and then subsequently integrated papers on for example: ethical mental health nursing practice; ethical medical surgical nursing practise and experiential application of ethical theory. Ethics education needs to sit more firmly in our practice based knowledge and understanding.

It is clear that new graduates struggle with the 'ideal versus real' dichotomy from ethical education to practice (Kelly, 1998; Vallance, 2003), so it seems that nursing education must become 'more real' if it is to truly prepare nurses to be workplace ready. Obviously there is tension with this and I am not suggesting that nurse educators lower their idealist standards. However we cannot prepare nurses with unrealistic aspirations and insufficient practical skills, to do so is to set them up to fail. The realities of mental health practice as it stands today are ethically highly complex and controversial (Happell, 2008). Clients are being secluded; clients are being restrained, do lack power and rely on nurses to help them through these difficult and vulnerable experiences.

If these interventions are necessary they must still be framed from a perspective of respect and regard rather than from a punitive or 'power over' approach. Ethical preparation must address these messy and dark aspects of our work and endeavour to equip novice nurses with knowledge and skills to manage and minimise such practices which result in removal of power and autonomy from service users.

6.1.2. Socialisation and undergraduate preparation of mental health nursing

The dilution of mental health content within generalist nursing programmes must be of considerable concern to the profession (Clinton & Hazelton, 2000; Hamer et al., 2006; Happell, 2001; Mullen & Murray, 2002). With a focus on general nursing in the undergraduate curriculum, mental health nursing is perceived as one of the least attractive practice areas by student nurses (Happell, 2001). Clearly if mental health nursing is to be valued by others, we must first value it ourselves professionally and attest to this by its central position in undergraduate nursing curriculums.

The quality of the undergraduate exposure to mental health education and mental health lecturers is critical to the development of the speciality (Owen et al., 2005). The idea that 'anyone can teach mental health' and 'if you can speak you can be a mental health nurse' (Patzel et al., 2007) are prime examples of the professional lack of regard and support for mental health nursing. The participants in this study described the continued discrimination and lack of respect for their practice as mental health nurses. With novice nurses valuing technical skills over relational mental health skills (Patzel et al., 2007) it speaks volumes about the philosophical values being assumed in undergraduate education.

The skills of therapeutic engagement, interpersonal communication, professional boundaries, response to distress and knowledge of mental illness are required in all clinical areas (Hurley & Rankin, 2008; Wilson, 2008). As nursing assumes itself to be a relational endeavour therefore the development of such skills and understandings should be valued as fundamental priorities for the preparation of 'fit for practise' nurses. If nurses are not adequately prepared in the relational aspects of mental health nursing, it will negatively affect client care (Mullen & Murray, 2002; Warelow & Edward, 2007). Therefore mental health nursing knowledge and skills should be given the utmost regard and be integrated through all aspects of nursing practice, as well as in foundation specialist mental health papers.

To be effective mental health clinicians, nurses must form successful therapeutic alliances whilst maintaining professional boundaries within the relationship. The therapeutic use of self, both intrapersonal and interpersonal is recognised as requiring complex knowledge and skill and a high level of emotional labour on the part of the nurse (Warelow & Edward, 2007). The demanding nature and complexity of mental health nursing renders it a potentially stressful nursing speciality which requires effective nurses to remain enthusiastic, empathetic and skilful in their provision of clinical care (Edward, 2005). In order to interact effectively with clients mental health clinicians must demonstrate emotional competence (Heron, 2004).

There is an increasing recognition that undergraduate nurses require education to support and develop their emotional intelligence (Freshwater, 2004) emotional competence (Wilson, 2008) and emotional resilience (Warelow & Edward, 2007). Nurses are required to manage their own emotions, be socially and emotionally competent and find ways to manage adversity and complexities of mental health nursing. Education to enhance emotional intelligence and resilience is required for nurses so that they can cope with the demands of the work and role model to client's healthy and adaptive coping and behaviours (Warelow & Edward, 2007). A lack of emotional competence in nurse educators and nurses in practice may be a problematic issue for students developing the skills themselves (Wilson, 2008). Nurse educators have a responsibility to role model the characteristics of emotional intelligence, resilience and interpersonal competence to nursing students.

With criticism that mental health lecturers are out of touch in relation to clinical practice (Wynaden et al., 2000) it must be a focus for mental health nurse educators to maintain clinical competence in their practice. The clinical complexities, nuances and difficulties of practice can only be fully understood and taught by lecturers who not only have relevant post graduate academic qualifications, but also currency with clinical experience. Lecturers themselves report on the benefits of being clinically active, with supportive strategies identified as: joint appointments between industry and educational facilities; utilising clinicians for teaching; academics having practice updates; clinical skills and practice development opportunities (Owen et al., 2005).

The participants in this study saw the quality of lecturers as not only being of significance to their development of theoretical and clinical knowledge, but also in terms of role models who 'walked the talk' and inspired them to be mental health nurses.

Again the 'real versus ideal' understanding of what it is to be a mental health nurse can only be understood fully by nurses who work on their own professional development. Nurse educators should be supported in their roles to have clinical updates and 'work on the floor' or closely with those who are, giving them a developed level of understanding and credibility. The participants repeatedly described a lack of knowledge around the difficult areas of compulsory treatment, seclusion, de-escalation and restraint minimisation which then impacted on their ability to effectively and confidently intervene as new graduates. Undergraduate education should address the potentially difficult clinical issues that nurses in practice face, through experiential learning opportunities. The preparation of clinically competent student nurses must reflect the realities of practice (Patzel et al., 2007).

The experiences student nurses have in clinical practice are recognised as key determinants of where they will choose to work when they graduate (Clinton, 2001; Ferguson & Hope, 1999; Hamer et al., 2006). With current recognition that there are limited quality mental health placements available for undergraduate students (Maben et al., 2006; Patzel et al., 2007), this further negatively effects theory to practice integration and recruitment of graduate nurses to the field of mental health nursing.

Undergraduate nursing education must include quality clinical experiences in mental health settings whereby students are well supported by suitably qualified preceptors (Hayman-White et al., 2007). If students are not provided with clinical experiences which allow them to develop the skills of mental health nursing they are unlikely choose to practice in the area, which may contribute to the vanishing of the psychiatric mental health specialty (Patzel et al., 2007). Strong collaboration and formal partnerships between education providers and clinical facilities is identified as a supportive factor in developing positive clinical experiences for student nurses (Williams-Barnard, Bockenhauer, O'Keefe Domaleski, & Eaton, 2006).

Student nurses require the opportunity to integrate theory into practice through clinical exposure to clients and other nurses. Positive role models are required for student nurses to watch and develop effective professional practice. If students are repeatedly exposed to poor practice they may become desensitized to moral issues and disconnected from the client (Greenwood, 1993). The participants verified the importance of having supportive and positive clinical experiences during their undergraduate education and recognised that negative experiences put other students off coming to mental health all together. The quality of preceptors and role models they were exposed to during clinical placements had a significant effect on whether or not they choose to practice in mental health.

Student nurses report a decrease in the quality of nursing care in inpatient settings resulting in them 'not seeing skilled nurses in action' (Patzel et al., 2007).

Student nurses lack exposure to clinical representation of the therapeutic relationship, with RNs spending more time on administrative tasks, medication and paperwork than time actually spent with the client (Patzel et al., 2007). Mental health nursing educators and clinicians need to model real and purposeful engagement with the client so that it does not become a lost art. Instead of busying ourselves in the nursing station with the 'important work' of paper and pills, mental health nurses must re-establish their primacy and purpose of partnership with clients.

Undergraduate institutions must recognise the value and importance of the work that mental health nurses do. There must be an adequate focus on the theoretical knowledge pertaining to the speciality, with integration throughout the students' entire nursing education. Mental health should only taught by academically prepared and clinically current, emotionally competent, mental health lecturers. Alongside this students require exposure to high quality clinical placements which are well supported by quality role models and preceptors. Educative experiences are vital to the development of ethical practitioners.

The values and beliefs that the participants based their nursing ideals on were developed through their nursing education and professional socialisation. In the workplace they applied their learning in practice and grappled with the ethical challenges and complex realties of the mental health services. The next part of this discussion chapter examines the organisational influences on the development of practice for new graduate mental health nurses.

6.2. Organisational influences

Each of the participants in this study worked for a New Zealand DHB, which was a powerful socialising and cultural influence on them, their nursing colleagues and the clients for whom they cared. The social context of mental health services and the way the mentally ill are viewed in society continue to influence how clients are perceived and treated in our hospital systems. Justice, fairness and respect were often not apparent for both the clients and the participants in this study.

Five of the graduates were able to successfully influence the outcome of the ethical situations they faced in what they believed to be a positive manner for the client. These graduates were able behave in a way that was morally congruent to their beliefs and values. When the graduates were able to maintain their moral position and responsibility to the client they believed they were able to provide ethical nursing care. The three participants, who believed that they had been unable to adequately intervene on behalf of their clients, felt they had let them down and described feelings of moral distress.

Moral distress has a multitude of negative consequences for nurses. These include feelings of stress, emotional exhaustion and job dissatisfaction (Pendry, 2007) which distances them from building and maintaining therapeutic relationships (Hamric, 2000). Unresolved experiences of moral distress may result in nurses exiting the profession (Corely et al., 2001). The participants felt ethically conflicted if they did not believe the clients' rights and moral entitlements were being met. The primacy of being an ethical mental health from the participants' perspective nurse was to do what was morally right for the client.

One of the most profound influences on their ethical practice was the culture of the workplace. The following discussion examines more closely the ethical issues that the participants in this study faced and relates those experiences to other published literature.

6.2.1. Ethical issues for new graduate mental health nurses

A culture of toughness is often a feature of psychiatric services with novice nurses being socialised to conform to the norms of the group (Brandon, 1991), and clients treated in a controlling manner (Holmes et al., 2004; Livingstone, 2007). There is a clear mandate to provide care to clients within mental health services in New Zealand in a 'least restrictive' manner, with a commitment to reduce the use of force, particularly the practices of seclusion and restraint (Mental Health Commission, 2004; O'Hagan et al., 2008). The most frequently reported ethical issues raised by the participants related to seclusion and compulsory treatment.

Seclusion, restraint and discrimination

Seclusion and restraint are reduced in organisations that have leaders who are committed to recovery and a no-force approach; this includes a high ratio of staff that are well trained and an organisational culture of respect (O'Hagan et al., 2008). Poor nursing leadership, high client acuity and nursing workloads are positively correlated to an increase in unethical care within metal health services (Severinsson & Hummelvoll, 2001). Short staffing is attributed to a reduction in therapeutic interactions with service users and an increase in the use of controlling measures such as seclusion (Breeze & Repper, 1998; Cleary et al., 1999; Muir-Cochrane, 1996).

If force must be used, it should be in a way that is respectful of the ongoing need to engage people as they recover. Mental health clients must be valued and treated in a fair and ethical manner.

Johnston (2004a) argues that stigma and discrimination are contrary to ethical nursing and suggests that nurses have a key part to play in ensuring the respectful, empathetic, supportive promotion of clients moral interests. Brannelly (2007) calls for care, community and citizenship for service users, whereby people are inherently valued for their humanness. Key political strategies by the New Zealand Government aim to increase understanding about mental illness, eliminate discrimination and strengthen the mental health workforce (Mental Health Commission, 1998).

Perhaps these remain an ideological goal rather than a realised achievement given the participant's accounts of not only clients being discriminated against but also mental health nurses themselves experiencing stigma and discrimination. With mental health nursing levels being in crisis (Clinton & Hazelton, 2000; McCloughen & O'Brien, 2005) urgent work must be achieved to reduce discrimination, value and support clients and the mental health workforce and realise a recovery focused, culturally competent approach to care.

Cultural safety, respecting people

The graduates perceived that some clients they worked with were not having their cultural needs met by the mental health staff and that this was inequitious and unethical.

With rates of psychiatric diagnosis and mental illness increasing in both Māori and Pacific Island populations (Oakley-Browne et al., 2006), Māori and Pacific Island nurses should be actively recruited and supported to develop and strengthen the mental health nursing workforce (Hamer et al., 2006). Organisations could also prioritise and support ongoing development of cultural competence in all members of the health team and monitor competence though national frameworks and standards such as the Whānau Ora Health Impact Assessment (Ministry of Health, 2007b).

Nurses in New Zealand have a professional responsibility to provide culturally safe care (New Zealand Nurses Organisation, 2001; Nursing Council of New Zealand, 2004). Whilst cultural safety is not limited to ethnicity (Ramsden, 1997), the needs of Māori using mental health services should be recognised by nursing education and health institutions. Māori are an over represented group within mental health services and are associated with experiencing greater severity of illness symptoms (Baxter et al., 2006).

The participants frequently described the needs of Māori not being well met. A key strategic direction mental health nursing in New Zealand is to recruit and develop more Māori and Pacific Island nurses in order to increase the delivery of culturally appropriate care to their people (Finlayson et al., 2005; Hamer et al., 2006). Angel whose educative experiences had a very high cultural content and focus repeatedly attested to the quality of the programme she attended and to the support that she believed Māori and Pacific nursing students were given in that model of education.

Therefore, nurse educators should also ensure that students from minority groups are supported in their learning within mainstream education systems.

Undergraduate nursing education needs to prepare nurses to recognise health inequities and provide culturally competent care to vulnerable and at risk populations. This includes the hospital systems being prepared to value and hear the perspectives of the nurses if clients are to receive meaningful and appropriate care.

Including nurses' perspectives

The participants in this study all discussed a clear moral commitment to the clients they worked with and an understanding of their needs and perspectives within the health care context. With nurses having an intimate, situated knowledge of clients' views as they interpret and attach meaning to their health and illness experiences (Bjorklund, 2004; Brannelly, 2007), their perspectives must be regarded as of central importance in dialogue about matters pertaining to the client and their cultural needs. Peter et al. (2004) argue that nurses' proximity to clients uniquely situates their moral understanding, resulting in intensified feelings of ethical accountability to the client and prevents them from walking away as other professionals can. They suggest a nurses' moral agency is constrained by their social positioning in the hospital systems and as such, renders them vulnerable to expectations that exceed their capacity to act (Peter et al., 2004). Nurses must be able to speak up and be heard in relation to the client's views and wishes, even when they are challenging the institutional or hierarchical status quo.

Woods (1999) confirms that nurses in New Zealand do have their practice controlled and constrained by institutional influences. Yarling and McElmurry (1986) hold that the interest of the hospital is at odds with the freedom and wellbeing of the client thus causing conflict for nurses. In such situations nurses are required to choose between the clients well being and their own professional responsibility to the organisation. Often, particularity for new nurses, such choices result in an inability to act as a self determining moral agent (Yarling & McElmurry, 1986). This further compromises nurses' beliefs of their own value and efficacy and potentially, their relationship with the clients. No one voice should have hegemonic dominance or be perceived to have greater value than another.

New graduate mental health nurses have a currency of knowledge, a fresh perspective, high aspirations and commitment to providing quality ethical care to clients and that is worthy of value and support. The following discussion encompasses the type of support which is suggested to be most effective in valuing and supporting new graduate during their first years of practice.

6.3. Mentoring and support of new graduates

Successful transition to practice for new graduate mental health nurses involves a high quality orientation (Godinez et al., 1999; Prebble & McDonald, 1997). Effective orientation supports a positive socialisation to the organisation. A well planned and supported orientation provides graduates with clear direction as to what is expected of them (Tradewell, 1996) including policy integration (Prebble & McDonald, 1997) and should consider the graduates workload (Charnley, 1997).

The participants discussed having a lack of knowledge concerning organisation expectations and policy requirements. This perceived lack of knowledge affected their confidence to speak out on moral issues. They also described feelings of being poorly supported and having few positive nursing role models to aspire to.

Pivotal to the reduction in stress during transition and development of graduate practice potential is the exposure to quality preceptors and mentors who offer support and encouragement (Maben et al., 2006). Preceptors should be carefully selected and appropriately trained to provide positive clinical role modelling, to be effective to graduate socialisation and development (Hayman-White et al., 2007). Preceptors should give encouraging, constructive feedback to graduates and should be well supported and regarded themselves by the organisation. A further organisational support for new graduates is clinical supervision.

Te Pou (2008) recognises the importance of supervision and pastoral care for new graduate nurses and acknowledges it is inconsistently provided in some New Zealand DHBs. This results in an increased risk of graduates leaving mental health services. Clinical supervision allows graduates to reflect on clinical experiences and relationships in order to develop and improve clinical and relational effectiveness (Finlayson et al., 2005; Magnusson et al., 2002). Clinical supervision is associated with increased job satisfaction, improved staff morale, reduced stress, sickness and burnout (Berg & Hallberg, 1999) and recommended for all New Zealand mental health nurses (Hamer et al., 2006). The participants indicated that their supervision was indeed of value to them, both for practice development and for taking action in regard to ethical dilemmas.

The following discussion takes the issue of organizational policies further and includes the need for debate about safe staffing and required work to develop a sustainable workforce through retention of new graduates.

6.4. Safe staffing and developing a sustainable workforce

As with all health care, mental health services take place in a heavily reformed and rationalised environment with a strong emphasis on cost containment (Cleary, 2003; Lowery, 1992). With limited beds available, inpatient care in New Zealand has a focus of rapid stabilisation and discharge of clients with high acuity and complex needs. Various authors suggest mental health nursing levels are in crisis (Clinton & Hazelton, 2000; Happell, 2001; McCloughen & O'Brien, 2005), with issues of safe staffing levels, overtime and burnout identified as factors that negatively impact on the quality of care clients receive (Corley et al., 2005; Munro & Baker, 2007). The participants in this study experienced that client and nursing needs were sometimes in conflict with the financial and resource restraints of the organisation, resulting in morally dubious care.

Ethically sound care cannot be provided by tired, emotionally exhausted nurses (Wilson, 2008). The consequences to the client will be that care they receive is not focused on best practice or positive outcomes and is potentially ethically and professionally substandard.

Nurses overworked by organisational demands can become morally desensitised to the legitimate needs of the client and practice can result in a mode to just 'survive' (Lutzen & Schreiber, 1998; Schreiber & Lutzen, 2000).

High workloads are directly associated with burnout, emotional exhaustion and depersonalisation from the client (Jenkins & Elliot, 2004). When nurses do not perceive themselves to be involved with the client in a therapeutic manner they may become distressed, burnt out and may exit the profession (Lutzen & Schreiber, 1998; Roberston et al., 1995). Research on burnout of new graduates from Finlayson et al. (2005), recommended that graduates only work 0.8 of a full time position or four days per week to support a transition to the role. The organisation must also make clear expectations of the new graduates' responsibilities to support them as they grapple with the newness of their role.

Delegation and supervision when someone is new

The participants in this study described ongoing difficulties in the responsibilities of delegation and supervision for Psychiatric Assistants (PAs) and at times, found their directions ignored or overridden. Despite little available literature on the topic there is an increasing use of unqualified staff being utilised in mental health services as organisation attempt to provide cost effective care (O'Hagan et al., 2008). In New Zealand, unregulated PAs are employed to provide various aspects of mental health care. RNs are responsible to delegate and direct the practice of unregulated staff and remain responsible for the client's care (Nursing Council of New Zealand, n.d.).

Unqualified staff have been associated with "hidden costs that include reduced productivity, increased absence and turnover, a decreased ability to work independently" (Buchan & Dal-Poz, 2002, p. 18).

Organisations have a responsibility to ensure that people work within the scope of their roles and responsibilities and that novice nurses are supported as they endeavour to manage the challenging task of delegation and direction of staff, especially those who may have been working in the service for many years. Graduates require clear policy statements and procedural guidelines that all members of the team are aware of, in order to support them to delegate and direct to others.

Key organisational and policy issues identified by the participants to support ethical nursing practice were: an increase in the perceived value of mental health nurses and clients and attention to the perspectives of both parties; changes to workplace cultures that include zero tolerance to bullying, discrimination and a reduction in the use of force; formalised orientation programmes which support graduates by suitably qualified and committed preceptors; clinical supervision and safe, adequate staffing.

The following discussion concludes with deliberation on the need to enable new graduate nurses to learn the skills to deal with conflict within interpersonal relationships and in the context of conflicting institutional practices.

6.5. Learning the skills to deal with conflict

A variety of authors suggest that nurses demonstrate the behaviours of an oppressed group which include horizontal violence, eating their young and bullying those with less power or status than themselves (Daiski, 2004; Roberts, 1983).

Others argue that oppression is in itself morally wrong and that power, privilege and social order must be recognised and addressed in nursing (Liaschenko & Peter, 2003; Walker, 2003). Roberts' (1983) seminal work argued that nursing is dominated by the medical model. As a result, medical ethics or bio-ethics are seen as the 'right' values and norms for the health care system. Watson (1999) asserted that having been so long subsumed by medicine, nursing has forgotten what it is and should be. In support, Peter et al. (2004) indicated that nurses are constrained in realising, recognising and upholding their values, thus inhibiting moral agency. Without being able to exert legitimate professional power nurses wield power over each other and vulnerable patients, demonstrating behaviours that reflect a low self esteem (Randle, 2003). To be able to value clients, nurses must first be self-aware and value themselves (Cook, 1999) with a healthy personal and professional sense of self in order to facilitate respectful and empathic therapeutic relationships (Randle, 2003).

The participants in the study gave frequent and disturbing accounts of a hierarchical system which they entered at the bottom, often assuming a position of 'being seen and not heard'. Not only did the participant's need to assimilate their new role as a RN, they had to work to 'fit in' and be accepted by their colleagues.

Matheson and Bobay (2007) suggest staff nurses are unconscious of their oppressed behaviour and argue that undergraduate educators must raise awareness about the phenomena and its consequences to nurses and clients. Education is also required to equip novice nurses with pragmatic skills to manage conflict in the workplace.

Interpersonal conflict with colleagues is reported as being more distressing than patient assault (Farrell, 1997). Horizontal violence has been associated with poor self-esteem (Randle, 2003) decreased job satisfaction, performance and increased turnover of staff (Gardner, 1992). Curtis et al. (2007) recommend that in order for novice nurses to mange horizontal violence, undergraduate educators must offer the opportunity to raise consciousness of the phenomena through supportive discussion and debriefing. They further advise the teaching of assertion skills and conflict resolution which were recognised as protective strategies and should be included in undergraduate education.

Seren and Ustun (2008) propose that the interpersonal skills of conflict resolution, including self-awareness and team communication are best taught through problem-based learning opportunities for nursing students. The participants recognised that the skills of assertive communication and conflict resolution could have been or were of significant use to them. Clearly these are skills that should be taught in undergraduate nursing programmes in order to support ethical assertion and the maintenance of moral practice for nurses when they graduate.

Education and developing the skills of conflict resolution does not stop for nurses on the completion of their nursing degree.
Ongoing education and in-service training were recognised by the participants as necessary to integrate and develop knowledge nurses required to work in the mental health system.

The theory to practice gap that is well reported for graduate nurses entering the mental health field (Clinton & Hazelton, 2000; Happell, 2001; Hayman-White et al., 2007), can in part be addressed by ongoing graduate mental health education. Graduate mental health nursing entry programmes (PECT) focus on the development and integration of nursing knowledge specific to the mental health arena and are recognised as key to recruitment and retention (Finlayson et al., 2005; Hayman-White et al., 2007).

Evaluations have indicated that the PECT programmes develop in graduates, specialist knowledge relevant to the mental health speciality and prepare them to be more able to cope with the clinical demands in their first year of practice (Finlayson et al., 2005). It would seem that PECT programmes also offer a formal support system for the graduates, whereby they reflect on the realities of practice. Debriefing, reflection and group discussion of clinical issues utilising problem based learning ideas, is suggested as valuable learning that could be included in the programmes. The greatest criticism of PECT programmes were the time commitments above and beyond a fulltime job position. This adds weight to the argument that the graduates should only be working 0.8% of a full time position in their first year to support role transition (Finlayson et al., 2005).

The participants identified further education that they believed was required following registration that would assist them to practice as ethical mental health nurses. These areas included: ongoing clinical ethics education, policy integration and clinical management of, and alternatives to seclusion and restraint.

Most of participants agreed that examining real life clinical issues from the perspective of a RN with other RNs would be of the greatest value to their ethical knowledge and skill development. This notion fits firmly with the literature that acknowledges the value of including clinical practice examples for discussion and deconstruction in ethics education (Benner, 1991; Bowman, 1995; Woods, 2005). The perspectives of service users should be included in the education of nurses.

In nursing education, both undergraduate and graduate, ongoing opportunities for training are powerful vehicles for developing and supporting ethical nursing practice. Reflection, self-awareness, critical thinking, conflict resolution, policy integration and sound clinical supervision are key components within the mental health services to establishing and maintaining ethical mental health nursing practice.

6.6. Strengths and limitations of the study

The strength of this research is that it is an honest exploration of the participants' experiences of ethical practice within mental health services in New Zealand, at this time. The data represents their legitimate realities and truths and in terms of usefulness facilitates the opportunity for them to be heard and better understood.

Each of the participants' accounts of ethical practice is their own construction of what occurred for them and their clients. Such subjectivity must of course be also acknowledged as to my part within the project.

Although every effort was made to stand aside from the data and view it with impartiality, the project will without doubt have been influenced by the relationships and understandings that I have as a mental health nurse and that which I formed with the participants during the interview and feedback process.

The small number of participants could be a limiting factor, although the intent was never to conduct a generalisable study. Another factor affecting the information in this study was that all of the participants were mature, with varied life and work experiences. This included them all having worked in health care environment prior to their nursing education and subsequent registration. It is likely then that they may have been a more confident and therefore ethically assertive group, than may be representative of the general population of graduates. All of the participants in the study were women. It would have been interesting to have captured the experiences and views of men, not necessarily for reasons of comparison, but to consider a balanced view from differing gender perspectives.

Although this study is a small investigation of ethical practice issues faced by new graduate mental health nurses, it has given the opportunity to create learning and understandings of what it is like for them and the opportunity to explore how to better support and prepare them. The nature of ethical practice in mental health nursing is a vast and complex topic and this study represents a portion of that.

6.7. Recommendations

Having conducted the study, recommendations are made that attend to the secondary outcomes of the project which relate to informing organisations and educators on how best to prepare and support new graduate mental health nurses to maintain their ethical integrity. Recommendations for nursing education, undergraduate and graduate are proposed as are recommendations for organisations employing new graduates.

6.7.1. Nursing education: undergraduate programmes

1. *Utilise a blend of theoretical approaches to teach nurses foundational ethics and include a relational ethic of care. Key focus must be on everyday 'practice ethics' that reflect the 'real world' of nursing and is integrated into all aspects of undergraduate practice papers. Include service user perspectives as part of the 'real world' of learning ethics and mental health nursing.*

2. *Increase content and regard of mental health nursing papers taught by clinically competent lecturers. Plan for quality clinical placements where students are supported by appropriate preceptors.*

3. *Recognise the interpersonal, therapeutic and relational aspects of ethical nursing practice as pivotal to ethical and effective nursing care. Undergraduate nurses require education on cultural and emotional competence, therapeutic engagement, conflict resolution skills and understandings about the implications of inequity, power and privilege in society.*

6.7.2. Nursing education: graduate mental health nursing

1. *Continue with PECT programmes and evaluate effectiveness. Focus content on clinical and ethical issues and strengthen interpersonal development building from undergraduate education.*

2. *Provide in-service education and forums on clinical practice issues, case studies, cultural safety and conflict resolution in nursing. Include service users in the development and provision of education to graduates, especially with regard to understanding potential ethical issues and how best to deal with these from a service user perspective.*

6.7.3. Mental Health Services employing new graduate nurses:

1. *Provide formal structured orientation with quality preceptors. Orientation should include clear role expectations, policy integration and reduced workload.*

2. *Develop and support mental health nursing leadership that is committed to the minimisation of controlling practices and misappropriation of power. A commitment must be made to a respectful, recovery focused mental health service, with zero tolerance to discrimination, violence and bullying. This includes clear processes about how graduates might seek help with regard to horizontal violence in practice.*

3. *Develop a forum where mental health nurses and service users discuss, develop and evaluate together mental health practice guidelines, service goals and service delivery. Ensure their perspectives are heard.*

6.8. Recommendations for future research

Further research in regard to the ethical practice of new graduates in the mental health settings is suggested. It would also be useful to explore with experienced nurses in mental health what they believe to be ethical mental health nursing practice and how they support new graduates in their first year in the workforce. Lastly, research with service users about their experiences of morally acceptable behaviour from nurses would be of use to nurses in practice. To explore with service users what they believe constitutes ethical mental health nursing care, are they receiving it and what if anything do they think needs to change?

6.9. Conclusion

This study has explored influences on ethical practice of new graduate nurses working in mental health. The work has given eight newly graduated nurses the opportunity to have their experiences and perspectives of working in the New Zealand mental health services, heard and understood.

The graduates were profoundly influenced in the development of ethical ideals, by their nursing education. Care and regard must be taken to ensure that ethical mental health nursing is adequately attended to and valued by the profession. The graduates were then further socialized by their nursing colleagues and required positive leadership, role modeling, guidance and support from their colleagues to develop their potential.

The profession of nursing should recognize and value the privileged relationship that we have with clients and the significant contribution that we make to their recovery. Nurses could then collectively ensure that they are valued and respected for this, and accordingly value, support and develop our new nurses.

The organizations that nurses work in are a significant determinant in how they can enact ethical nursing care. Nurses are pivotal to the successful delivery of mental health care and should be recognized for this. The culture and values of the organization must allow for the perspectives of nurses to be valued and for them to be allowed and supported to practice in ways that are in accordance to their moral beliefs.

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WANTED

New Graduate Nurses working in mental health

who want to be part of a nursing study on making ethical decisions.

Your experiences are important to nursing.

For more information contact:

Katheryn Butters

kj.butters@ucol.ac.nz

06 9653801 ext 60727

This study has been approved by the Central Regional Ethics Committee.

This notice has been reformatted for thesis presentation.

Morality of caring: A qualitative study of ethical decision making by new graduate nurses working in mental health

INFORMATION SHEET

Researcher Introduction

My name is Katheryn Butters and I am undertaking a thesis in order to attain a Masters in Philosophy at Massey University. The research I am conducting is a qualitative study about ethical decision making by new graduates in mental health. I am currently employed as a nursing lecturer in Whanganui where I teach ethics, law and mental health. Prior to this I have worked at Whanganui District Health board for 11 years in the mental health services.

My supervisors for the study are Martin Woods and Stacey Wilson who are both lecturers at Massey University. Our contact details are:
Katheryn Butters. Ph 063478454, 0276306921,kj.butters@ucol.ac.nz ; Martin Woods, 063569099 Ext 2241, m.woods@massey.ac.nz; Stacey Wilson, 063569099 ext 7513, s.wilson@massey.ac.nz.

Participant Recruitment

I am seeking to interview 8 - 12 nurses for the study. If you are interested in applying please make contact with me if you are:
- **A registered nurse working in the mental health services having graduated in the last 2 years.**
- **Willing to be interviewed by me and with your permission be audio taped**

Project Procedures
- **If you consent to participate in the study you will be given a pseudonym to protect your identity**
- **Data will be stored to ensure privacy and confidentiality and destroyed after five years**

- **Data will be analyzed to describe and gain an understanding of new graduate nurses experiences in mental health related to ethical decision making**
- **You will be given a summary of the findings from the study.**
- **The study has been approved by the Central Regional Ethics Committee.**

Participant involvement
- **Data will be collected through interviews with me. It is anticipated that interviews will take an hour with a maximum of two interviews.**
- **Interviews will take place at a private and mutually agreed venue.**

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:
- **Decline to answer any particular question;**
- **Withdraw from the study at any time until the data has been analyzed;**
- **Ask any questions about the study at any time during participation;**
- **Provide information on the understanding that your name will not be used unless you give permission to the researcher;**
- **Be given access to a summary of the project findings when it is concluded.**
- **Ask for the audiotape to be turned off at any point**

Support Processes
- **It is not envisaged that the interviews will cause undue distress however they can be stopped at any time if you become distressed**
- **The hospital also has a Employee Support Programme that you can access if you feel you need to.**
- **Should unsafe or illegal practice be disclosed you will be responsible for informing your team leader or manager, with the support of the researcher.**

Please feel free to contact either myself or my supervisors if you have any questions

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Te Kura Pūkenga Tangata

Morality of caring: A qualitative study of ethical decision making by new graduate nurses working in mental health.

PARTICIPANT CONSENT FORM
This consent form will be held for a period of five (5) years

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

I agree to the interview being audio taped.

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

I wish/do not wish to have my tapes returned to me.

I understand I can to decline to answer any particular question.

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

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

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

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

Signature: ....

Full Name - printed ....

Morality of caring: A qualitative study of ethical decision making by new graduate nurses working in mental health.

Semi structured interview guide.

- Tell me about a situation that you have faced in your practice which you associate with ethical decision making?

- Tell me about what happened and who was involved?

- What was your response?

- How did you know what to do?

- What helped you to make decisions?

- Did anything prevent you from acting the way you thought was right?

- Would you do anything differently in the future?

- Did your nursing education help you make the decision you acted on?

- In the future, what support do you think is needed to make sound ethical decisions?

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Te Kura Pūkenga Tangata

Morality of caring: A qualitative study of ethical decision making by new graduate nurses working in mental health.

Authority for the release of tape transcripts

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

I confirm that I have had the opportunity to read and amend the transcript of

the interview/s conducted with me.

I agree that the edited transcript and extracts from this may be used by the

researcher, Katheryn Butters in reports and publications arising from the

research.

Signature

Full   Name   -
printed

Appendix VI: Ethics approval

11 July 2007

Mrs Katheryn Butters 166 Blueskin Road RD 1 Whanganui

Dear Katheryn

CEN/07/05/030 - Morality of caring: A qualitative descriptive study of ethical decision making by new graduate nurses working in mental health
Mrs Katheryn Butters

The above study has been given ethical approval by the **Central Regional** Ethics Committee.

Approved Documents
Information sheet and consent form version 1

Accreditation
The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Progress Reports
The study is approved until **July 2009**. The Committee will review the approved application annually and notify the Principal Investigator if it withdraws approval. It is the Principal Investigator's responsibility to forward a progress report covering all sites prior to ethical review of the project in **July 2008**. The report form is available on http://www.newhealth.govt.nz/ethicscommittees.   Please note that failure to provide a progress report may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

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

Please quote the above ethics committee reference number in all correspondence.

The Principal Investigator is responsible for advising any other study sites of approvals and all other correspondence with the Ethics Committee.

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

Yours sincerely

Claire Yendoll
Central Ethics Committee Administrator

Email: claire_yendoll@moh.govt.nz

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Te Kura Pūkenga Tangata

Morality of caring: A qualitative study of ethical decision making by new graduate nurses working in mental health.

TRANSCRIBER'S CONFIDENTIALITY AGREEMENT

I .... (Full Name - printed) agree to transcribe the tapes provided to me.

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them, other than those required for the project.

Signature: ....