Overriding the choices of mental health service users; a study examining the acute mental health nurse's perspective

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➢ Smith, G. (2012b) 'Psychological interventions within an ethical context' in Smith, G. (Editor) (2012) Psychological Interventions in Mental Health Nursing, pp.143-154. Maidenhead, Open University Press

➢ Smith, G. (2016) A Practical Introduction to Mental Health Ethics. Oxon, Routledge

➢ Smith, G. (2017) 'Ethical Issues in Mental Health Nursing' in Scott, P.A. Key Concepts in Nursing Ethics, pp.145-158. Cham, Springer

Abstract

This study explores the mental health nurse's experience of ethical reasoning while overriding the choices of mental health service users within an acute mental health context. When working with service users in acute mental distress a mental health nurse's clinical decisions will have a controlling element, which can lead to the service user's freedoms being restricted. This power to restrict freedoms also known as coercion can be explicit, it follows the rule of law, and implicit; ways of controlling that are 'hidden'. The ethical use of this power requires the nurse to be an effective ethical reasoner who understands both the explicit and implicit nature of this power. Coercive power, which is explicit, has been thoroughly explored; however, there is limited work exploring the use of this power within an ethical context and as a 'real-time' practice issue. In addition, there is little work exploring implicit power as a practice issue or as an ethical issue. To examine this knowledge gap this study adopts an interpretative phenomenological analysis (IPA) approach to engender an understanding of the mental health nurse's personal meaning and experience of using both explicit and implicit coercive power. This approach affords the researcher the opportunity to tease out the personal 'ethical' meaning of the participants' experiences by facilitating an in-depth and sensitive dialogue, which focuses on stimulating conscious ethical reflection. IPA is an idiographic mode of inquiry where sample purposiveness and analytical depth is more important than sample size. On this basis, six qualified mental health nurses were recruited who have used coercive strategies while nursing service users in acute mental distress.

The semi-structured interviews were thematically and interpretively analysed, the five superordinate themes that were generated are; the nurse as a practitioner, their values, their practice, their use of coercion, and their ethics. In addition, the results of the study highlighted that coercive strategies are a key part of a mental health nurse's daily practice both explicitly and implicitly. These strategies can be beneficent; however, this is dependent on the ethical reasoning ability of the nurse and the professional support they receive in practice. Being an effective ethical reasoner requires the nurse to acquire 'good habits', a basis for enabling the nurse to work through an ethical challenge in 'quick time'. Furthermore, to enhance these good habits they also need to have an 'ethical imagination'. Considering these points, this study recommends mental health nurses when using coercive power use a multi-faceted ethical reasoning approach. This approach should aim to create good ethical habits through continually rehearsing good responses to common practice issues. In addition, this approach should not neglect the need for the nurse to use their ethical imagination and to feel for an ethical solution where required. As a future area for research, this study recognises the skilled use of ethical imagination in the field of mental health nursing requires further exploration.

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I declare that I am the sole author of this thesis and the work of which this thesis is a record has been completed by myself

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Grahame Smith

Table of contents

Chapter 5: Findings

Chapter 6: Discussion

Chapter 7: Conclusion

Figures and Tables

Appendices

References

Chapter 1: Introduction

1.1. <u>The need for the study</u>

The following thesis details in depth a study, which examines the acute mental health nurse's perspective of overriding the choices of mental health service users. This chapter will describe the need for this study, its intention, and its original contribution in addressing a significant knowledge gap. In addition, this chapter will signpost the chosen research methodology; it will also briefly explain why this approach was chosen.

The clinical decisions mental health nurses make on a daily basis while working with people in acute mental distress can have a controlling element. These decisions can lead to the freedoms of the service user being restricted or it is implied their freedoms could be restricted (Carroll 1991, Hall 2004, Roberts 2005, Cutcliffe and Links 2008). This element of control imbues the mental health nurse with two forms of power, explicit power and implicit power. Specifically within in-patient settings explicit power according to Roberts (2005) relates to the *'use of mental health legalisation, control and restraint, seclusion, locked wards and the covert administration of medicines'* (pp.35). Implicit power again according to Roberts (2005) relates to '*levels of observations, record keeping, ongoing assessments and reviews, care planning, and nursing interventions*' (pp.36). These forms of power can lead to practices that turn the service user into a subject to be controlled by others and by themselves (Roberts 2005). Taking this into consideration the challenge for the contemporary mental health nurse is to practice in a way that both acknowledges explicit and implicit power while promoting a recovery-based approach (Borg and Kristiansen 2004, Roberts 2005, Borg and Davidson 2008). Being a recovery-orientated mental health nurse requires the nurse to be collaborative in a way that; "*... means sharing power with the service-user and acknowledging the wisdom and insight of people with the lived experience of mental illness*" (Borg and Kristiansen 2004, p.501).

As a mental health nurse with nearly thirty years post-qualifying experience I have always been fascinated by the capacity of some of my peers to effectively balance 'being in control' against 'being collaborative and sharing power'. It was not until late on in my career that I started to link this capacity to be 'balanced' with being ethical. Reflexively I started to relate this 'fascination' with my own clinical experiences this includes two incidences which have had a significant impact. The first incident happened many years ago. A service user on the acute mental health ward I was in charge of was extremely unwell and risky. The service user was trying to smash a window on the ward to escape and they were not responding to any verbal interventions. They were becoming increasingly frustrated and as they could not break the window, they started to attack the ward staff. At this juncture the staff formed a control and restraint team and physically restrained the service user. As the service user was standing up they tried to move away from the team and in doing so the momentum of this action pushed everyone through the ward door and then onto the corridor floor.

The door which was not reinforced at this time, broke, the team momentarily lost their 'holds' and some of the team were injured, minor cuts and bruises. The service user immediately bit one of the staff members. Within seconds the team were back in control, subsequently the service user was given medication and in time the service user became less distressed and the risk they posed reduced. In terms of outcomes, the team appeared to have done the 'right thing' and yet the process was a mess or was it? Yes, the incident was messy, however, the team throughout acted ethically, always trying to do the right thing. Controlling only when necessary and always treating the service user with respect even in the most difficult circumstances. The second incident happened sometime after the first incident. I was off duty and someone tapped me on the shoulder, I turned around and I recognised the person as someone I had nursed. They immediately shook my hand, told me I was a good person, and thanked me for looking after them. I was surprised by this encounter due to restraining this person on a number of occasions; under these circumstances, I would not have been surprised if they 'bore a grudge'. This started a train of thought. Could control and restraint be a good thing? If it is ethical, does this relate directly to the actions and intentions of the people involved in the restrain process? These two incidents among others created a sense of curiosity about how mental health nurses ethically reason during these types of incidents and how this process influences a mental health nurse's ethical behaviour – potential need for a research study.

When reviewing the literature, it was with great disappointment that I noticed a significant knowledge gap relating to how little researchers had specifically explored this area within a mental health nursing context. My disappointment stems from a belief that if we can engender this balanced approach in all mental health nurses this can only be good for service users. This belief has to be tempered alongside the radical view; should we at any time be controlling individuals by the virtue they are given the 'mental illness' label (Szasz 1960)? In addition, it is essential to recognise three important points related to the context of mental health nursing practice. The first point is mental health nursing practice is practical in nature and on this basis ethical reasoning is also more likely to be practical or pragmatic in nature (Cohen 2004). The second point is there is a uniqueness inherent within mental health practice of being able to treat a '*fully conscious adult of normal intelligence*' without their consent (Fulford 2009, p.62). This second point links to the third point whereby society over time has created special rules to control mental health service users which the nurse as an ethical agent enacts (Morse 1977). The assumption being that the mental health nurse imbued with these special powers will be able to effectively deal '*with the problems and risks caused by the perplexing phenomenon of mentally disordered behaviour*' (Morse 1977, p.529).

1.2. Background to the study

The societal expectation that the mental health nurse controls aspects of a service user's behaviour while being recovery-focused can create a certain amount of tension (Borg and Kristiansen 2004, Borg and Davidson 2008, Clarke *et al.* 2015).

The mental health nurse will strive to be recovery-focused and 'share power' while at the same time balancing the sharing of power against the need to take control if the situation necessitates (Borg and Kristiansen 2004, Woodbridge and Fulford 2004). It could be argued that through operational and strategic policies, which highlight the common features of a recovery-based approach, control within this context is expected to be empowering, fair and responsible (Department of Health 2011). Like most policies they do not give explicit examples of how this approach would work in practice rather they provide general principles (Leamy *et al.* 2011, Slade 2012). An example is the 'No Health without Mental Health' policy document (Department of Health 2011) which articulates the following three general principles which should guide the delivery of mental health care; Freedom – having personal control; Fairness – respecting equality and rights; and Responsibility – everyone is valued. Providing principles rather than specific detail is not surprising as the intention of any social policy is to articulate a vision, in this case what a recovery-based approach would look like in a modern society (Nolan 2014). At a policy level a recovery-based approach is aspirational, something the mental health nurse uses to frame their practice (Anthony 1993, Borg and Kristiansen 2004, Slade 2012). The 'No Health without Mental Health' policy document (Department of Health 2011) does provide a definition of recovery within a mental health context which is based on the work of Anthony (1993);

"*This term has developed a specific meaning in mental health that is not the same as, although it is related to, clinical recovery. It has been defined as: 'A deeply personal, unique process of changing one's attitudes, values, feelings, goals skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life*"

(Department of Health 2011, p.90)

This definition situates recovery as a person-centred approach, however it has to be acknowledged this approach is contextualised and potentially limited by the power dynamic of mental health nursing practice (Roberts 2005, Gilburt *et al.* 2008). The mental health nurse is professionally accountable for the clinical decisions they make within this power context, if they are too controlling this could lead to an accusation of abuse, if they are not controlling enough this could lead to an accusation that there is a dereliction in their duty of care (Coady 2009, Nursing & Midwifery Council 2015a). In addition clinical decisions can involve a high degree of complexity with little time to make a reasoned decision and with the mental health nurse not always certain of the outcome (Welsh and Lyons 2001, Fairchild 2010). Irrespective of these issues the mental health nurse will always have to be able to justify the decisions and any subsequent actions they have taken, even if a great deal of time has elapsed (Nursing & Midwifery Council 2015a).

This professional expectation that mental health nurses ought to behave and act in a certain way gives clinical decision-making an ethical dimension (Roberts 2004, Cutcliffe and Links 2008, Coady 2009, Nursing & Midwifery Council 2015a, Abma and Widdershoven 2006). Nurses in all fields of practice will make clinical decisions that have an ethical dimension, the unique difference for the mental health nurse within their field of practice is that; ".... *a fully conscious adult patient of normal intelligence may be treated without consent, not for the protection of others (though this is also possible) but in their own interests*" (Fulford 2009, p.62). Controlling people with a mental health condition is not a new phenomenon it is something that has developed over a long period of time (Porter 2002). This includes the use of legal rules that have developed over time; *"For hundreds of years, the Anglo-American legal system has been developing special rules for dealing with problems caused by the inherently perplexing phenomenon of mentally disordered behavior"* (Morse 1977, p.529). Specifically, mental health nurses practicing within acute mental health services implement rules and strategies on a daily basis (Alexander and Bowers 2004) that have the effect of controlling mental health users in their care (Roberts 2005). The City 128 Study published by the Department of Mental Health & Learning Disability explores this controlling aspect within in-patient settings which includes such measures as special observations, door locking and restraint to name a few (Department of Mental Health & Learning Disability 2006). Preventing harm to self and/or others is an intended aim of these measures but as a consequence these measures also restrict the freedoms or liberty of the mental health service user, in effect they are coercive (Ripstein 2004, Roberts 2005, Department of Mental Health & Learning Disability 2006).

Roberts (2005) building on the work of Foucault (1961) illustrates how the use of the power to confine and conform operates within contemporary mental health nursing practice. Two forms of power are identified by Roberts (2005) 'explicit' power and 'implicit' power. Explicit power is power that mental health nurses exercise using the law and/or through medical treatments, whereas 'implicit' power is utilised through subtle strategies to monitor and control the mental health service user. These subtle strategies or Panoptic strategies (based on Foucault's concept of Panopticism) take the form of interventions that are used in everyday mental health nursing practice (Foucault 1961, Roberts 2005). The common function of these strategies is to a greater or lesser degree to monitor a mental health service user's behaviour and where deemed necessary by the mental health nurse corrective and controlling action is taken, thus maintaining the power relationship (Roberts 2005). The danger of this approach is the mental health service user becomes a 'subject to be controlled' rather than being viewed as a truly free person in their own right (Roberts 2005). The mental health nurse as the societal expert determines what behaviour is acceptable and what behaviour needs to change, they also have power over the service user to ensure they conform (Foucault 1961, Roberts 2005). This power may also be open to abuse, especially in a society where Coppock and Hopton (2000, p.146) highlights there is '*little tolerance towards the mentally distressed*'.

At a minimal level having the power to control certainly creates a potential ethical tension between respecting the mental health service user as a person and keeping them safe as a patient - duty of care (Roberts 2004, Robertson *et al.* 2007, Robertson *et al.* 2007a). Mental health nurses utilising this power in the form of controlling or coercive interventions require specific knowledge and skills, but there is also the professional expectation they will follow the required ethical and legal rules and in addition exhibit the required values and behaviours (Coady 2009, Nursing & Midwifery Council 2015a). A mental health nurse would ordinarily locate themselves within the professional community of nursing including following the relevant ethical code i.e. the Nursing and Midwifery Council's (NMC) code of conduct (Coady 2009, Nursing & Midwifery Council 2015a). The aim of any professional code including the NMC's code is to establish standards of professional conduct and in doing so a code also offers behavioural guidelines, but it does not and nor does it intend to give specific detail that can be used in every situation (Nursing & Midwifery Council 2015a). In addition, the code does not provide the mental health nurse with a specific method of resolving ethical dilemmas, though it does give the nurse a framework to work within as they develop their own ability to ethically reason within a professional context (Cohen 2004, Ford 2006, Smith 2012b).

Clearly being ethical is dependent on effective ethical reasoning skills but it must also take into account the value-laden nature of mental health nursing practice (Woodbridge and Fulford 2004, Fulford *et al.* 2006, Fulford 2008, Cooper 2009, Fulford 2009, Lamza and Smith 2014). The importance of recognising this values-based dimension relates to the conflicting nature of control. A mental health nurse may take the view that by restricting freedoms they are doing good, however the service user may have an alternative view and believe that it is a bad thing; this places control within the ethical domain (Fulford 2008, Fulford 2009). Taking this into consideration the mental health nurse must be aware of conflicting values inherent within their clinical practice and in a way that assists them to make ethical decisions that enables them to quickly respond in the right way (Woodbridge and Fulford 2004, Cooper 2009, Lamza and Smith 2014). To make clinical decisions that are also ethical and take into account the context of their clinical practice the mental health nurse has to be an effective ethical reasoner (Cohen 2004, Ford 2006, Smith 2012b). Ethical reasoning will be framed by ethical rules, frameworks, and theories, it will also be influenced by the practical and situational nature of clinical practice (Cohen 2004). On this basis the mental health nurse should be adept at top-down ethical reasoning, using rules and frameworks, and bottom-up ethical reasoning, paying attention to the situational nature of clinical practice (Cohen 2004). Making clinical decisions that lead to a mental health service user being controlled and their freedoms restricted will be based on top-down and bottom-up ethical reasoning, however one form of reasoning may be preferred more than the other (Cohen 2004, Roberts 2004). This preference will be dependent on such factors as the rules inherent within a situation, the character of the nurse, and their relationship with the service user (Cohen 2004, Cushman *et al.* 2006, Ford 2006, Dierckx de Casterle *et al.* 2008, Carson and Lepping 2009).

Whatever the preference the professional expectation is that ethical reasoning will be structured, rational, and any subsequent actions will be justifiable (Cohen 2004, Ford 2006, Nursing & Midwifery Council 2015a). These decisions are not made in isolation, they are made in the real world where complexity is a given within mental health nursing practice (Brimblecombe *et al.* 2007, Anderson and Waters 2009, Currid 2009, Bowers *et al.* 2010, Duxbury 2015). There are acknowledged difficulties of working with people in acute mental health distress whether it be in the community or within in-patient settings, these include safety concerns, lack of therapeutic activities, high staff vacancy rates, bed shortages and crisis-driven care (Currid 2009, Cleary *et al.* 2013, The King's Fund 2015). Due to this complexity and situational pressure it is not always clear how the mental health nurse should ethically act in situations that can be interpreted in different ways (Cutcliffe and Links 2008, Fulford 2009, Lutzen *et al.* 2010, Abma and Widdershoven 2006). It has to be acknowledged that the controlling and coercive nature of mental health practice and how mental health practitioners in general should act in these situations has been thoroughly debated (Hall 2004, Bindman *et al.* 2005, Cutcliffe and Happell 2009, Newton-Howes 2010). However, this body of work does not specifically explore from the mental health nurse's perspective how they make sense of those experiences (Smith *et al.* 2009).

Making a judgement on how the mental health nurse should act is made by referring to acceptable standards of behaviour, such as codes of conduct and agreed principles (Cohen 2004). In effect this work is exploring the ethical dimension of these practices, but not in way that is explicit (Cohen 2004). In addition by using 'professional' principles and standards as a frame of reference to explore how mental health practitioners act there is an attempt to understand the practitioners reasoning processes within the ethical dimension as top-down ethical reasoning (Cohen 2004). Ethical reasoning can be top-down, driven by principles or standards, or bottom-up, where an ethical evaluation of a situation leads to the application of what is deemed to be an appropriate ethical principle or principles (Cohen 2004). Mental health nurses will tend to use both types of reasoning, however due to the practical nature of their practice they will more often than not engage in bottom-up ethical reasoning (Cohen 2004). Mental health nursing practice constantly generates ethical situations that need to be reasoned through, these situations can be fast paced and complex, the mental health nurse's response will need to be both immediate and relative in nature (Welsh and Lyons 2001, Cohen 2004, Cleary *et al.* 2012, Cleary *et al.* 2013). This will involve a pragmatic use of ethical principles where the mental health nurse will constantly be critically reflecting and deciding at a post-conventional level which ethical principles do and do not have utility (Dierckx de Casterle *et al.* 2008). Being able to critically reflect in this way, in the moment, is a common feature of expert mental health nursing and can be described as reflecting-in-action (Schön 1983, Welsh and Lyons 2001, Berg 2008). Taking this into consideration a mental health nurse's knowledge of an ethical incident involving coercive strategies will not only be rational and objective it will also be personal and tacit (Polanyi 1958, Welsh and Lyons 2001).

In addition, it is a professional requirement for the mental health nurse to reflect continuously on their practice and in a way that improves the care they deliver (Nursing & Midwifery Council 2015a, Nursing & Midwifery Council 2015b). In summary the important issue of coercion within mental health practice has been thoroughly explored unfortunately there is little work on the bottom-up ethical reasoning of mental health nurses using coercive strategies (Lutzen 1998, Cohen 2004, Kjellin *et al.* 2004, Roberts 2004, Roberts 2005, Department of Mental Health & Learning Disability 2006, Jarrett *et al.* 2008, Link *et al.* 2008, Ohlenschlaeger and Nordentoft 2008, Newton-Howes 2010, Newton-Howes and Stanley 2012, Hutchinson *et al.* 2013, Lorem *et al.* 2015). To tease out this missing personal and tacit knowledge this study will adopt a research approach that focuses on exploring in depth the mental health nurse's personal meaning and experience of using sanctioned authority to override the choices of mental health service users.

1.3. <u>Research approach</u>

Teasing out personal 'ethical' meaning of an experience requires a suitable methodological approach (Flick 2011, Dowling and Cooney 2012). On this basis this study uses an idiographic phenomenological approach which not only acknowledges the complexity of 'acute' mental health nursing through offering an 'in-depth discussion' (Dean *et al.* 2005, p.627) it also addresses the experience and meaning dimension by 'stimulating conscious ethical reflection' (Bolmsjo *et al.* 2006, p.249). The opportunity created by using this type of approach is that any subsequent data will be 'rich' in nature; to effectively manage this richness of data this study will use an interpretative phenomenological analysis (IPA) approach (Dean *et al.* 2005, Eatough and Smith 2006, Langdridge 2007, Smith *et al.* 2009, Pringle *et al.* 2011, Shinebourne 2011). IPA as a specific phenomenological approach gives the researcher not only the tools to effectively address the opportunities rich data affords it also gives the researcher the scope to explore in great detail the meaning of the participant's experience (Langdridge 2007, Smith *et al.* 2009). Smith and Osborn (2007, p.520) also highlight IPA, as in this case, is 'useful where the topic under study is dynamic, contextual and subjective, relatively under-studied and where issues relating to identity, the self and sense-making are important'. IPA as a research method came to prominence through the work of Jonathan Smith in the mid-1990's, it was intended as research method within the field of psychology to capture both the 'qualitative and experiential' (Smith *et al.* 2009, p.4). IPA is 'pluralistic' (Smith *et al.* 2009, p.4) being based on ideas that stem from phenomenology and hermeneutics. In addition, it is centrally;

"... concerned with the detailed examination of human lived experience. And it aims to conduct this examination in a way which as far as possible enables that experience to be expressed to be expressed in its own terms, rather than according to predefined category systems. This is what makes IPA phenomenological and connects it to the core ideas unifying the phenomenological philosophers...."

(Smith *et al.* 2009, p.32)

As IPA broadly focuses on 'how people engage with the world' it is now being used outside the field of psychology but as a research method it maintains its psychological essence by being used primarily to explore a person's cognitive inner world (Smith *et al.* 2009, p.5). IPA also acknowledges that this exploration of a person's inner world has an interpretative element which needs to be based on an explicit interpretative methodology (Smith *et al.* 2009). Philosophically;

"IPA concurs with Heidegger that phenomenological inquiry is from the onset an interpretive process. IPA also pursues an idiographic commitment, situating participants in their particular contexts, exploring their personal perspectives, and starting with a detailed examination of each case before moving to more general claims."

(Smith *et al.* 2009, p.32)

This detailed examination is based on the production of 'thick interpretative accounts by a small number of participants rather than a thinner report of a larger sample group' (Hunt and Smith 2004, p.1001). IPA also offers a systematic approach where each account is examined separately in great detail before more general 'group' claims are made; these generalised claims are shaped and supported by a narrative that includes detailed extracts from the individual participants' accounts (Osborn and Smith 2006, Smith and Osborn 2007, Smith *et al.* 2009). It is also important to note during this process IPA explores 'how participants make sense of experiences, a form of 'insider research that connects the researcher with intimate knowledge' (Davies *et al.* 2010, p.142). In essence IPA views the person 'as an experiencing, meaning making, embodied and discursive agent', IPA is concerned with 'unravelling the relationship between what people think, say and do' (Eatough and Smith 2006, p.485). Further to this (Eatough and Smith 2006, p.485) highlight that to IPA, 'cognitions are not isolated separate functions but an aspect of being-in-the-world', therefore cognition is not detached reflection but in fact part of our basic attitude to the world'. IPA affords the researcher the opportunity to tease out and fore-ground the mental health nurse's subjective experiences of using coercive strategies, to explore in detail how the nurse interprets those experiences, and in addition explore how the nurse constructs meanings in relation to their interpretation of the experience (Smith and Osborn 2007, p.520).

1.4. <u>Research aim</u>

➢ Explore how mental health nurses who within their practice have used sanctioned coercion make 'ethical' sense of their experiences

1.5. Research objectives

- ➢ Elicit the participants shared experience of making ethical decisions while applying sanctioned coercion
- ➢ Draw-out the participant's personal meaning of making ethical decisions while applying sanctioned coercion
- ➢ Frame the participants personal and shared experiences within a theoretical context

1.6. Moving the study forward

To address the aim and objectives of the study a purposiveness sample was recruited, the data accrued from this activity was thematically and interpretively analysed (see the methodology and methods chapters for greater depth). The following chapter, the literature review, situates this study and its intentions within the literature; it also articulates the 'non-prescriptive' nature of a literature review within an IPA context (Smith et al. 2009). Due to the philosophical nature of ethical reasoning both contemporary and historical literature is considered (Porter 2002, Smith et al. 2009, p.112). In IPA the literature is reviewed in detail after the analysis stage, therefore the literature chosen was influenced by the themes generated from the analysis stage. In addition, to ensure a robustness to the literature review while at the same time being respectful to the hermeneutic nature of IPA a hermeneutic literature review approach was used. Building on the literature review chapter the methodological chapter embeds the study within its underpinning methodological context by teasing out the distinct ingredients of IPA as a research method. This includes examining the origins of IPA and the theoretical approaches that have directly influences its development. The methods chapter describes in detail how, within the context of this study, IPA was used. The findings and discussion chapters, though separate, explore in depth the themes that were generated through the analysis of the data. The findings chapter is more reflective in it presentation, where the reader will find the researcher's insights alongside extracts from the participant interviews. Whereas the discussion chapter starts to link the findings of the study within the relevant theories and literature. Both chapters refer to the participants' insights through selected extracts whereby maintaining the phenomenological essence of the study. The conclusion chapter highlights the main points of the study through a brief summary; it then affords the researcher the opportunity to critically reflect on the study including outlining the study's original contribution to the body of knowledge while at the same time considering any practice implications - recommendations.

Chapter 2: Literature Review

2.1. A literature review within an IPA context

The purpose of this literature review is to '*determine if the topic is researchable, to report the results of closely related studies and other relevant literature, and to establish the importance of the study in relation to its original contribution to the subject area*' (Rocco and Plakhotnik 2009, p.125). IPA provides a flexible structure that is not intended to be prescriptive, however, it is suggested the existing literature is not examined until the data is analysed (Hunt and Smith 2004, Eatough and Smith 2006, Osborn and Smith 2006, Smith et al. 2009, Smith and Osborn 2015). Nevertheless, Smith et al. (2009) does acknowledge that to formulate a research topic and then a research question the researcher will look to the literature, which is indeed the case in relation to this study. Furthermore, Smith et al. (2009) advises that during this process the researcher should remain open-minded and bracket any underlying assumptions when moving onto conduct the research. Smith et al. (2009) also highlight that typically within IPA the literature review can be short and it is more evaluative and discursive than other types of literature reviews. On this basis this chapter captures a 'bracketed' visit of the literature which was briefly undertaken when considering the research topic and after the study's findings were generated a fuller revisiting of the relevant literature was undertaken (Smith et al. 2009).

To ensure a sense of robustness this literature review focuses on developing an overview of the '*current state of research*' and thinking within the topic area including identifying any knowledge gaps; contemporary and historical (Porter 2002, Smith et al. 2009, p.112). The literature chosen is also driven by the themes that were generated from the analysis of the data (Langdridge 2007, Smith et al. 2009). The range of literature reviewed is extensive; it includes naturalistic and empiric studies, in addition, due to the nature of the topic 'philosophical type literature' is also incorporated, which includes an overview of major ethical theories and models (Langdridge 2007, Smith et al. 2009). To make sense of these different types of literature this chapter has been split into two contextual parts, the first part relates to the development of contemporary mental health nursing practice from its earliest roots to the practices we know today. The second part relates to the ethical dimension of mental health nursing practice and how it is shaped by major ethical theories, ethical rules, and ethical values.

To evaluate the literature while still connecting to the methodological context of the study a hermeneutic approach to reviewing the literature was used (Boell and Cecez-Kecmanovic 2014). In essence, this approach required the researcher to analytically read and then identify key concepts, theories, and potential assumptions. This process started at the research proposal stage where the researcher became orientated to the literature through literature database and more general internet searches, using 'key word' terms such as ethics, coercion amongst others (Boell and Cecez-Kecmanovic 2014; le May and Holmes 2012).

To be congruent within an IPA approach this knowing is bracketed and then revisited after the findings have been generated (Langdridge 2007, Smith et al. 2009). This knowing of the literature is iterative and it '*unfolds and develops*' as the researcher recognises the importance of individual publications to the aim of the study and to the study's findings (Boell and Cecez-Kecmanovic 2014, p.266). In addition to recognising this importance the following questions were considered when reviewing each publication (Silverman 2011);

> ➢ Is it related to the topic area?
> ➢ Does it critically add something to the topic area?
> ➢ Has another publication said something similar?
> ➢ Does it present the latest position and/or most significant position?

2.2 *Part One – The Practice Context*

2.2.1. The historical context

Mental disorder as a label is relatively new, historically people who would now be considered as having a mental disorder were labelled as 'mad' (Porter 2002, Scull 2011). Porter (2002) describes madness as possibly being as 'old as mankind' (pp.10). Using archaeological evidence to support this view Porter (2002) highlights that human skulls dated at 5,000 BC had holes drilled into them to allow 'devils to escape' (pp.10). Predominately madness was viewed as a punishment by the gods which was visited upon a person who had committed a supposed wrong (Porter 2002, Scull 2011). This view changed during early Christian times where madness was viewed in a more dualistic light, it could be good or bad. Good if it related to saintly visions and bad if it was related to satanic possession, the remedy for possession being exorcism (Porter 2002, Scull 2011). Around the Enlightenment (1620s–1780s) madness was starting to be medicalised with it increasingly being viewed as a 'mental disorder' possibly caused by a nervous system defect (Porter 2002, Scull 2011). Studying madness at close hand became possible due to the rise of the asylums and the confinement of the 'mad' (Porter 2002, Scull 2011).

During this period it was still relatively rare to confine the 'mad', it would usually happen where their family or the local community could not take care of them or if they were viewed as being a risk to themselves or others (Porter 2002, Scull 2011). By 1800 5,000 people in England were confined in an asylum out of a population of ten million, by the 1950's this had peaked to 148,000 (Scull 1977, Porter 2002). At the same time as confinement become a societal option the medical discipline of psychiatry was forming and in time became more influential this included the introduction of a requirement that asylums were only state licensed if they had 'medical doctor' on the staff (Porter 2002, Smith 2016). The types and standards of care offered in the asylums varied greatly this was irrespective of whether the asylum was funded through private money or through charitable donations (Porter 2002, Killaspy 2006).

Care tended to constitute anything that appeared to control a person's behaviour, this could include the use of mechanical restraints, and or physical punishment such as routine beatings, some asylums did offer a regime of rest and recuperation (Nolan 1993, Porter 2002, Nolan 2009). As the asylums became more established legal rules started to follow;

"County asylums were the recommendation of a House of Commons select committee, which had been set up in 1807 to 'enquire into the state of lunatics'. Legislation in support of the establishment of asylums followed, including Wynn's Act of 1808 'for the better care and maintenance of lunatics, being paupers or criminals' and the Shaftesbury Acts of 1845 'for the regulation of the care and treatment of lunatics'."

(Killaspy 2006, p.247)

Creating these rules started to standardise the care that was delivered within the asylums or county hospitals, it was also the beginning of creating special rules for individual's whose behaviour was viewed by society as not being the norm, not criminal but not normal – 'mentally ill' (Morse 1977, Killaspy 2006). Displaying behaviour that was not considered to be normal was not in itself a good reason for overriding a person's autonomy, their behaviour also had to be viewed as socially irresponsible, breaking societal rules and norms (Barry 1964, Morse 1977, McGrath 1998, Sayce 1998, Newton-Howes 2010). Creating special rules and special facilities to manage the 'mentally ill' was the start of society perceiving the 'mentally ill' as a risk to be controlled (Morse 1977, Newton-Howes 2010).

The societal imperative to control the behaviours of individuals who are perceived to be a threat or risk to society has been debated throughout history by political philosophers, however little attention has been paid to risky behaviour arising from a person's 'mental distress' (Wolff 2006, Newton-Howes 2010). For the 'normal' person a societal expectation had now formed that they were fairly free from state interference if they did not break certain social rules and norms (Wolff 2006). If they broke these rules and norms they could be punished which in effect meant their freedoms could be restricted (Wolff 2006). Having and using societal rules in this way potentially prevents individuals from engaging in behaviours that are destructive to self, others, and wider society (Wolff 2006). An important and influential philosophical position famously articulated by John Stuart Mill in the philosophical essay 'On Liberty' in 1859 was that individuals should be free to self-govern;

"That the only purpose for which power can be rightfully exercised over any member of a civilised society, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant.

He cannot be rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he do otherwise."

(Mill 1991, p.14)

There is a restriction to this self-governance which relates to not being allowed to harm others, this position did not go as far as the Kantian position that a person's freedoms could be restricted if it was for the 'good of society as a whole' (Newton-Howes 2010, p.218). Neither Kant or Mill took a specific position on the 'mentally ill', however Mill did take this position;

"It is, perhaps, hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties. We are not speaking of children, ... [and]. Those who are still in a state to require being taken care of by others, must be protected against their own actions as well against external injury."

(Mill 1991, p.14)

The second part of this position has been broadly interpreted as relating to people diagnosed with a mental disorder (Wolff 2006, Newton-Howes 2010). The impact of both Mill's and Kant's positions on 'power over others' has been significant within a mental health context (Gostin and Gostin 2009, Newton-Howes 2010). The Kantian position has influenced mental health law and the formation of special rules to restrict the freedoms of people with a mental disorder with the view that it is for the good of society as whole (Morse 1977, Newton-Howes 2010). Mill's position is more subtle in that it conveys power to those taking care of person with a mental disorder, usually the psychiatrist, however this power can be delegated to the rest of the professional team (Roberts 2005, Newton-Howes 2010). Having this power is of course explicitly conveyed through mental health legislation, however 'power' can also be implicit as articulated originally by Foucault (1961) and then within a mental health nursing context by Roberts (2005).

This increasing use of special rules enshrined in mental health law continued after the Shaftesbury Acts of 1845 with an emphasis on certifying the 'insane' (Killaspy 2006). The 1890 The Lunacy Act set the conditions for the certification of the 'insane' and the grounds for their admission to a local 'asylum' (Killaspy 2006). This did not mean people were not admitted who were not certified insane, however this only took place at registered hospitals such as the Bethlem (Killaspy 2006). The differences between registered hospitals and local asylums changed at the advent of the welfare state in 1948 (Killaspy 2006).

The impact of these special rules were the 'mad', now known as 'lunatics' and soon to be labelled 'mentally ill' being slowly segregated from mainstream society in self-sufficient asylums or what in time would become county hospitals (Porter 2002, Killaspy 2006, Scull 2011). Mental health nursing similar to the discipline of psychiatry albeit at a slower rate started to become a distinct profession as the asylums moved into becoming county asylums and then county hospitals (Nolan 1993). In the 1930s mental health nursing became recognised as a field of nursing practice, however its roots within the UK can be traced back to the 1800's (Nolan 1993, Nolan 2009).

The origins of mental health nursing practice are closely aligned to the origins of psychiatry, as the 'asylum' doctor in time became the psychiatrist, the 'keeper' and then the 'attendant' became the mental health nurse (Nolan 1993, Nolan 2009). The role of the keeper emerged during the advent of the asylums, their role was to look after the asylum, control the 'inmates', and as required be a servant to the asylum doctor (Nolan 1993). With the asylums becoming more medicalised and focusing on both control and treatment the keeper role transformed into the role of attendant (Nolan 1993). This move towards considering treatments was influenced by the burgeoning view that mental health conditions like physical conditions could be 'cured' (Nolan 1993, Berrios 1996, Porter 2002, Clarke 2008, Nolan 2009). Treatments could include rest, promoting good hygiene habits, a better diet, and a regime of exercise, it could also include fettering (tying people down), and blood-letting (Porter 2002, Scull 2011). The role of the attendant was to assist the doctor in the delivery of these treatments (Nolan 1993, Nolan 2009). The attendant like the keeper was initially given no training, this changed in 1889 where there was a requirement for attendants to attend a national training course (Nolan 1993). From around 1923 female attendants could be called nurses, and male attendants from around 1926 (Nolan 1993).

With the advent of the nurse role there became a greater emphasis on the delivery of care, which included rest, good hygiene, nutrition, and exercise (Nolan 1993, Nolan 2009). At this time talking therapies were in their infancy, over time these therapies used in conjunction with psychiatric medication became an important part of the mental health nurse's role. Managing risk through physical control as a treatment became less common as practices such a fettering and mechanically restraining began to slowly disappear (Nolan 1993, Roberts 2005). Treating a person's mental distress was continuing to be influenced by the medicalisation of madness; different mental disorders were being identified and corresponding treatments were then formulated (Berrios 1996, Porter 2002). By the 1920 to the 1950's mental hospital populations had peaked and with the promise of the new psychiatric medications in the 1950's in-patient care started to become less politically fashionable (Scull 1977, Killaspy 2006). By the 1970's plans were being discussed to reduce in-patient bed provision by at least half (Killaspy 2006). By 2012 there were around 22,000 in-patient beds a reduction of around 126,000 beds since the 1950's (The King's Fund 2015).

This reduction in available in-patient beds was underpinned by a greater emphasis on community-based mental health care with current mental health policy advocating a more public health approach; 'preventing mental ill health', current policy also advocates a recovery-based approach (Department of Health 2006a, Department of Health 2006b, Nolan 2009, Department of Health 2011, Nolan 2014). At the same time the law evolved to take into consideration this change to community-based care with special rules developed to convey some service users back to in-patient care if they do not comply with their treatment plan (Murphy and Wales 2013). Up until these changes a mental health nurse would spend most of their career working within in-patient services, now it is more common for a nurse to work across different settings with the expectation they possess an adaptable set of skills (Nolan 2009, Nursing & Midwifery Council 2010).

Even with the advent of human rights law and amendments to mental health law within the UK there is still an expectation that where a mental health service user demonstrates 'risky behaviours' the mental health nurse through their duty of care establishes a reasonable level of control (Department of Mental Health & Learning Disability 2006, Fulford 2009, Murphy and Wales 2013). Protecting people against themselves where they have a mental disorder, are acutely unwell, and potentially risky, is a human resource challenge irrespective of the setting (Nolan 2009). The nurse has to have the right skills and knowledge, the right support, and access to the right physical resources (Nolan 2009). Certainly within in-patient care an increase in demand for these types of services set against a decrease in physical resource makes the nurse's role more difficult as does the increase in bed occupancy and the increase in detained service users admitted to in-patient services (The King's Fund 2015). At the same time community-based services are increasingly dealing with service users who are 'high risk' having to be managed in the community due to a lack of appropriate services (The King's Fund 2015).

Since this shift to community-based care the media have negatively portrayed people with mental health conditions through high profile incidents that suggest they are a 'risk' to society if not properly supervised (Walsh 2009, Wood *et al.* 2014). Usually mental health services are highlighted as failing which is based on the view that incident could have been prevented if services had controlled the individual through better supervision and monitoring (Walsh 2009, Wood *et al.* 2014). The view that people with mental health conditions need to be monitored and supervised has led to mental health legislation being amended in a way that in certain circumstance mental health services have been given more control (Coppock and Hopton 2000, Murphy and Wales 2013). This expectation that people with mental health conditions should be controlled by society stems both from the philosophical position of protecting certain groups for the good of society and from the 'medicalisation of madness' where there was a tacit promise that 'madness' could be cured and at the very least controlled (Mill 1991, Newton-Howes 2010, Scull 2011). One outcome of this increase in control is the recent increase in compulsory admissions to mental health services (Johnson 2013).

Another is the increase in 'door locking' on in-patient mental health wards (Ashmore 2008). During the 1960's and 1970's it was unusual to lock the main ward door, now it is unusual for the main ward door to be permanently unlocked (Ashmore 2008, Bowers *et al.* 2010, CQC 2015). In 2015 it was reported by the Care Quality Commission (CQC) that '86% of wards (1,109) they visited had locked doors' (pp.34). This practice is in essence is a return to the restrictive and controlling practices of the past (Hall 2004, Ashmore 2008). Not locking the main ward door and encouraging more freedom was a key part of creating an environment that felt and looked therapeutic (Hall 2004, Ashmore 2008). A study by Ashmore (2008, p.182) highlights; "*they locked the doors not to safeguard patients but to protect themselves from criticisms from service managers, potential litigation and their own fears about being held accountable for events they saw as out of their control*". Locking doors is not a return to the brutality of the past such as fettering and blood-letting, however it does highlight that mental health service users are still treated in a way that still focuses on confining and conforming (Roberts 2005, Scull 2011).

2.2.2. <u>Acuteness</u>

Acuteness in contemporary mental health services relates to the severity of the service user's mental disorder and the service they subsequently receive (Burton 2006, Nolan 2014, Morrison 2014a). Measuring severity is something that is now embedded within the process of diagnosing a mental disorder (Morrison 2014a). Traditionally in physical illness the terms acuteness means 'short and recent' with a 'sudden and severe onset' whereas chronic relates to a long-term illness (Nicol 2015, Tait *et al.* 2016). The types of services offered tend to be defined by the distinction between 'chronic' and 'acute', hence the term acute mental health services (Nolan 2009, Horsfield *et al.* 2011, Nolan 2014). A person's mental disorder including their symptoms and the severity of their symptoms are elicited through an assessment process which is underpinned by the latest classification system, at this juncture a decision is made about the services they should receive (Burton 2006, Morrison 2014a). Currently there are two, albeit similar, classification frameworks used in the field of psychiatry; the International Classification of Diseases (ICD) version 10, published by the World Health Organisation, and the Diagnostic and Statistical Manual of Mental Disorders (DSM) version 5 published by the American Psychiatric Association, (World Health Organization 1992, American Psychiatric Association 2013). To ensure compatibility and consistency in terms of global data collection it is a World Health Organization requirement that DSM version 5 maps to ICD version 10 (World Health Organization 1992, American Psychiatric Association 2013). The diagnostic process within in psychiatry is similar to physical medicine in that it aims according to Fulford *et al.* (2006) to; provide a descriptive label of a service user's symptoms; support the treatment decisions-making process; and estimate prognosis. Where this process differs from physical medicine relates to establishing a cause for the service user's condition, however there are physical conditions where establishing a cause is difficult such as migraine (Fulford *et al.* 2006, Blows 2011).

For mental health conditions not being able to link symptoms to cause means that symptoms are descriptive, staying at the level of the service user reporting their symptoms rather than highlighting a specific cause such as pain related to an identifiable physical change in the body (Fulford *et al.* 2006). Fulford *et al.* (2006) describes psychiatry position as a conceptual challenge one that relies on trying to makes sense of complex processes, higher cognitive function, rather than simpler processes, physical function, hence the difficulty in pinning down causation. On this basis psychiatry and to the same extent mental health nursing is dependent on exploring and describing the experience of mental distress (Fulford *et al.* 2006, Brimblecombe *et al.* 2007, Coombs *et al.* 2013).

Describing and conceptualising a person's mental distress is dependent on the 'lens' the observer uses to view these descriptions (Merleau-Ponty 1945/1962, Bracken and Thomas 2005, Coombs *et al.* 2013). Fulford *et al.* (2006) provides a brief historical summary of how this 'lens' has generally changed over time, **see Figure 1**.

Figure 1: a summarised timeline

Pre-enlightment	• In the classical Greek period mental distress was described as madness and conceptualised within the harmony of the humours theory • In the Middle Ages and during the reformation madness was generally viewed as 'possession' and conceptualised within a religious framework.
The enlightment onwards	• In the enlightenment period madness was viewed as something caused by nature including poverty and illness, and was conceptualised by a more humanitarian view. • From 1850 to 1910, the first biological phase, madness was being medicalised and started to be conceptualised as an organic problem to be solved and treated.
The 20th Century	• The 20th century onwards multiple ways of describing mental distress were being formed and this included multiple ways of conceptualising mental distress, this includes biological, psychoanalytical, behavioural and social theories. • From the 1980's onwards, the second biological phase, mental distress is described in scientific biological terms and conceptualised through agreed classifications.

The work of Jaspers (1913/1997) in the field of descriptive psychopathology has heavily influenced how psychiatry describes and make sense of a person's mental distress (Fulford *et al.* 2006, Thornton 2007). This work was shaped by the first biological phase with psychiatry focusing on the experiences and subjective meaning of mental distress (see figure 1) (Thornton 2007). By taking this approach Jaspers was not subscribing to a particular theory or cause of mental distress, this theory-free approach underpins current psychiatric classification systems and is now part of the current diagnostic process (Thornton 2007). Jaspers' approach to assessing mental distress is split into two phases; static understanding and genetic understanding (Thornton 2007).

Static understanding is where the practitioner understands an individual's experience of their mental distress from a phenomenological viewpoint; they only capture the phenomena presenting itself to the individual's consciousness, any underpinning theories the practitioner holds should be stripped away (Jaspers 1913/1997, Thornton 2007). Genetic understanding is where the empathic practitioner both rationally and emotionally understands the meaningful connections between the presenting phenomena (Jaspers 1913/1997, Thornton 2007). Thornton (2007) provides the following example of genetic and static understating in action;

"*Thus, the relationship between static and genetic understanding is like this. The articulates and vividly represents what it is like, for example, to have a sudden realisation or what it is like to be in a state of happiness. It makes these kinds of state clear for further inquiry prior to the imposition of psychological theory. Genetic understanding adds to this the connection of how one state arises- ideally and typically- from the other. Such connections are shared empathically by psychological subjects ...*"

(Thornton 2007, p.96)

Gathering diagnostic information in this way is now framed by a structured assessment process which includes; collecting historical information, conducting a psychological examination, and then conducting a physical examination (Burton 2006, Geddes *et al.* 2012). Once this information has been collected a diagnosis is assigned through comparing this information to a diagnostic criteria; either DSM 5 or ICD 10 (World Health Organization 1992, Geddes *et al.* 2012, American Psychiatric Association 2013). Geddes *et al.* (2012) highlights that diagnostic criteria have the following five elements, **see table 1**, which need to be considered when assigning a diagnosis. Morrison (2014b) describes '*symptoms as the features that a service user will complain of and signs as the features the practitioner will notice*' (p.8). Severity according to Geddes *et al.* (2012) is; "Often expressed as the extent of functional impairment …" (Geddes *et al.* 2012, p.45). Severity can also include risk especially where harm to self and others is a feature of an individual's mental distress, for example thoughts of killing oneself may impair an individual's ability to function it may also be a clear and present risk where they have clear intent to kill themselves (Geddes *et al.* 2012, Morrison 2014b). Suicide according to Morrison (2014b) and Geddes *et al.* (2012) account for approximately 1% of all deaths, the rate of suicide being higher in males than females. When assessing for risk of suicide within a mental health context the following factors need to be considered (Geddes *et al.* 2012); are suicidal ideas present; does the individual have a mental disorder, and are there other factors present such as adverse social circumstances?

Table 1: five diagnostic elements

Element	Description
1	Main features of the disorder, usually referred to as signs and symptoms
2	Associated features of the disorder, other signs and symptoms
3	Duration of the symptoms
4	Severity of the symptoms
5	Other disorders which need to excluded before a final diagnosis can be assigned

Geddes *et al.* (2012, p.63) also recommends the practitioner during the assessment process is cognisant of social factors related to suicide which include;

> *Old age*

> *Living alone*

> *Lack of family and other support*

> *Stressful events*

> *Publicity about suicides*

In addition, Redfield Jamison (2000), Geddes *et al.* (2012), and Morrison (2014b) make the point that in the majority of cases of suicide or attempted suicide individuals have a 'diagnosable' mental disorder. In about 50% of suicides the individuals were 'diagnosable' with either major depression or a bipolar disorder (Morrison 2014b). Depression as a component part of another mental disorder such as an anxiety disorder also increases the risk of suicide (Redfield Jamison 2000, Morrison 2014b). Approximately 10% of individuals diagnosed with schizophrenia who have depressive and/or paranoid symptoms commit suicide (Morrison 2014b). In addition, the presence of substance abuse also increases the risk of suicide especially opiate dependence (Morrison 2014b). These figures and statistics underpin the design and use of clinical risk management tools within contemporary mental health nursing practice (Department of Health 2007, Eales 2009, Boland and Bremner 2013) .

It is important to note mental health nurses do not medically diagnose, however the information they provide feeds into the diagnosing process as does the information from other non-medical mental health professionals (American Psychiatric Association 2013, Morrison 2014a, Morrison 2014b). Of course mental health nursing practice over time has been greatly influenced and in part shaped by the medical model, yet at the same time it has also been influenced by other models which include psychological, social, and nursing models (Romme and Escher 1989, Watkins 1998, Barker 2001, Silverstein 2008, Gournay 2009, Nolan 2009, Cleary *et al.* 2013, Kilbride *et al.* 2013, Clifton and Banks 2014). In terms of current practice mental health nurses would focus less on the diagnosis and more on the experience of feeling depressed and 'suicidal' including exploring the presenting issues and then focusing on the types of solutions or interventions that could be delivered in partnership with the service user (Thompson *et al.* 2008, Anderson and Waters 2009, Gournay 2009, MacNeela *et al.* 2010).

Nevertheless, this process even if person-centred can reconstruct the service user's story or narrative in a way that fits both the nurse's professional viewpoint and their need to collect the information they believe is required to complete the assessment process (Merleau-Ponty 1945/1962, Bracken and Thomas 2001, Bracken and Thomas 2005, Brendel 2006, Martinez 2009). Managing risk is a professional obligation and one that requires the mental health nurse to manage risk in accordance with the relevant legal and professional frameworks, and in addition any relevant clinical guidelines and policies (Nursing & Midwifery Council 2015a).

One of the challenges facing the mental health nurse when using these frameworks and guidelines is how they make sense of them within their practice. As an example the issue of managing risk within a mental health context cuts across a number of clinical guidelines, some of these guidelines relate to the risk posed, self-harm or harm to others, and some of these guidelines are disorder specific (Wand 2011, Hughes *et al.* 2013, National Institute for Health and Care Excellence 2013). On this basis there is the potential for these guidelines to provide conflicting advice especially where a service user presents a complex clinical picture which references to a number of guidelines and corresponding treatment options (Eales 2009, Wand 2011, Hughes *et al.* 2013). In the case of prescribing medication for a number of 'risk-related' symptoms it could lead to multiple medications being prescribed, an approach which could lead to greater harms (Hughes *et al.* 2013). In addition to these frameworks and guidelines there is also a Department of Health (2007) best practice guide - *Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services,* this guide was updated in 2009. The guide sets out 'sixteen best practice points for effective risk management', **see figure 2**.

This best practice guide was developed after an extensive review of best practice across the health care system, however it did not go as far as to mandating the implementation of these sixteen best practice points, instead implementation was left to local interpretation by healthcare provider organisations (Boland and Bremner 2013). In part this approach is due to not wanting to mandate a 'one size fits all approach' especially in the case of using risk assessment tools which have limited utility, and also in part recognising that management of clinical risk is a dynamic and interpersonal endeavour which is not easily reduced to a 'tick box exercise' (Boland and Bremner 2013).
This dynamic and interpersonal context is acknowledged by the best practice guide;

"Safety is at the centre of all good healthcare. This is particularly important in mental health but it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must include both sympathetic support and objective assessment of risk."

(Department of Health 2007, p.4)

Figure 2: best practice points

1. *Making decisions based on knowledge of the research evidence, the individual service user and their social context, and the service user's own experience, and clinical judgement*
2. *A positive risk management approach*
3. *Risk management should be conducted in a spirit of collaboration*
4. *Risk management should emphasise recovery*
5. *Risk management requires an organisational strategy*
6. *Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or minimising harm*
7. *Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm*
8. *Knowledge and understanding of mental health legislation is an important component of risk management*
9. *The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis*
10. *Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach*
11. *Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user*
12. *All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.*
13. *Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach.*
14. *Risk management plans should be developed by multidisciplinary and multi-agency teams operating in an open, democratic and transparent culture that embraces reflective practice.*
15. *All staff involved in risk management should receive relevant training and should be updated at least every three years.*
16. *A risk management plan is only as good as the time and effort put into communicating its findings to others*

(Department of Health 2007, pp.6-7)

The process of assessing and then managing risk is situated within the mental health nurse-service user therapeutic relationship; it is also situated at a macro level within a service (Lester and Glasby 2010, Geddes *et al.* 2012, Kapur *et al.* 2014, Nolan 2014). Typically, service users have been admitted to acute in-patient services due to being a risk to self and/or others, however the level of risk necessitating an admission is not always clear (Fitzpatrick *et al.* 2003). What is clear is that acute in-patient beds have decreased in number making it more difficult to admit to these types of services (Thompson *et al.* 2004, Royal College of Psychiatrists 2009, The King's Fund 2015). As bed numbers have decreased compulsory admissions have risen in number therefore it could be argued that a service user is more likely to be admitted only if they meet the 'risk' criteria threshold highlighted within the mental health act legislation (Johnson 2013). This may mean services users who are acutely unwell who do not yet meet this criteria have to be managed outside of these types of services (Johnson 2013).

Indeed, over recent years there has been a political drive will to reduce acute in-patient services and to focus of providing more community-focused services (Killaspy 2006, Department of Health 2011, Hannigan 2014, Nolan 2014). This includes community services having a greater remit to prevent admission and also to promote early discharge from acute in-patient services leading to the potential of more acutely ill service users being managed in the community (Royal College of Psychiatrists 2009, The King's Fund 2015). This re-structuring of acute mental services has led to acute in-patents services being one part of a larger service which now contains a numbers of parts, according to the Royal College of Psychiatrists (2009) these include;

➢ crisis resolution and home treatment teams
➢ respite care
➢ crisis house, place of safety, and supported housing provision
➢ a range of other services with direct and indirect links to acute services

At the forefront of acute mental health services are the crisis resolution and home treatment teams, these teams have an increasing role in managing within community settings '*a greater number of service users who at high risk of harm*' (The King's Fund 2015, p.6).

2.2.3. Coercion

Restricting an individual's freedom is a topic that has been widely discussed by both political and legal philosophers (Anderson 2011). Coercion is a term that is used broadly within society to infer any restriction of an individual's freedoms including 'social pressure to conform' (Anderson 2011). This broad understanding emanates from a lack of an agreed definition (Anderson 2011). Anderson (2011) taking into account the work of a number of prominent philosophers describes coercion as a type of power where one individual or the state compels another individual to do something or not do something, during this process the individual's freedoms are restricted. Feinberg (2000) highlights when being coerced the individual has choice, albeit a limited choice which is also potentially an 'unappealing' choice. Coercion can be a violation of an individual's rights, it can also be state sanctioned as a way of controlling individuals so as to prevent harms, or it can be used by society to punish individuals who break the law (Feinberg 2000, Anderson 2011). Coercion can be indirect through the use of coercive offers or what is more commonly known as threats, for Carr (1988, p.65) a coercive offer is an 'instance of impermissible leveraging' which ultimately restricts an individual's freedoms. According to Feinberg (2000) for an offer to be coercive a vulnerability within the individual has to be deliberately created which potentially leads to exploitation. Preventing individuals harming others and promoting societal cooperation is a general justification for coercion at a societal level (Anderson 2011). An article by Ripstein (2004) *Authority and Coercion* explores state authorised coercion in detail, in summary Ripstein's view is; '*both the use of official force and the claim of states to tell people what to do are justified because, in their absence, arbitrary individual force prevails, even if people act in good faith*' (p.3).

Based on this justification that coercive measures are sanctioned by the state and for the good of society these measures are more likely to be right and moral (Ripstein 2004, Anderson 2011). Ryan (1980) points out there is a rightness and a wrongness to the use of coercion, Ripstein (2004) builds on this 'moral' view by explicitly linking political authority and coercion together as sanctioned coercion as a justification for the moral use of coercion. On this basis sanctioned coercion is the right thing to do; if it hinders wrongful action, as an example Ripstein (2004, p.21) highlights that coercion can wrongly interfere with external freedoms in the following ways; it infers with an individual's ability to pursue their own course of action, and it forces an individual to adopt a course of action that is not theirs. In addition, failing to support an individual to pursue a course of action where there is a moral obligation to do so is also viewed by Ripstein (2004) as being hypothetically coercive. The right thing to do where there is wrongful coercion present would be to hinder this coercion, the original wrong, at this point this type of coercion would be the right thing to do (Ripstein 2004).

At this point it is important to note that the body of work on coercion emanating from a political philosophy perspective is focusing specifically on the 'rational person' in society (Smith 2016). Taking this into consideration the challenge is to understand coercion in terms of individuals who have considerable periods of being classed as not being 'rational', i.e. the 'mentally ill' (Scull 1977, Porter 2002, Radden 2002a, Radden 2011, Scull 2011). Over time 'special' rules have been developed by the legal system within the UK to sanction the restriction of certain freedoms of individuals who are diagnosed with a mental health condition (Morse 1977). Currently the Mental Health Act 1983 (amended 2007) for England and Wales details how the freedoms of an individual diagnosed with a mental health disorder can be restricted and by whom (Legislation.gov.uk 2017a, Legislation.gov.uk 2017b). This act does not sit in isolation it interacts with other relevant legislation which will further specify this power to restrict freedoms (Murphy and Wales 2013). A further justification for the use of the power is not just that an individual is diagnosed with a mental disorder it should also be in the interest of the individual's health and safety and/or the protection of others (Legislation.gov.uk 2017a). Mental health legalisation also conveys certain rights and protections however it has still led to the view that restricting freedoms, coercion, is a necessary evil within mental health care (Newton-Howes 2010). This power to coerce is clearly sanctioned by the state and echoes with Ripstein's views on the use of sanctioned coercion, however it goes further by specifying harm to self not just harm to others (Ripstein 2004, Legislation.gov.uk 2017a, Legislation.gov.uk 2017b). This state sanctioning process includes;

"Initiation of Mental Health Act legislation to require admission to hospital, locked psychiatric wards and the use of community treatment orders that require community patients to accept treatment are examples of interventions that can be seen to reduce an individual's liberty and coerce them into accepting psychiatric management."

(Newton-Howes 2010, p.217)

Using coercive power in this way is an explicit use of power and is easily identifiable unlike more implicit or subtler forms which can be no less coercive (Lutzen 1998, Roberts 2005). Newton-Howes (2010) highlights that even though the use of explicit forms of coercion are on the increase the use of these types of coercion does not necessarily improve treatment outcomes. It is important to note as Newton-Howes highlights the service user's negative experiences of these coercive measures are lessened if the respective mental health service has a listening and caring culture in place (Newton-Howes 2010). These negative feelings are not just experienced by service users who are the recipients of explicit coercive measures; services users who experience subtler forms of coercion have similar but less intense feelings (Strack and Schulenberg 2009, Newton-Howes and Stanley 2012). The study by Newton-Howes and Stanley (2012) does not say why this is the case, however it infers that the culture of mental health care as a controlling culture is a factor. Roberts (2005) from a Foucauldian perspective highlights that;

"*A psychiatric hospital ward, for example, can be understood as employing a variety of Panoptic strategies. Varying levels of client observations, record keeping, the ongoing assessment, planning, implementation and evaluation of 'nursing interventions', individual and group therapy, ongoing risk assessments, regular ward reviews, and so on, can all be understood as examples of Panopticism.*"

(Roberts 2005, p.36)

Panopticism in this context is understood as a form of power that emanates through the observing and monitoring activities inherent within the delivery of mental health care (Roberts 2005). The service user is aware they are being observed and monitored and that any 'unacceptable' behaviour on their part will be dealt with (Roberts 2005). The effect of power is the service user also monitors their own behaviour and where able they correct their behaviour to fit in and conform or self-regulate their behaviour (Foucault 1961, Roberts 2005). Duxbury (2015) acknowledges mental health care can be overly coercive, however the term 'coercive practices' is used in relation to explicit forms rather than more subtler forms. Duxbury (2015) refers directly to the work of O'Brien and Golding (2003) who again acknowledge the widespread use of coercive practices, this work also acknowledges the lack of an agreement of what amounts to coercion within mental health care. In part this lack of an agreed definition emanates from viewing coercion within the context of explicit power (O'Brien and Golding 2003). In terms of subtler forms of coercion O'Brien and Golding (2003) recognise the role that manipulation, persuasion, and restricting choices play, however they do not mention practices such as observing and monitoring. By acknowledging a broader view of coercion O'Brien and Golding (2003) define coercion within a mental health care context; '*as any use of authority to override the choices of another*' (p. 168).

In addition, O'Brien and Golding (2003) reject justifying the routine use of a coercion on the grounds of being in the best interests of the service user. This best interest's argument is a reasonable approach where it takes into account situational and interpersonal factors (O'Brien and Golding 2003). However, O'Brien and Golding (2003) reject this position when it is used as a 'catch-all' approach which sometimes happens in soft or weak paternalism. Beauchamp and Childress (2013) describe these two types of paternalism;

"In soft paternalism, an agent intervenes in the life of another person on grounds of beneficence or nonmaleficence with the goal of preventing substantially nonvoluntary conduct. Substantially nonvoluntary actions include cases such as poor informed consent or refusal, severe depression that precludes rational deliberation and addiction that prevents free choice and action."
Whereas hard paternalism;
".... by contrast, involves interventions intended to prevent or mitigate harm to or to benefit a person, despite the fact that the person's risky choices and actions are informed, voluntary, and autonomous."

(Beauchamp and Childress 2013, pp.216-217)

O'Brien and Golding (2003) highlight there is an underlying assumption that hard paternalism is more difficult to ethically justify whereas soft paternalism is less difficult to justify and in some cases is not justified at all especially where subtler forms of coercion are used. This lack of justification according to O'Brien and Golding (2003) relates to the three following summarised factors;

1. A mental health nurse may assume that just having a duty of care is a legitimate justification for using a coercive strategy
2. It is legitimately justified to use coercion where it appears to protect others even if the service user does not lack capacity
3. The presence of a mental health condition and a lack of capacity are routinely perceived to go hand in hand and on this basis the nurse has a duty of care to act on the service user's behalf – best interests

These factors may stem from the generally accepted view that individuals diagnosed with a mental disorder are irrational and are more likely to be risk to themselves and/or others and on this premise society has a right to act on their behalf – best interests (Coppock and Hopton 2000, Tuckett 2006, Varelius 2009, Joyce 2010). Taking this best interests argument into consideration being paternalistic and restricting the freedoms of service users is also generally accepted within the mental health field (Roberts 2004, Hoop *et al.* 2008, Gostin and Gostin 2009, Prinsen and van Delden 2009, Newton-Howes 2010). However, Roberts (2004) does highlight that there should be further ethical justification rather than just accepting this position this includes ensuring that a coercive act is beneficent, it ensures good, and it is non-maleficent, it prevents harm.

As an example stopping a service user from harming themselves or others may be justified firstly by presenting the evidence (facts) that they have a mental disorder, they lack capacity (competence), and the intervention prevents harm and in doing so promotes good (Roberts 2004). Beauchamp and Childress (2013) taking a similar approach go further and argue on the grounds of being beneficent the mental health practitioner has a duty to intervene and not to do so would be a breach of this duty. The difficulty with taking this almost dogmatic position is that an act of coercion may well be undertaken on the grounds of being in the service user's own good or benefit, however it does not necessarily follow that it is ethically justifiable (Berlin 1998, Berlin 2000, O'Brien and Golding 2003, Weiner 2007, Hoop *et al.* 2008). Routine measures to prevent harm such as the use of locked doors are indiscriminate coercive strategy, for one service user they may justifiably prevent harm as an anti-absconding measure, for another service user they may be harmful by increasing emotional distress which relates to being locked in (O'Brien and Golding 2003). As further justification it may be argued that the service user lacks capacity with evidence being provided this is indeed the case, however it is important to recognise capacity or competence fluctuates so a service user's lack of capacity can change from situation to situation (O'Brien and Golding 2003, David *et al.* 2010).

The challenge with using an indiscriminate coercive strategies is that at one moment it can be ethically justified for one situation and potentially at the same time it cannot justified for another albeit similar situation (O'Brien and Golding 2003, Ashmore 2008, Ashmore and Carver 2014). On this basis there is a case for the assessment of situational competency; "*If non-competence is a reason to coerce someone, they must be non-competent in the situation*" (O'Brien and Golding 2003, p.171). As an additional concern O'Brien & Golding (2003) view coercive strategies as blunt instruments and ones that should be used as a last resort; "*... even if beneficence justifies coercive practices for the good of the client, this does not justify any type of coercive practice. To be beneficent, we can only justify the least coercive means of achieving the good end*" (O'Brien and Golding 2003, p.171). The work of O'Brien and Golding (2003) is an important contribution to the rightness and wrongness of applying coercive strategies within mental health care, however it does not address in detail why mental health practitioners use coercion in the way they do.

Duxbury (2015) suggests the endemic use of coercion arises out of the societal pressure for mental health services to control certain behaviours. Having the mandate by society to control these behaviours has led to a culture where coercion is more acceptable than in other healthcare fields (Lutzen and Nordin 1994, Berlin 1998, Duxbury 2015). These approaches still have to be justified and some would argue that on the whole this process of justification is based on the facts and yet others would argue that mental health care cannot be values-free and what appear to be facts are values turned into facts (Szasz 1960, Boorse 1975, Kendell 2004, Woodbridge and Fulford 2004, Fulford *et al.* 2006, Fulford 2008, Cooper 2009, Fulford 2009, Lamza and Smith 2014).

In relation to this values-free debate Fulford (2009, pp.61-62) presents a scenario where a service user diagnosed with depression, feeling suicidal, and believing they have brain cancer (even though there is no 'empirical evidence this is the case), was legally detained in hospital. Fulford (2009) uses this scenario to make the point that what appears to be a 'fairly straight forward case' at a deeper conceptual level is more problematic than first thought (p. 62). From the ethical perspective of principlism the issue of detention does not appear to be problematic as it appears to be the case that the service user was not acting autonomously and they were actively trying to harm themselves, on this basis an explicit coercive measure such as legal detention would be justified and the right thing to do (Beauchamp 2009, Beauchamp and Childress 2013).

To tighten up this form of ethical justification Beauchamp and Childress (2013) suggest being non-autonomous, lacking capacity or being non-competent, is empirically established through use of a test. Within the UK mental capacity is measured through an agreed legal framework such as the Mental Capacity Act 2005 (Legislation.gov.uk 2017c). Beauchamp and Childress (2013) suggestions for what should be tested are slightly wider than this Act nevertheless they are similar. Beauchamp and Childress (2013) recommend that rational abilities such as coherent thinking, understanding and deliberation are tested, whereas the guidance on how to use the capacity framework within the Act is more specific;

"The Act makes use of a 'functional' test of capacity, adapted from the common law, which focuses on the decision-making process itself. First it must be established that the person being assessed has 'an impairment of, or a disturbance in the functioning of, the mind or brain' which may affect their ability to make the decision in question.

Under the Act, a person is regarded as being unable to make a decision if, at the time the decision needs to be made, he or she is unable:

> - *to understand the information relevant to the decision*
> - *to retain the information relevant to the decision*
> - *to use or weigh the information; or*
> - *to communicate the decision (by any means).*

Where an individual fails one or more parts of this test, then they do not have the relevant capacity and the entire test is failed."

(British Medical Association 2008, pp.10-11)

Focusing on the first part of the capacity framework there is a need on the part of the practitioner to establish that the person has; *'an impairment of, or a disturbance in the functioning of, the mind or brain' which may affect their ability to make the decision in question*; once this establish the rest of the test is applied (British Medical Association 2008, p.10).

Returning to Fulford's scenario the service user is diagnosed with depression and their symptoms include suicidal thoughts and delusional thinking in other words they appear to have a clear disturbance of the mind influencing them to make irrational decisions (British Medical Association 2008, Fulford 2009). The challenge for mental health practitioners is that unlike testing for an infection that is not a specific test for depression, admittedly there is an agreed framework; however like all frameworks it can only provide guidance and not definite answers (Fulford *et al.* 2006, Fulford 2008, Fulford 2009). Focusing specifically on the issue of delusion thinking, the definition for a delusion is based on the work of Jaspers (1913/1997, pp.96-108) in effect 'they are false judgments held with extraordinary conviction and incomparable subjective certainty, they are impervious to other experiences and to compelling counterargument and their content is impossible'. Due to ongoing criticism this definition is only used as a working definition and it is suggested that delusions are understood as 'false beliefs' with the decision to determine whether a belief is delusional being a judgement call made by an expert external observer (Oyebode 2008). This process of diagnosing and determining capacity appears to be based on the accumulation of facts where it may be the case that is based on value-based judgements and value-based frameworks (Fulford *et al.* 2006, Fulford 2009). Due to the value-based nature of mental health practice this can leave the rightness and wrongness of applying coercive strategies open to interpretation, especially the subtler forms of coercion (Olofsson and Norberg 2001, O'Brien and Golding 2003, Woodbridge and Fulford 2004, Anderson and Lux 2005, Ohlenschlaeger *et al.* 2007, Ohlenschlaeger and Nordentoft 2008, Newton-Howes 2010, Newton-Howes and Stanley 2012). O'Brien and Golding (2003) do provide a minimum standard of when coercion should be used;

- The service user lacks capacity
- The harms prevented or benefits provided outweighs the harms caused by the coercive act
- The least coercive intervention is used that will promote good or prevent harm

Liegeois and Eneman (2008) highlight that applying coercive strategies that are justified on similar grounds, incapacity, harm and proportionality, would be compatible with human rights legislation not do so would be incompatible with human rights legislation. Again this work relates to more explicit forms of coercion with subtler forms not being mentioned (Roberts 2005). Coercion that is applied sensitively has better outcomes which includes decrease rates of self-harm and aggression, however most of these studies focus on the use of explicit coercion (Bowers *et al.* 2002, Bowers *et al.* 2003, Alexander and Bowers 2004, Bowers *et al.* 2005, Ryan and Bowers 2005, Bowers *et al.* 2006, Jarrett *et al.* 2008, Bowers *et al.* 2010). Studies like the City 128 Study published by the Department of Mental Health & Learning Disability take a general view of coercion, in the report it is refer to as containment measures and only ones used within an in-patient context (Department of Mental Health & Learning Disability 2006). By exploring this more generic focus some subtler forms of coercion are briefly addressed such as pressuring and persuading a service user to take their medication (Department of Mental Health & Learning Disability 2006).

Pressure includes strong pressure; a service user being told that they must take their medication if not it will be given forcibly; and weak pressure, the service user being told they must take their medication to get better and once they are better they can go home (Widdershoven and Berghmans 2007, Verkerk *et al.* 2008, Widdershoven *et al.* 2009, E Landeweer *et al.* 2011). In the City 128 report summary it infers the forms of coercion that were explored in the study can be a good thing if they are justified and prevent harm, lead to better treatment outcomes, and are sensitive to the needs of the service user (Department of Mental Health & Learning Disability 2006).

2.3. *Part Two – The Ethical Context*

2.3.1. <u>The ethical dimension of mental health nursing</u>

A number of ethical theories influences the clinical decisions that mental health nurses make on a day-to-day basis (Roberts 2004, Bloch and Green 2009, Barker 2011). Mental health nurses due to the apparent inaccessibility of ethical theory do not always acknowledge this influence; these theories may also appear not to be relevant to everyday practice;

"An initial encounter with ethics can be both a confusing and discouraging experience. The variety of ethical approaches, technical terms and critical discussions may lead to the conclusion that ethics is somehow too 'abstract', 'philosophical' or, worse still, 'irrelevant' for mental health nurses."

(Roberts 2004, p.583)

Ethics as a term is derived from the Greek word 'ethikos', which roughly translated means 'disposition' (Bloch and Green 2009, p.3). Ethics as a subject is located within the wider subject area of moral philosophy and generally relates to; "… *the study of conduct with respect to whether an act is right or wrong, to the goodness and badness of the motives and ends of the act*" (Bloch and Green 2009, p.3). The study of ethics can be broken down into descriptive and prescriptive ethics; broadly descriptive ethics describes ethical actions and behaviours, whereas prescriptive ethics prescribes how a person or groups of people ought to act and behave (Cohen 2004). It is important to recognise that prescribing ethical behaviour is not necessarily deduced from describing ethical behaviour (Cohen 2004). Cohen (2004) makes the point based on the original work of Hume (1738/1973) describing and believing that an action is ethical does not necessarily mean a person ought to act in the way that is described. Similarly, ethical theories can be divided into prescriptive or normative and descriptive or nonnormative theories (Sumner 1967). Nonnormative theories are not just descriptive they can also be concerned with the high level analysis of normative meanings (Sumner 1967). However, nonnormative ethics is generally not concerned with what a person ought to ethically do (Sumner 1967, Cohen 2004).

Normative ethical theories are concerned with what a person ought to ethically do, this includes right and wrong behaviours, intentions, and character traits (Sumner 1967, Cohen 2004). In addition, these theories advocate certain approaches a person should adopt, this can include following certain duties, and principles or considering the outcome of an action or cultivating the right character (Sumner 1967, Cohen 2004).

Traditionally two main ethical theories have dominated normative ethics, Consequentialism and Deontology. LaFollette (2000a) highlights that other normative theories have emerged over time as the dominance of these theories have been challenged. Consequentialism is commonly known as utilitarianism; however the use of the term consequentialism pre-dates the use of the term utilitarianism (LaFollette 2000a). Utilitarianism became a popular term first through the work of Jeremy Bentham in 1781 (Bentham 1996) and the work of John Stuart Mill in 1861 (Mill 1991). Consequentialism is sub-divided into two main forms; act-utilitarianism and rule-consequentialism (LaFollette 2000a). Act-utilitarianism takes the position that an action can viewed has right or wrong dependent on the aggregated basis of the outcome (Frey 2000). Whereas rule-consequentialism does not just focus on the aggregated outcome of an act it also considers the rightness and wrongness of an act through the lens of selected set of rules such as the law (Hooker 2000). Even though there are differences within these two approaches generally consequentialism focuses on the outcome of an act as the determining factor of whether the act is ethical (Robertson *et al.* 2007, Plant and Narayanasamy 2014). In addition, the outcome to be ethical has to create; "*... the greatest good for the greatest number*" (Plant and Narayanasamy 2014, p.128). An example of this approach in action is where a mental health service user's freedoms are restricted, the justification being that managing risk in this way, measured by outcome, reduces harming behavior (Smith 2012b). The difficulty with using a consequentialist approach relates to agreeing a way of calculating which action led to which outcome (Bloch and Green 2009).

Deontology also known as Kantianism; however Kantianism, based on the work of Immanuel Kant circa 1797, is in reality a deontological approach, deontology in essence views the ethical person as someone who adheres to their duties, to not adhere would be unethical (Broad 1930, Plant and Narayanasamy 2014). Duties can relate to societal rules which includes the legal and professional rules, they can also be wider such always as 'telling the truth' (Seedhouse 2009, Plant and Narayanasamy 2014). Kant (1948) took the view that duties were universal and though at times enshrined within the law, they could always be identified through reason. This is a deductive process; "*Our lives are governed by duties (deon means duty), and these can be deduced from rational principles – that is, principles any rational person would arrive at – and which will then direct our actions, if they are to be moral*" (Hughes and Common 2015, p.44). To be ethical it is not just a case of doing your duty because it makes you look good, you have to be committed to do your duty because it is the right thing, it is not a means to an ends (Kant 1948, Plant and Narayanasamy 2014).

Within a nursing context it is expected that nurses adhere to certain duties it is also expected that they are committed to those duties; "*You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code..*" (Nursing & Midwifery Council 2015a, p.15). One such duty is being compassionate, a nurse is expected to treat people in their care with '*kindness, respect and compassion*' (Nursing & Midwifery Council 2015a, p.4). Being compassionate as an ethical act it not just determined by the act itself it is also determined by the nature of the act, is it truly compassionate, and the intention of the person carrying out the act, are they really being compassionate (Kant 1948, Plant and Narayanasamy 2014). Knowing what duty to follow is not always clear, however reason will help a person to determine what their duty should be (Kant 1948, Seedhouse 2009). One limitation of this approach is that a person may identify more than one duty; the deontological approach does not in this case provide a robust way of solving this conflict (Seedhouse 2009). As an example within a mental health context, the mental health practitioner has a duty to respect the service user's right to self-determine while at the same time they have a duty to prevent harm. Where the service user wants to commit suicide and has capacity this can create a conflict of ethical duties, conflicting ethical duties can also lead to ethical (moral) distress (Bloch and Green 2006, Cutcliffe and Links 2008, Bloch and Green 2009, De Veer *et al.* 2013).

Alongside consequentialism and deontology there is a third major ethical theory, virtue ethics, this theory pre-dates consequentialism and deontology, it is based on the writings of Aristotle and Plato (Anscombe 1958, Hursthouse 1991, Hursthouse 1999). However, virtue ethics as a distinct theory came to prominence through the work of Anscombe (1958). Virtue ethics in essence views the character of a person as the basis for ethical action; the virtuous person (Hursthouse 1991, Hursthouse 1999). These right character traits are learnt and include amongst others being courageous, patient, truthful, and modest (Smith and Godfrey 2002). The virtuous person will not only learn these traits and live by these traits they will know how to use them wisely, possessing practical wisdom (phronesis) (Hursthouse 1991, Hursthouse 1999, Gardiner 2003). Within a mental health context the virtuous nurse will utilise these character traits to guide their actions and decision making (Armstrong 2006, Bloch and Green 2006, Christie *et al.* 2008). For example to prevent the service user from harming themselves the nurse through the therapeutic relationship will use virtuous character traits to work with and guide the service user to safely manage their risky behaviours (Mckie and Swinton 2000, Roberts 2004, Christie *et al.* 2008). One limitation of the virtue ethics approach relates to the list of virtues, there is no unified agreement; on whether this list is definitive, which virtues are essential, and how these virtues are acquired (Robertson and Walter 2007b, Seedhouse 2009).

Specifically within a healthcare context Principlism which is a 'mid-level' ethical approach rather than an ethical theory has gained prominence over the last twenty years (McCarthy 2003, Bloch and Green 2006, Robertson *et al.* 2007a, Walker 2009).

Principlism embraces aspects of utilitarian and deontological theory; it does not according to Beauchamp and Childress (2013) choose one ethical over another rather it provides a framework in which ethical theory can be applied to real world situations. On this basis Bloch and Green (2006, p.9) locate principlism within the 'tradition of philosophical pragmatism', however Thornton (2007) and Schmidt-Felzmann (2003) identify principlism as a deontological approach due to its use of ethical principles as ethical justification. These principles are viewed as being based on common morality in that they have been accrued through observing human conduct throughout history (Tong 2002, Beauchamp and Childress 2013). Originally there were three principles which were first articulated in the Belmont Report in 1978; respect for persons, beneficence, and justice, over time as principlism has developed there are now four principles; do no harm (non-maleficence); act to benefit others (beneficence); respect a person's autonomy; and treat people fairly (justice) (Evans 2000, Beauchamp and Childress 2013). These four principles are of co-equal importance; they provide a general ethical approach in which ethical decision making can be undertaken (Walker 2009, Beauchamp and Childress 2013). Where principles conflict (Beauchamp and Childress 2013) advocate the use of balancing, finding reasons to support which principle should prevail; and weighing where the relative strength of a principle is considered in detail. The appeal of principlism is it is less cumbersome than applying an ethical theory and as a framework it is more supportive of decision-making process that have an ethical dimension (Iltis 2000, Callahan 2003). In addition Iltis (2000, p.275) highlights that principlism as an approach rather than 'focusing on finding the right answer it focuses on resolving ethical dilemmas in way that can be justified'. This process of justification positions principlism as an objective ethical methodology rather than a subjective one (McCarthy 2003).

Another ethical theory which has gained traction within nursing including mental health nursing is the ethics of care or care ethics (Horsfield *et al.* 2011, Vanlaere and Gastmans 2011, Lachman 2012). The ethics of care according to Bloch and Green (2009) draws on a number of sources which include virtue theory, developmental psychology, feminist thinking and the work of the Scottish Philosopher, Dave Hume. The ethics of care originated through the work of Gilligan (1982) which started to explore the closeness of human relationships and how this can impact upon moral deliberation. The utility of this approach within a healthcare context stems from the emphasis on the caring relationship which is a key feature of nursing practice (Lachman 2012). In addition to be a nurse reflects a moral commitment; "*Care ethics stem from the idea that care is basic to human existence… However, when a person chooses to be a nurse, he or she has made a moral commitment to care for all patients*" (Lachman 2012, p.114). Care ethics is framed by real life care with ethical behaviour being determined by the interaction within the caring relationship including the emotional context (Vanlaere and Gastmans 2011). For example the mental health nurse delivers care through a therapeutic relationship, and as the professional carer they have certain responsibilities.

They have to emotionally build the relationship using their personal qualities, and in addition the relationship has to be collaborative (Reynolds *et al.* 2000, Roberts 2004, Perraud *et al.* 2006, Silverstein 2008, Vanlaere and Gastmans 2011, Gallagher 2013, Kapur *et al.* 2014). The challenge with using a care ethics approach is that it is relative to the situation, being ethical in one situation may not necessarily mean it is applicable to another, albeit similar, situation (Bloch and Green 2009, Vanlaere and Gastmans 2011). Gallagher *et al.* (2016) gives a 'feeding' example where the nurse knows what to because of their unique relationship with the service user, however the nurse's actions may not be applicable when working with another service user in a similar situation due to the uniqueness of the therapeutic relationship.

Principlism and care ethics within a nursing context may have gained prominence over the last few years however nursing ethics is still influenced by the more traditional ethical theories; deontology, consequentialism, and virtue ethics (Plant and Narayanasamy 2014). This may be due to nursing ethics in the UK not being a distinct theory rather it takes a multi-theory approach which is articulated through a code of conduct (Coady 2009, Plant and Narayanasamy 2014, Nursing & Midwifery Council 2015a). However, the interest in nursing ethics has a long history which according to Plant and Narayanasamy (2014) dates back to the 1870's. This does not mean nursing theorists have not tried to either to create a theory of nursing ethics or to focus on one specific theory, however; "*Existing ethical theories and models have provided a limited foundation for nurses and other health professionals dealing with ethical situations in their everyday practice*" (Varcoe *et al.* 2004, p.317). Nursing practice is '*relational and highly contextual*' meaning that contextual factors such as poor staffing levels and a lack of leadership support cannot be ignored (Varcoe *et al.* 2004, p.323). The impact being that rather than one ethical theory driving a nurse's ethical practice, a top-down approach, the nurse starts with the practice issue first and then looks for the most appropriate ethical theory or theories to assist them to solve any arising ethical problems, bottom-up approach (Dierckx de Casterle *et al.* 1997, Cohen 2004, Varcoe *et al.* 2004, Bolmsjo *et al.* 2006, Dierckx de Casterle *et al.* 2008). It is important to note this is a tacit process where on-reflection an ethical theory is identified rather than a specific theory being used explicitly and in a pre-determined way (Dierckx de Casterle *et al.* 1997, Dierckx de Casterle *et al.* 1998, Roberts 2004, Varcoe *et al.* 2004, Dierckx de Casterle *et al.* 2008).

Specific to mental health nursing Roberts (2004) highlights when using any ethical theory the unique paternalistic nature of practice needs to be taken into consideration. On this basis Roberts (2004) suggests that a singular approach such as principlism does not fully address the unique nature of mental health nursing practice, there is an implicit suggestion that a more unified or multiple ethical theory approach may be more useful. This approach is also advocated within the field of psychiatry by Bloch and Green (2006) and Radden (2002b).

In a paper by Radden (2002b), *Notes towards a professional ethics for psychiatry*, Radden teases out the unique features of psychiatric practice; the therapeutic relationship, the characteristics of the service user, and purpose of the therapeutic enterprise. However, Radden similar to Roberts (2004) does not explicitly suggest which ethical theories should be used to manage the unique nature of mental health practice. Whereas Bloch and Green (2006) take-up the 'challenge' of identifying these theories;

"*Our aim is to review competing theories, note their strengths and limitations briefly, and offer a new framework and corresponding pragmatic guidelines, which we hope will meet the needs of those who have to grapple with the multifaceted ethical dilemmas inherent in the psychiatric encounter.*"

(Bloch and Green 2006, p.7)

The ethical theories identified by Bloch and Green (2006) include principlism, ethics of care, and virtue ethics. Roberts (2004) acknowledges the usefulness of these theories within a mental health nursing practice context, however with the caveat of '*which approach to adopt and why*' (p.587). Bloch and Green (2006) advocate using these theories in a unified approach as a way of managing the uncertainty of mental health practice and giving the practitioner the latitude to solve ethical issues in a more iterative manner. The justification for using this approach is based on the perceived weaknesses of more traditional and absolute theories such as deontology and utilitarianism (Crowden 2003, Bloch and Green 2006). It addresses these perceived weaknesses by using a multiple theory approach to provide a balance between rules-based and character-based ethical theories, thus granting ethical significance to the emotional context of practice while at the same time paying attention to the ethical rules (Crowden 2003, Bloch and Green 2006). Placing practice at the centre of this approach and then finding the relevant ethical theory or principle that fits within a practice context subscribes to ethical reasoning that is bottom-up and pragmatic (LaFollette 2000b, Cooke 2003, Fesmire 2003, Hester 2003, Schmidt-Felzmann 2003, Cohen 2004, LaFollette 2007, Dewey 2015). The use of the term pragmatic refers to pragmatic ethics which arose out of philosophical pragmatism (LaFollette 2000b, Fesmire 2003, LaFollette 2007, Bacon 2012, Dewey 2015). In essence pragmatic ethics advocates the use of singular or multiple ethical theories with a focus on giving society, it is a social approach, the latitude to evolve where required beyond these theories, similar to the evolution of scientific theory (LaFollette 2000b, LaFollette 2007).

Pragmatic ethics holds that meaningful inquiry or theorising is only meaningful if it emanates from practice and in due course informs practice (LaFollette 2007). As an example within a mental health nursing context the use of coercion is an ethical issue, being pragmatic means this issue is solved by using ethical theories, rules, and approaches that best fit the circumstances rather than using a theory for theory sake (Cohen 2004, LaFollette 2007).

On this basis the mental health nurse as a skilled ethical reasoner has to take what is in effect a flexible approach to solve a particular ethical challenge (Dierckx de Casterle *et al.* 1997, Dierckx de Casterle *et al.* 1998, Cohen 2004, Dierckx de Casterle *et al.* 2008).

2.3.2. <u>The development of the ethical mental health nurse</u>

Upon qualifying the mental health nurse is expected to practice ethically, this expectation is framed by a code of conduct or covenant (Coady 2009, Nursing & Midwifery Council 2015a). Every three years after qualification the nurse is required to revalidate, this process involves the nurse demonstrating that they are engaging in lifelong learning and they are safe practitioners who abide by the code of conduct (Nursing & Midwifery Council 2015a, Nursing & Midwifery Council 2015b). It also has an ethical element in that the nurse has to frame this learning with reference to the code of conduct – ethical rules (Nursing & Midwifery Council 2015a, Nursing & Midwifery Council 2015b). To qualify and to be registered by the NMC the nurse has to be certified as professionally competent by a training programme (Nursing & Midwifery Council 2010). Currently the intention of this training is to;

".... enable nurses to give and support high quality care in rapidly changing environments. They reflect how future services are likely to be delivered, acknowledge future public health priorities and address the challenges of long-term conditions, an ageing population, and providing more care outside hospitals. Nurses must be equipped to lead, delegate, supervise and challenge other nurses and healthcare professionals. They must be able to develop practice, and promote and sustain change. As graduates they must be able to think analytically, use problem-solving approaches and evidence in decision-making, keep up with technical advances and meet future expectations."

(Nursing & Midwifery Council 2010, pp.4-5)

In addition, the curriculum should '*reflect the application of ethical, professional and legal frameworks*' (Nursing & Midwifery Council 2010, p.8). With the intention of enabling the student nurse during the programme and at the point of qualification to; "*Act with professionalism and integrity, and work within agreed professional, ethical and legal frameworks and processes to maintain and improve standards*" (Nursing & Midwifery Council 2010, p.5).

Being able to ethically reason using ethical, legal and professional frameworks teases out the rational element of nursing practice (Cohen 2004, Ford 2006), however, there is also an emotional element which is expressed generically (all fields of nursing practice) as giving 'emotional support' and specifically for mental health nursing students;

"They must also engage in reflection and supervision to explore the emotional impact on self of working in mental health; how personal values, beliefs and emotions impact on practice, and how their own practice aligns with mental health legislation, policy and values-based frameworks."

(Nursing & Midwifery Council 2010, p.23)

This approach places an emphasis on being self-aware and being sensitive to the emotional dimension of care (Akerjordet and Severinsson 2004, Roberts 2004, Valdesolo and DeSteno 2006, Nursing & Midwifery Council 2010). There is also an emphasis on both the rational side of reasoning and the emotional side of reasoning working in tandem (Akerjordet and Severinsson 2004, Roberts 2004, Valdesolo and DeSteno 2006, Nursing & Midwifery Council 2010, Nursing & Midwifery Council 2015a). This is important within a mental health nursing context as the therapeutic relationship with the service user is the medium for treatment which is both a rational and emotional endeavour and it also has to take into account the potential irrationality and unpredictability of mental distress (Armstrong *et al.* 2000, Radden 2002b, Radden 2004, Armstrong 2006, Brendel 2006, Gilburt *et al.* 2008). The rational dimension of this relationship is influenced by frameworks and the burgeoning use of evidence-based approaches (Gournay 1995, Gournay 2009). The emotional dimension focuses on the use of self, the way the nurse communicates during a therapeutic encounter this includes using character traits such as kindness, patience, tolerance and compassion, to name a few (Armstrong 1999, Armstrong *et al.* 2000, Armstrong 2006, Radden and Sadler 2008). In addition, the controlling nature of mental health nursing practice plays a part requiring the mental health nursing to be emotionally supportive even when at the same time they may be required to restrict a service user's freedoms (Roberts 2004). This paradox can lead to ethical conflict and distress for both parties, hence the reference to values-based frameworks in the Nursing & Midwifery Council (2010) quoted above (Cooper 2009, Eizenberg *et al.* 2009, Pauly *et al.* 2009). This approach is seen as a good way of resolving this type of conflict specifically through the work of Woodbridge and Fulford (2004).

Ethical conflict which is not handled correctly and in a sensitive manner may lead to a perception that the nurse is abusing their power (Hannigan and Cutcliffe 2002, Roberts 2005, Hamilton and Roper 2006, Kress 2006, Kuosmanen *et al.* 2007, Strous 2007, Chodoff 2009, Peele and Chodoff 2009, Han *et al.* 2010, Lutzen *et al.* 2010, E.G.M Landeweer *et al.* 2011). Being self-aware to the point of being able to make the right choice even in the most difficult situations is no easy task; however it is highlighted as a key feature of expert nursing practice (Benner 1982, Benner and Tanner 1987, Hardy *et al.* 2002, Gardiner 2003, Bowers 2010, Morrison and Symes 2011). At a general level the self is described as having component parts, the outer component, the self that other people see and the inner component, the self which is a person's inner world, being fully aware of both these components leads to being self-aware (Anderson and Lux 2005, Wilkin 2006, Knott 2012).

As there is no agreed definition of self-awareness this is a general description, as a hard to pin down concept Philippi *et al.* (2012) highlight self-awareness is; "*... a complex, rich and integrated phenomenon of self-knowledge, which is central to consciousness and incorporates multiple components*" (Philippi *et al.* 2012, p.1). This a neurocognitive view of self-awareness which is similar to the general view of self-awareness articulates three components instead of two these include; core self-awareness, the self as sense of self-agency; extended self-awareness, autobiographical memories; and introspective self-awareness, self-reflective processes (Philippi *et al.* 2012). The utility of being self-aware as a mental health nurse relates to the nurse being the treater within the therapeutic relationship with their main therapeutic tool being the therapeutic-self (Gilburt *et al.* 2008, Anderson and Waters 2009, Chambers *et al.* 2015). By being self-aware the mental health nurse uses the therapeutic-self more effectively, responding to the service user's needs as required by the service user (Cutcliffe 1997, Wilkin 2006, Brimblecombe *et al.* 2007, Hurley and Rankin 2008, Anderson and Waters 2009). As an example the mental health nurse is expected to have the skills, knowledge and values to work in variety of settings and with a variety of mental health conditions (Nursing & Midwifery Council 2015a, Nursing & Midwifery Council 2015b). They are also expected to look beyond the presenting mental health condition and deliver person-centred care using person-centred skills (Barker 2001, Barker 2003, Brimblecombe *et al.* 2007, Nursing & Midwifery Council 2015a). On this basis mental health nurse has to move beyond the scientific formulation of a service user's presenting symptoms to work with the person as a service user in recovery and not as a mental health condition per se (Carper 1978, Bracken and Thomas 2001, Borg and Kristiansen 2004, Bracken and Thomas 2005, Wilkin 2006, Borg and Davidson 2008, Cleary *et al.* 2013). Self-awareness mediates this process knowing which person-centred skills to use and why (Wilkin 2006, Hurley and Rankin 2008). This knowing is based on the skilled use of empathy (Carper 1978, Yegdich 1999, Reynolds *et al.* 2000, Olsen 2001, Wilkin 2006, Knott 2012, Smith 2012a, Smith 2014).

Empathy is an often used term and yet according to Nunes *et al.* (2011) is not fully understood. Defining empathy is a challenge (Batt-Rawden *et al.* 2013), however Kane *et al.* (2014) suggests mental health nurses will use 'trained empathy' to know and understand a service users perspective and experiences both objectively (cognitively and behaviourally) and subjectively (ethically and emotionally). Knowing in this holistic way corresponds to seminal work of Carper (1978) who identifies four ways of knowing within nursing practice;

1. empiric - knowledge from the sciences
2. esthetic - knowledge from doing in this case practicing as a mental health nurse
3. personal - knowledge from knowing self and others knowing
4. ethical - knowledge from ethical reasoning

These ways of knowing interact and can be used simultaneously depending on the skill of the nurse (Carper 1978). In addition, being self-aware and empathetic extends to the nurse being able to work with their values and other people's values in a positive and mutually collaborative way (Richards *et al.* 2010, Nursing & Midwifery Council 2015a, Johns 2016). Duncan (2010) makes the point that what a person values may not be valued by another person. Values can be divided into three types; subjective, instrumental, and intrinsic (Dworkin 1995, Duncan 2010). Subjective value relate to things we value because we like them, instrumental value relate to the usefulness of a thing, intrinsic value relates to a thing we value even it is not useful or necessarily liked (Dworkin 1995, Duncan 2010). These values develop over time and on becoming a mental health nurse they become entwined with professional values (Duncan 2010). Professional values include professional body values and also values that are shaped by the field of practice (Fulford 2008, Fulford 2009). A mental health nurse may subjectively and instrumentally value a person-centred approach within their practice; however their practice will also be shaped by the intrinsic value of classifying mental disorders (Fulford 2009, Duncan 2010). There may well be an underlying assumption that this classifying process is value-free and based on facts (Boorse 1975). Some commentators such as Szasz (1960) would argue;

"Mental illness, of course, is not literally a "thing"—or physical object—and hence it can "exist" only in the same sort of way in which other theoretical concepts exist. Yet, familiar theories are in the habit of posing, sooner or later—at least to those who come to believe in them—as "objective truths" (or "facts")."

(Szasz 1960, p.113)

Others would argue differently, however there is an acknowledgment there is a need to challenge underlying assumptions and any corresponding values;

"... although his (Szasz) *core arguments have not, broadly speaking, been accepted, he has made many psychiatrists, social scientists, and jurists think about issues they might not otherwise have considered and key assumptions they might never have questioned."*

(Kendell 2004, p.46)

The work of Woodbridge and Fulford (2004) in *Whose Values? A workbook for values-based practice in mental health care* directly addresses the need to understand and work with these values and also challenge any underlying assumptions which may unknowingly shape a mental health nurses practice to the detriment of the care they provide. This need is contextualised by the unique controlling aspect that is inherent within mental health care (Woodbridge and Fulford 2004, Fulford *et al.* 2006, Fulford 2008, Fulford 2009).

Woodbridge and Fulford (2004) connect 'understanding values' with good practice in mental health care and on this basis they provide an overview of a good process in which to work with these values. Using this approach the mental health nurse has to be self-aware, they also have to be able to ethically reasoning using ethical theories and professional frameworks (Woodbridge and Fulford 2004). They also have to recognise that values are wider than ethical theory, they can be related to self-interest amongst other things (Woodbridge and Fulford 2004). It is important to recognise these values are brought into nursing at the point of starting a pre-registration nursing programme with the expectation that they are professionally shaped over time, however this assumption is based on the premise that personal values also change (Nursing & Midwifery Council 2010, Pitt *et al.* 2014, Nursing & Midwifery Council 2015a, Nursing & Midwifery Council 2015b). If it is accepted that nursing practice is also an ethical practice then any corresponding values have an ethical dimension which can be both personal and professional (Gastmans *et al.* 1998, Goethals *et al.* 2013).

Johnson *et al.* (2012) highlight that personal and professional values within a nursing context do converge where there is a systematic process in place that engenders a robust professional identity. Due to the complex nature of nursing practice this convergence process is more haphazard than systematic (Currid 2009, Johnson *et al.* 2012). Where these values may not have converged when the nurse is making an ethical decision and even if they are not aware of the impact of their personal values they can still have an impact (Woodbridge and Fulford 2004, Fulford *et al.* 2006, Fulford 2008, Fulford 2009, Johnson *et al.* 2012, Kaya *et al.* 2016) The implication for nursing practice is; "*Nurses are guided in their everyday lives by their personal values and beliefs about what is right and good. Such personal beliefs define nurses' sense of morality and influence how they customarily make decisions and react to usual problems ...*" (Cohen and Erickson 2006, p.776). A mental health nurse's ethical reasoning skills including their values are shaped by their training and subsequent post-qualifying practice, in addition, these skills are also shaped by their ethical development - pre-nursing (Dierckx de Casterle *et al.* 1998, Baxter and Boblin 2007, Gross 2015, Kaya *et al.* 2016).

Psychological theorists link the development of ethical reasoning skills with the normal psychological or cognitive development of a person from early childhood onwards (Gross 2015). These theories are primarily influenced by the work of Jean Piaget circa 1936 and Lawrence Kohlberg circa 1958 (Baxter and Boblin 2007, Gross 2015). Both Piaget's and Kohlberg's theories are based on a staged approach, these stages encompass early childhood up to adulthood, both approaches refer to a person's ethical development and how they make cognitive sense of society's ethical rules (Kohlberg 1981, Kohlberg 1984, Piaget and Inhelder 2000, Gross 2015).

Summarising Piaget's position, a child from an early age develops their ethical reasoning skills, which is viewed as a component of general cognitive functioning, through the influence of authority figures such as teachers and parents, over time as the child moves through to adulthood they become more independent as thinkers using ethical rules and frameworks to shape their ethical reasoning (Piaget and Inhelder 2000, Gross 2015).

Kohlberg building upon Piaget's theory again took a staged approach, unlike Piaget, Kohlberg focused specifically on a person's ethical development including a greater focus on adulthood (Kohlberg 1981, Kohlberg 1984, Piaget and Inhelder 2000, Gross 2015). Kohlberg identifies six stages which correspond to age, as a person passes successfully through each stage their ethical reasoning becomes more effective (Kohlberg 1981, Kohlberg 1984, Gross 2015). This approach comprises of three levels and two stages per level:

1. Pre-Conventional
   ➢ Obedience and punishment orientation
   ➢ Self-interest orientation
2. Conventional
   ➢ Interpersonal Accord and Conformity
   ➢ Authority and Social-order Maintaining Orientation
3. Post-Conventional
   ➢ Social Contract Orientation
   ➢ Universal Ethical Principles

Generally a child will ethically reason at the pre-conventional level and adults at the conventional level and beyond or what is known as the post-conventional stage (Kohlberg 1981, Kohlberg 1984, Gross 2015). An over-arching feature of the conventional level is how a person uses society's rule and norms to shape their ethical reasoning and their sense of right and wrong (Kohlberg 1981, Kohlberg 1984, Gross 2015). During this process a person adapts their behaviour to correspond to social rights and wrongs, being influenced by feedback from others, with the consideration 'I would prefer to be seen as a good person' (Kohlberg 1981, Kohlberg 1984). The person during this process also recognises that to function effectively as a member of society it is important to follow society's rules (Kohlberg 1981, Kohlberg 1984). Most people are seen as operating at the conventional level, however some people can operate at the post-conventional level where a person is ethically reasoning in an abstract way (Kohlberg 1981, Kohlberg 1984). In relation to the post-conventional level and specifically stage six, universal ethical principles, there is a lack of empirical data to support the notion that people ethically reason in way that corresponds to this stage (Kohlberg 1981, Kohlberg 1984). A feature of the post-conventional stage is the person reasoning using ethical rules, however they also recognise the reasoning process is a human endeavor and can lead to multiple outcomes (Kohlberg 1981, Kohlberg 1984).

later on in Kohlberg's work it was acknowledged that some people appear to regress from one stage to another (Kohlberg 1981, Kohlberg 1984). Kohlberg conceptualised this as a person not transitioning fully from one stage to another, this being a case of a person having the characteristics of two stages and when they do not fully transition they have the characteristics of the lower stage, therefore appearing to have regressed (Kohlberg 1981, Kohlberg 1984).

Carol Gilligan (1982) in her seminal text, *in a different voice*, criticised Kohlberg's approach for focusing on a 'justice' model of ethical reasoning rather taking into consideration the interpersonal aspect of ethical reasoning. For Gilligan this demonstrated a gender bias, based on the assumption that males are more justice focus (Gilligan 1982). Kohlberg acknowledged that the 'justice' and 'interpersonal' elements of ethical reasoning should have equal weight, however he did not accept that males were more justice orientated (Kohlberg *et al.* 1983). In response to Kohlberg's theory Gilligan developed an ethical reasoning model that took into account the female or interpersonal view. It is argued that Gilligan's response; *"... suggested that women have a distinct moral voice and describe moral situations using a distinct language."* (Baxter and Boblin 2007, p.22). The female voice being 'care focused' and contextualised within the interpersonal relationship whereas the male voice is more logical and justice focused (Gilligan 1982). Baxter and Boblin (2007) summarised Gilligan's model in terms of three perspectives;

1. Caring for the self to ensure survival
2. A maternal morality that seeks to ensure care for the dependent and unequal
3. A focus on the dynamics of relationships and the resolution of tension between selfishness and responsibility for others

During the same period of time James Rest integrated and extended the theories of Kohlberg and Gilligan (Rest 1979, Rest 1986, Rest *et al.* 1999). Rest proposed a four component model (Baxter and Boblin 2007);

1. Interpretation of the situation
2. Decision regarding a course of action
3. Conflict of other values with moral values
4. Execution and implementation of a plan of action

Key to this model are two premises, the person is cognitively making sense of the ethical issue as a an active problem solver, and secondly the person's ethical characteristics also play a part which includes being resilient and empathetic (Rest *et al.* 1999, Baxter and Boblin 2007). Rest also highlighted the important of formal education shaping the person's ethical reasoning skills rather than it being age-related as in Kohlberg's theory (Rest *et al.* 1999, Baxter and Boblin 2007).

Within a nursing context the theories of Kohlberg, Gilligan, and Rest have influenced nursing theorists to consider how the nurse's personal ethical development impacts upon the ethical decisions the nurse makes in practice (Dierckx de Casterle *et al.* 1997, Dierckx de Casterle *et al.* 1998, Gastmans *et al.* 1998, Cohen and Erickson 2006, Baxter and Boblin 2007, Dierckx de Casterle *et al.* 2008, Goethals *et al.* 2013). There is an acceptance that in clinical practice not only shapes the nurses pre-nursing ethical reasoning by converging personal and professional values it also shapes the way the nurse ethically reasons (Dierckx de Casterle *et al.* 1997, Dierckx de Casterle *et al.* 1998, Dierckx de Casterle *et al.* 2008, Kaya *et al.* 2016). In reference to Kohlberg's theory Dierckx de Casterle *et al.* (1998) takes the position that this theory needs to be adapted to take into account how nurses ethically reason within a practice context. The limiting factor in relation to this theory is the reliance on justice-based rules as a foundation for ethical reasoning rather than acknowledging that ethical reasoning in nursing practice is embedded within a particular situation (Dierckx de Casterle *et al.* 1998, Dierckx de Casterle *et al.* 2008). This position situates the way nurses ethically reason at a post-conventional level, it also embodies the features of Gilligan's theory, the interpersonal dimension, and Rest's theory, the impact of formal education and personal qualities (Dierckx de Casterle *et al.* 1998, Baxter and Boblin 2007, Dierckx de Casterle *et al.* 2008). Being able to use ethical rules and also to reflect and act ethically in the moment can also be seen as the expert nurse acting the right way and at the right moment is a form of tacit knowledge (Carlsson *et al.* 2000, Welsh and Lyons 2001, Crowe and O'Malley 2006, Berg 2008, Dierckx de Casterle *et al.* 2008, Sumner 2010, Jasper and Rolfe 2011).

Tacit knowledge or as it is originally known as the 'tacit component of knowledge' a concept that came to the fore through the work on Polanyi (1958) specifically in his book, *Personal Knowledge: Towards a Post-Critical Philosophy*. Carlsson *et al.* (2000) gives an example of the use of tacit knowledge within mental health nursing practice; *"if one observes, for example, an experienced nurse, it seems that he or she instinctively knows what to do, appearing wholly immersed in the activity of caring, drawing on, and taking for granted, the knowledge and understanding needed at the moment"* (Carlsson *et al.* 2000, p.535). Tacit knowledge is in essence knowledge acquired from experience, it is implicit rather explicit, and it is augmented through action (Polanyi 1958, Matthew and Sternberg 2009). The process of reflecting during and after an act may make tacit knowledge explicit, however for this to happen the process of reflection has to make use of transferrable tacit knowledge which is applied within a problem-solving context (Hummelvoll and Severinsson 2001, Smith and Johnston 2002, Gould and Masters 2004, Kuiper and Pesut 2004, Matthew and Sternberg 2009, Freshwater 2011, Jasper and Rolfe 2011, Gardner 2014).

2.3.3. Ethical decision-making and reasoning

Clinical decision-making is a fundamental part of a mental health nurse's clinical practice, coupled with making decisions is the use of clinical judgement (Banning 2008, Bjørk and Hamilton 2011, Thompson *et al.* 2013, Puschner *et al.* 2016). In terms of defining, 'making clinical decisions' and using 'clinical judgement'; *"Many definitions of judgements and decisions exist, and so for clarity, when we refer to judgements we mean the assessment of alternatives... When we refer to decisions we mean the act of choosing between alternatives…"* (Thompson *et al.* 2013, p.1721). This decision making and judgement process is contextualised by the uncertainty of nursing practice, mental health nurses will not always have all the information at hand or be sure of outcomes, however irrespective of this uncertainty they will still have to make the 'right' decisions and judgements (Welsh and Lyons 2001, Carson and Lepping 2009, Thompson *et al.* 2013). Even when presented with the same information while dealing with a similar situation nurses will not necessarily make the same decisions and judgements (Carson and Lepping 2009, Thompson *et al.* 2013). This variation in itself is understandable if the uncertain nature of nursing practice is accepted, where it is more of problem relates to not knowing why these differences occur and what impact they have on care outcomes (Thompson *et al.* 2013). On this basis Thompson *et al.* (2013) advocate nurses using more 'rational and deliberative methods of clinical reasoning' as a robust foundation for making clinical decisions which includes judgements. There are a number of systematic decision making models available these include; information processing, analytical, intuitive-humanist, Hammond's, and O'Neill's models (Banning 2008, Bjørk and Hamilton 2011).

Information processing and analytical models emphasise the rational component of clinical decision making, this includes modelling the decisions nurses make within a rules-based process or a structured process (Banning 2008, Bjørk and Hamilton 2011). Rules-based processes are incorporated within computer-based clinical decision-making packages, or policies and guidelines that use decision trees, and flow-charts (Banning 2008, Bjørk and Hamilton 2011, National Institute for Health and Care Excellence 2013). A structured process within a clinical context comprises of four key stages; information gathering, developing a premise based on the information gathered, testing this premise against the clinical evidence, and then deciding on the best course of action (Hamers *et al.* 1994, Bjørk and Hamilton 2011). This 'rational' approach is then used to assist other nurses in making rational sense of a similar situation or related clinical challenge (Banning 2008). The limitation with this type of approach is that not all scenarios can be modelled especially when dealing with uncertain clinical situations, in addition, deliberative thinking may not always precede action, sometimes nurses just have to act (Banning 2008, Bjørk and Hamilton 2011, Thompson *et al.* 2013). Intuitive-humanist models according to Banning (2008) focus on; "*… intuition and the relationship between nursing experience, the knowledge gained from it and how it enriches the clinical decision-making process as the nurse progresses along the professional trajectory*" (Banning 2008, p.189).
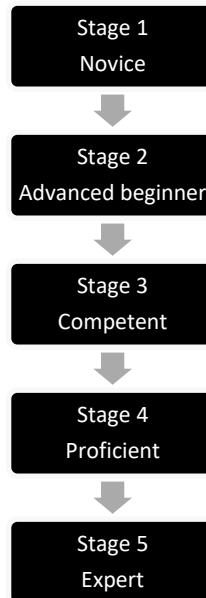
This approach is based on the view that experiential or tacit knowledge can be converted to useable formal knowledge by a nurse's reflective endeavours (Carper 1978, Benner 1982, Schön 1983, Benner and Tanner 1987, Crook 2001, Hardy *et al.* 2002, Lyneham *et al.* 2008). This store of knowledge which is accrued through reflective experience presents itself as intuition, knowing the right thing to do, which in itself is activated by the nurse implicitly recognising familiar characteristics of a situation (Polanyi 1958, Pang 1999, Banning 2008, Matthew and Sternberg 2009). Intuition used in this way is described by Benner (1982) as being a fundamental part of expert practice;

"At the expert level, the per-former no longer relies on an analytical principle (rule, guideline, maxim) to connect her/his under-standing of the situation to an appropriate action. The expert nurse, with her/his enormous back-ground of experience, has an intuitive grasp of the situation and zeros in on the accurate region of the problem without wasteful consideration of a large range of unfruitful possible problem situations."

(Benner 1982, p.405)

This use of intuitive reasoning according to Benner (1982) is refined over time but not just through the passage of time, rather it is through the way the nurse reflects on their experiences as they develop their practice. This model of development is articulated within a staged approach, **see figure 3** (Benner 1982). Criticisms of the intuitive-humanist approach relate to it is not easily being explained through scientific theory and it is lack of recognition that a solution is prone to human error (Banning 2008). The Hammond and O'Neill models are hybrid or multi-dimensional models taking components from the information processing, analytical, and intuitive-humanist models (Banning 2008, Bjørk and Hamilton 2011). The O'Neill model in essence provides a computerised analytical model which is based on how nurses reason from novice to expert, this model is currently uses a small set of data (Banning 2008). The Hammond model is not in itself a model it is a theory which views all other models as not being different models but different parts of continuum of cognitive reasoning, intuition being quasi-rational cognition and analytical being analytical cognition (Bjørk and Hamilton 2011).

Figure 3: novice to expert staged approach

Stage 1
Novice

Stage 2
Advanced beginner

Stage 3
Competent

Stage 4
Proficient

Stage 5
Expert

Using a multi-dimensional approach is advocated by Thompson *et al.* (2013) where over time as the nurse becomes more expert they integrate intuition within their skilled use of rational models of decision making. This focus on rationality as the cornerstone for making decisions according to Bortolotti (2015) stems from the pervasive view that 'human agency is rational agency' and 'irrational behaviour is the exception' (p.1). In addition, Bortolotti (2015, p.3) highlights that an individual is potentially deemed to be irrational under the following circumstances;

➢ Beliefs not fully supported by scientific evidence

➢ Reasoning which does not conform to accepted logical standards

➢ Emotional-based decisions rather deliberative decisions

➢ Intentions do not match beliefs

➢ Actions do not match intentions

➢ The appropriate means are not selected

➢ Goals are inconsistently pursued

There are potential consequences to appearing irrational;

"*Depending on the context and on the extent to which their behaviour deviates from the norm, agents exhibiting irrational behaviour may be regarded as foolish, ignorant, unwise or even mad. When their departure from rational forms is significant, their very agency is called into question.*"

(Bortolotti 2015, p.3)

Being seen to be a rational decision-maker is influenced by a strong positivist position which is prevalent within contemporary mental health nursing practice and healthcare practice per se (Paley and Shapiro 2001, Franks 2004, Gournay 2009, Nolan 2009). This influence also extends to the type of evidence the mental health nurse should use with scientific evidence being the preferred form of evidence (Gournay 1995, Gournay 2009). Even though tacit knowledge is a recognised form of knowledge its use has been both criticised and at times devalued (Benner and Tanner 1987, English 1993, McCutcheon and Pincombe 2001, Pearson 2013). This view creates a challenge for the nurse who then has to be seen as a rational decision maker and one who provides a rational justification based on using acceptable forms of evidence (Thompson *et al.* 2013). Deciding which forms of evidence are acceptable is an evaluative judgement based on the value the evaluator places on the evidence (Bortolotti 2015). As scientific or rational forms of evidence are highly valued it may mean that the nurse rationalises any emotional evidence they have used so it appears to be more acceptable or more scientific (Merleau-Ponty 1945/1962, Bortolotti 2015). This process of rationalising can happen when the nurse reflects post-incident and they down-play the role their emotions played in reaching an outcome or they can completely remove the role their emotions played while at the same time over-emphasising the use of more acceptable (rational) forms of evidence (Boud and Walker 1998, De Veer *et al.* 2013, Bortolotti 2015). In addition, Bortolotti (2015) highlights that historically emotions within a decision making context were seen as something that the rational person rises above or controls. However, recently it has been recognised that emotion not only plays a significant part in the decision making process it can also enhance the goal-driven part of the process, for example, through an individual harnessing their motivations which are emotionally driven (Bortolotti 2015).

At times nurses do not recognise that clinical decision making has an ethical dimension such as the expectation to do the right thing (Cohen 2004, Nursing & Midwifery Council 2015a). It is not unusual for this ethical dimension to become apparent when ethical conflict arises, especially where there are two or more views on what the nurse ought to have done (Cohen 2004, Woodbridge and Fulford 2004, Fulford *et al.* 2006). This hidden ethical dimension may be due to everyday mundane issues not appearing to be ethical issues, for example in mental health nursing, the routine locking of doors may not appear as an issue compared to forcibly giving a service user medication (Cohen 2004, LaFollette 2007, Ashmore 2008, Verkerk *et al.* 2008, Cutcliffe and Happell 2009). It also may be due to the spontaneity of the ethical choices made whether it be in a professional or everyday context, *"All of us must make ethical choices. Sometimes those choices seem so easy that we do not see them as choices. We don't consciously decide to comfort a close friend whose son was just killed; we just do"* (LaFollette 2007, p.7). Most of these everyday ethical decisions do not have to be explicitly justified this is not the case within a nursing context as nurses are professional accountable for their practice decisions (Nursing & Midwifery Council 2015a).

This level of accountability does not disappear when the nurse is outside their place of work; "*You should display a personal commitment to the standards of practice and behaviour set out in the Code*" (Nursing & Midwifery Council 2015a, p.15). Making the right decision is professionally expected even where there is a high degree of complexity present and the nurse is uncertain of the right outcome (Cohen 2004, Nursing & Midwifery Council 2015a). This type of situation is more likely to lead to a degree of ethical conflict, however, if challenged the nurse is still expected to be able to robustly justified their decisions and their subsequent actions (Fulford 2008, Nursing & Midwifery Council 2015a). This process of justification has to be in line with the 'best available evidence and best practice' (Nursing & Midwifery Council 2015a, p.8). This viewpoint does lend itself to the use of rational evidence, however the professional code for nurses also recognises the emotional dimension of nursing through the use of such terms as kindness and compassion (Nursing & Midwifery Council 2015a). The Nursing & Midwifery Council (2015a) code does not explicitly use the term rational, however it is clearly a rational framework of ethics and one that nurses should comprehensively follow throughout their nursing career;

"*For the many committed and expert practitioners on our register, this Code should be seen as a way of reinforcing their professionalism. Through revalidation, you will provide fuller, richer evidence of your continued ability to practise safely and effectively when you renew your registration.*"

(Nursing & Midwifery Council 2015a, p.3)

This in essence means that the 'right thing to do' when making a decision is located with the nurse's professional training and the code (Nursing & Midwifery Council 2010, Nursing & Midwifery Council 2015a, Nursing & Midwifery Council 2015b). In addition, the process of revalidation provides nurses with a formal opportunity to formally reflect on the ethical scope of their practice (Nursing & Midwifery Council 2015a, Nursing & Midwifery Council 2015b). The code's purpose as a general set of ethical principles is to aid and structure the nurse's ethical decision-making (Cohen, 2004, NMC, 2015a). Using principles and frameworks to shape the clinical decision making process aligns to a top-down ethical reasoning approach (Cohen 2004). Cohen (2004) highlights that;

"*According to this approach, the task for moral reasoning is to bring particular moral judgements or intuitions about particular situations into harmony with overarching general principles, which, themselves, are paramount and non-negotiable in this process. Sometimes, the application of the principle will correct a judgement; and it will simply bring about a judgement*"

(Cohen 2004, p.61)

For example, when dealing with an uncertain situation the nurse will analyse the situation and identify what the issues, they will then check that their approach is accordance with the relevant ethical rules, if not, they will change their approach accordingly (Cohen 2004). However, nurses do not just use the rules in this way, due to the experiential and emotional nature of nursing practice nurses at an expert level according to Dierckx de Casterle *et al.* (2008) use post-conventional ethical reasoning skills. This level of ethical reasoning is akin to bottom-up ethical reasoning approach;

"*Rather than independently derived, overarching principles, it is these ground-level judgements themselves – perhaps intuition, perhaps feelings, but certainly reactions to the particular situations – that are the foundational, fundamental elements of moral reasoning. It is these judgements that serve to generate principles, and thus a fit between principles and judgements.*"

(Cohen 2004, p.62)

This approach is a more pragmatic approach where the nurse recognises that there is an ethical issue and only uses ethical principles that have utility within that particular situation (Cohen 2004, LaFollette 2007). Similar, to Thompson *et al.* (2013) recommendation in relation to clinical decision-making, Cohen (2004) recommends there should be a balanced approach which creates equilibrium between top-down and bottom-up reasoning. Cohen (2004) does not offer a structural model instead suggesting that balancing is processed and tested through the individual using their imagination, similar to creating a thought experiment. There are a number of structural models available some like Rhodes and Alfandre (2007) model which is underpinned by a particular ethical theory, in this case, principlism, and others like Ford (2006) and Bolmsjo *et al.* (2006) models which are not aligned to a particular ethical theory. All these models have similar tenets, which include identify the issue, identify its relationship to the relevant principles, ethical theories and legal rules, and then action plan a way forward (Bolmsjo *et al.* 2006, Ford 2006, Rhodes and Alfandre 2007). The model by Ford (2006) is contextualised by mental health practice, specifically clinical psychology, however it is heavily influenced by a code of conduct approach. Whereas the approach of Bolmsjo *et al.* (2006) is less of a model and more of a case of identifying features that nurses use to ethically reason through issues within older adult care, some of these issues are mental health related such as dealing with risk and restriction of certain freedoms. Woodbridge and Fulford (2004) within a mental health context do not offer a model instead they offer a good process and one that focuses on managing an issue that is prevalent within mental health care, the restriction of certain freedoms. This process is intended to work in alongside and complement other models which are more rational-based, in essence signposting a way of managing the values-based element of mental health practice (Woodbridge and Fulford 2004).

2.4. <u>Learning lessons from the literature</u>

The literature reviewed builds an extensive picture of the historical context of mental health nursing and how this relates to the mental health nursing care currently delivered to individuals in acute mental health distress. Mental disorder is a relatively new label; however, it still carries the historical expectation that people with this label should be controlled by society. This expectation stems from both a philosophical and medical position – 'greater good' and the 'medicalisation of madness'. Furthermore, within a mental health services perspective identifying and managing risk has become an important mediating factor when deciding 'how much control to apply'. This mediating factor operates at a macro level; access to services, and at a micro level; the care delivered within the mental health nurse-service user relationship.

A key component of this care is the routine and sanctioned use of coercion. Within an acute in-patient context studies take a general view of coercion referring to it as containment. However, coercion is wider than just containing, it can take subtler forms such as pressuring and persuading, and it is not just an inpatient issue especially as acute mental distress is not fixed within a specific service. The use of coercion is viewed as a good thing if it is justified, prevents harm, leads to better treatment outcomes, and is sensitive to the needs of the service user. When using coercion, the mental health nurse has to be an effective clinical decision maker, at the same time they have to be an effective ethical reasoner. It is important to recognise that mental health nurses due to the apparent inaccessibility of ethical theory do not always acknowledge the influence that this ethical dimension has on their everyday practice. This does not mean mental health nurses are not ethical or do not acknowledge the importance of being ethical rather ethics becomes meaningful when it emanates and informs practice - pragmatic reasoning. The journey towards being a skilled ethical reasoner is also shaped by the professional expectation that the mental health nurse will be ethical – follow a code of conduct. In addition, this journey is underpinned by the mental health nurse's reflective endeavours. These endeavours accrue tacit knowledge where knowledge is acquired from experience and is then augmented through action. For learning to take place this tacit knowledge has to be applied within a problem-solving context, in other words making clinical decisions. This process, for the mental health nurse, is contextualised by both the uncertainty of mental health nursing practice and also its unique controlling element. Irrespective of these factors, the mental health nurse has to professionally make the 'right' decisions and judgements. Ethical reasoning models and processes can assist the mental health nurse in the process of making and justifying ethical decisions even if they do not reflect the fluidity of their practise.

To summarise, the literature does not to any great extent articulate from the mental health nurse's perspective the personal meaning and experience of ethically reasoning while using coercive power. To address this knowledge gap this study uses a specific phenomenological research approach. The following chapter will methodologically justify the use of this approach.

Chapter 3: Methodology

3.1. Interpretative Phenomenological Analysis (IPA)

This chapter will introduce the research method used in this study, Interpretative Phenomenological Analysis (IPA), its theoretical underpinnings, and its relationship to 'sense making', reflexivity, and validity. IPA as a research method came to prominence through the work of Jonathan Smith in the mid-1990's, it intended within psychological research to capture both the qualitative and the experiential (Smith et al. 2009, Shinebourne 2011). To achieve this intention IPA focuses on the detailed exploration of a person's lived experience (Smith and Osborn 2015).

"... *it aims to conduct this examination in a way which as far as possible enables that experience to be expressed in its own terms, rather than according to predefined category systems. This is what makes IPA phenomenological and connects it to the core ideas unifying the phenomenological philosophers....* "

(Smith et al. 2009, p.32)

Due to IPA's utility in broadly focusing on '*how people engage with the world*' it is now being used within other disciplines and fields (Dean et al. 2005, Al Omari and Wynaden 2014, Maguire et al. 2014, Albert and Simpson 2015, Smith and Osborn 2015). Irrespective of its wider use IPA maintains its psychological essence by being used primarily to explore a person's inner cognitive world (Smith et al. 2009). To ensure robustness this exploration of a person's inner world, which is an interpretative pursuit, is based on an explicit methodology that is underpinned by three theoretical considerations; phenomenology, hermeneutics, and idiography (Smith et al. 2009, Shinebourne 2011). In this pursuit the IPA researcher (Smith and Osborn 2015) is '*trying to make sense of the participant trying to make sense*' of their individual and unique (idiographic) lived experience (p.1). Once the researcher has made sense they can then move onto making more general claims (Smith and Osborn 2015).

"*IPA concurs with Heidegger that phenomenological inquiry is from the onset an interpretive process. IPA also pursues an idiographic commitment, situating participants in their particular contexts, exploring their personal perspectives, and starting with a detailed examination of each case before moving to more general claims.*"

(Smith et al. 2009, p.32)

This detailed examination is shaped by an open and exploratory approach where the participant's description of a lived experienced is analysed in fine detail and only after this is undertaken are shared themes then identified across the participant cohort (Smith et al. 2015). IPA is useful when a topic is relatively new or under-studied and issues are about identity or sense-making (Smith and Osborn 2007, Smith et al. 2009).

Taking this into consideration IPA is compatible with the intention of this study which is simply to 'grasp' what it feels like for the mental health nurse to have to ethically reason through coercive situations (Eatough and Smith 2006). In addition, IPA gives the researcher space within a real world context to acknowledge that coercive acts are not only complex acts happening in real time but they are as much based on 'tacit knowledge' as rules and policies (Welsh and Lyons 2001, Dierckx de Casterle et al. 2008, Fulford 2008). IPA not only helps in acknowledging this complexity through offering an in-depth discussion it also addresses the tacit knowledge dimension by stimulating a process of conscious reflection (Dean et al. 2005, Bolmsjo et al. 2006). A key opportunity when using IPA is that any subsequent data is 'rich' by nature, to effectively manage this richness of data at the analysis stage IPA provides the researcher with not only the tools to exploit fully the opportunity of having rich data but also the scope to explore in great detail the meaning of the participant's experience (Smith et al. 2009, Shinebourne 2011).

3.2. Theoretical underpinnings

IPA is a distinctive research method that was used first within the field of psychology before being used within other fields of practice (Shinebourne 2011). IPA was specifically developed to reconcile within psychological research the experimental with the experiential (Shinebourne 2011). Smith *et al.* (2009) describes IPA's development as a return to the pluralistic psychology of William James rather than developing a fresh new approach. On this basis IPA as a real world or pragmatic approach, using theory based on its utility, draws on ideas from three theoretical approaches; phenomenology, hermeneutics, and idiography (Smith *et al.* 2009, Shinebourne 2011, Smith 2011). In addition to these theoretical approaches Shinebourne (2011) highlights that symbolic interactionism also has an influence, 'how meanings are constructed by individuals within both their social and their personal world' (p.17). Smith *et al.* (2009) accepts that other research methodologies will utilise these theoretical approaches in a similar way, however what differentiates IPA is its focus on the psychological aspect of living in the real world. The influence of phenomenological philosophy on IPA stems from the work of three phenomenological philosophers; Husserl, Heidegger, Merleau-Ponty, and Sartre (Smith *et al.* 2009).

The phenomenological ideas of Husserl which have directly influenced the development of IPA includes Husserl's interest in the careful examination of a person's experience, and how specifically a person could 'accurately know their experiences of a given phenomenon' (Smith *et al.* 2009, p.12). Husserl (1931/2012) positions his phenomenological approach as 'a new way of looking at things (experiences in the world) with the aim of learning what stands before our eyes' (p.3). This process involves a 'person stepping outside of their everyday experiences' and instead of gazing at objects in the world gazing inwards at their perception of those objects (Smith *et al.* 2009, p.12).

Husserl (1931/2012) distinguishes between the study of 'facts and realities' and pure phenomenology as a study of 'essential being' which focuses on understanding the 'essence' of an experience; an experience stripped of its worldly dependencies (p.3). This approach known as descriptive phenomenology or second phase phenomenology is based on the view that phenomena or objects in the world should be described rather than explained (Koch 1995, Paley 1997, Yegdich 2000, Sadala and Adorno 2002, Schultz and Cobb-Stevens 2004, McConnell-Henry *et al.* 2009, Smith *et al.* 2009). The phenomenological reality of this research approach is contingent on describing the experience of knowing the phenomenon (Schultz and Cobb-Stevens 2004, Smith *et al.* 2009). This description as a research process should include a description of the phenomenon itself and the participant's perceptions of the phenomenon. (Paley 1997, Yegdich 2000, Schultz and Cobb-Stevens 2004, Smith *et al.* 2009). From a realist perspective the reality of the phenomenon is both the phenomenon presented to the participant's consciousness and the participant's experience of that phenomenon as it is presented to their consciousness (Sadala and Adorno 2002, Smith *et al.* 2009). As a layer of assumption may distort the description of this experience the process of describing the phenomenon as presented through a participant's consciousness is not adequate on its own to describe the reality of the experience (Sadala and Adorno 2002, Smith *et al.* 2009). To move through this layer of assumption to discover the essence of the phenomenon this description has to be managed through a process of phenomenological reduction in which the layers of facts and assumptions about a phenomenon are removed (Smith *et al.* 2009). This systematic examination of consciousness which includes phenomenological reduction, also known as bracketing, is a core part of the methodological approach of IPA (Smith et al. 2009). Husserl (1931/2012) builds on Descartes philosophical method of 'doubting everything' to articulating a phenomenological method of both identifying an experience and then disconnecting from that experience in a way that the world of facts is suspended. According to Husserl (1931/2012) at this stage there is no '*analytical interest in the attempt to doubt everything only what is extracted from the process of disconnecting*' (p.58).

In addition, IPA also promotes Husserl's proposal that the phenomenological researcher adopts a phenomenological attitude which is achieved through the process of phenomenological reduction (Smith et al. 2009, Shinebourne 2011). A phenomenological attitude takes place when the researcher moves away from taking every day experiences and objects for granted and attends to the perception of those experiences or phenomena (Sadala and Adorno 2002, Smith et al. 2009). To achieve this attitude the researcher has put aside this taken for granted viewpoint and bracket, allowing the researcher to focus on their 'real' perception of the world (Sadala and Adorno 2002, Smith et al. 2009). This taken for granted sense of the world does not disappear when bracketing, instead it is reduced through a series of reductions which allow the researcher person to grasp the essence of a phenomena (Sadala and Adorno 2002, Smith et al. 2009).

These series of reductions require the researcher to constantly reflect on the description of the phenomenon, through their reflections they identify and then put aside their assumptions and distractions, and then the process starts again (Smith et al. 2009). This approach is important due to the data rich nature of these types of descriptions and at times it can be difficult to distinguish between the participants experiences and the researcher's assumptions (Paley 1997, Schultz and Cobb-Stevens 2004, Smith et al. 2009). By bracketing and also being committed to adopt a phenomenological attitude the researcher will suspend any prior assumptions (Smith et al. 2009, Shinebourne 2011). The outcome being that the researcher only sees the phenomenon and in doing so can strip away any prior assumptions (Smith et al. 2009, Shinebourne 2011). IPA specifically utilises bracketing as a way of '*systematically and attentively reflecting on everyday lived experience*' (Smith et al. 2009) (pp.33). Utilising the work of Husserl in this way provides IPA with a theoretical framework in which processes like bracketing are undertaken in a logical manner (Smith et al. 2009, Shinebourne 2011). In addition, this framework affords the researcher with the opportunity to explore in depth the way the participant makes sense of a given phenomenon (Smith et al. 2009, Shinebourne 2011). This detailed investigation of a participant's experience is not an exercise in explaining the experience, it is not generalizable, rather the value of experience is inherent within its description (Smith et al. 2009, Shinebourne 2011). Taking this neither inductive nor deductive position gives the researcher the conceptual space to value the subjective meaning of shared and common experiences (Jones 2001, Smith et al. 2009, Shinebourne 2011).

IPA is also influenced by the work of Heidegger especially the notion that inquiry is an interpretative process (Shinebourne 2011). Smith *et al.* (2009) highlights that IPA takes from Heidegger the idea that people are '*thrown into the world of objects, relationships, and language*' (p.18). Heidegger's world is perspectival, temporal and is in relation to something (Smith *et al.* 2009). To interpret meaning or the meaning making activities of people a specific method is utilised through the interpretation of the phenomenological description; this method is embedded within the notion of the hermeneutic. Using this hermeneutic method is to seek meaning while at the same time acknowledging that the things within a description always present themselves in a manner which is at the same time self-concealing (Smith *et al.* 2009, Shinebourne 2011). Heidegger's understands the term phenomenon as something that 'shows itself' when brought to the fore or the 'light of the day' (Heidegger 1927/2010, Shinebourne 2011). On this basis the focus of Heidegger's phenomenology is to explore phenomenon in way that it 'shows itself from itself (Heidegger 1927/2010). Heidegger's phenomenology has a different focus than Husserl's approach in that it is more concerned with the hermeneutic and existential than the transcendental (Smith *et al.* 2009). For Husserl revealing the truth (transcendental) which is concerned with the individual and their psychological processes is a goal, whereas Heidegger is not searching for a truth rather Heidegger's approach is to make interpretative sense (existential) of the individual's existence within the world and how this existence is made meaningful (Smith *et al.* 2009).

This interpretative process according to Shinebourne (2011) concentrates on 'dis-closing, un-covering, discovering, revealing, what is hidden' (p.19). Heidegger (1927/2010) contextualises this process in the following way;

"*Although "appearing" is never a self-showing in the sense of phenomenon, appearing is possible only on the basis of a self-showing of something. But this, the self-showing that makes appearing possible, is not appearing itself. Appearing is an announcing of itself through something that shows itself. If we then say that with the word "appearance" we are pointing to something in which something appears without itself being an appearance, then the concept of phenomenon is not thereby delimited but presupposed.*"

(Heidegger 1927/2010, p.28)

This process of revealing what is hidden is not an exercise in describing the hidden as separate to the world rather it is a case of describing the hidden as embedded with all its relatedness to the world (Smith *et al.* 2009, Shinebourne 2011). Acknowledging this notion of relatedness requires the researcher to have practical engagement with the world while also being able to self-reflect and also to be self-aware, this includes recognising that being in the world is finite (Smith *et al.* 2009). In addition, the researcher to interpret this being in the world has to base their interpretation on a discourse between the researcher and the participant (Shinebourne 2011). This discourse utilises good communication, a good understanding of the shared language between the researcher and the participant, and to be interpretative the researcher has to frame their reasons and judgements within a Heideggerian perspective (Smith *et al.* 2009, Shinebourne 2011). Smith *et al.* (2009) highlights that during this discourse the appearance of the phenomenon is perceptual and as the discourse progresses to an interpretative level the discourse becomes more analytical. As an example the researcher during the discourse facilitates the phenomenon to appear, to make sense of this appearance the researcher engages in further discourse that analyses the meanings of this phenomenon and its relatedness to the world (Smith *et al.* 2009).

It is important to recognise that this discourse is more than language and communication it is about understanding 'meaning within language' something that is discovered through an interpretative method (Smith *et al.* 2009, Shinebourne 2011). Making sense of meaning in language through a Heideggerian discourse is to accept that both participant and researcher are both in this world and both immersed in being in the world (Shinebourne 2011). By being immersed in the world this method of interpretation can never be 'presuppositionless' (Heidegger 1927/2010, Shinebourne 2011). The researcher will always bring their fore-conceptions in this interpretative method, including their prior experiences, thoughts and feelings, and assumptions and pre-conceptions (Smith *et al.* 2009, Shinebourne 2011).

The impact of this Heideggerian method on IPA is the acceptance that phenomenology is an interpretive pursuit and one that builds on Husserl's ideas of carefully examining a phenomenon or experience (Smith *et al.* 2009). This pursuit is also shaped by the notion of the researcher bringing fore-conceptions to the research discourse that can be partially understood during the process of bracketing if according to Smith *et al.* (2009) 'bracketing is cyclical and dynamic' (p.25). Partial understanding it could be argued is full understanding within an embedded world, and within this world to understand fore-conceptions bracketing has to be a constant activity (Smith *et al.* 2009).

The work of Merleau-Ponty influences IPA through the notion that that individuals are described as seeing themselves as separate from the world rather than being in the world, they feel as if they are looking at the world (Merleau-Ponty 1945/1962, Smith *et al.* 2009). By looking into the world an individual's body does not feel part of the world; it is a means to communicate with the world (Merleau-Ponty 1945/1962, Smith *et al.* 2009). For example as I type I am touching a keyboard, I am in effect engaging with the world through the act of touching (Merleau-Ponty 1945/1962, Smith *et al.* 2009). In relation to experiencing other individuals they feel like separate entities who engage with the world, an individual's world, by bringing different perspectives of their world, which cannot be entirely shared with others, only certain aspects can be communicated through the body (Merleau-Ponty 1945/1962, Smith *et al.* 2009). The importance of this notion within IPA is the need for the researcher to recognise the sensations of being a body in the world has a crucial role to play in understanding the experiences of others, however they also have to recognise that that they cannot fully understand another body's (participant's) perspective (Merleau-Ponty 1945/1962, Smith *et al.* 2009).

Building on this view of being a body within the world IPA utilises the work of Sartre to empathise that individuals are constantly engaged in activities within the world which are as highlighted in Smith *et al.* (2009) 'action orientated and meaning-making, and self-conscious' (p. 19). As these activities are action orientated there is a focus on being concerned by what will be rather than what is, this means that individuals do not just engage with objects or things that are in the world they also engage with objects that they think that should be in the world (Sartre 1943/2003, Smith *et al.* 2009). For example, I am currently typing while being aware that I have a meeting in one hour, I am thinking about what I am typing (object in the world) at the same time I am thinking about the agenda and what may happen at this meeting (objects that should be in the world) (Sartre 1943/2003). In addition, I am already anticipating my responses to what people at the meeting may say, however if none of the people turn up to the meeting there is no meeting and yet I have still engaged with the nothingness of the meeting as an object in the world (Sartre 1943/2003, Smith *et al.* 2009).

Engaging with nothingness has a temporal aspect;

"… we can say that the static temporal can be considered separately as a certain formal structure of temporality – what Kant calls the order of time – and that the dynamic corresponds to the material flow or – using Kantian terminology – to the course of time."

(Sartre 1943/2003, p.153)

On this basis the IPA researcher has to acknowledge that individuals in the world actively engage through personal and social relationships with the objects in the world and objects that are temporally in the world (Smith *et al.* 2009). For example, my response to the proposed meeting is to consider future objects, how I feel while I am typing is in the present, which is soon to be the past; past, present, and future being the order of time (Sartre 1943/2003). My feelings about the meeting possibly of anxiety-provoking are situated in the present and soon to be past, they also shape my future responses; the dynamic course of time (Sartre 1943/2003).

In summary phenomenological theory influences IPA according to Smith *et al.* (2009) through Husserl's work providing IPA with a robust background and a focus on the role of experience and perception. Whereas, Heidegger, Merleau-Pony, and Satre provide a sense of the individual in the world; their embeddedness and how they relate to a world of objects (Smith *et al.* 2009).

In addition to IPA being influenced by the phenomenological ideas of Husserl, Heidegger, Merleau-Pony, and Sartre, it has also been influenced from a hermeneutic perspective (J.A Smith et al., 2009). In IPA hermeneutics and phenomenology comes together through the work of Heidegger, however others have also been influential such as Schleiermacher and Gadamer (Smith *et al.* 2009). At this juncture it is also important to note from a mental health nursing perspective that hermeneutic phenomenology has also been widely utilised in nursing research since the early 1990's (Annells 1996, Fleming *et al.* 2003, Chang and Horrocks 2008, Austgard 2012, Abalos *et al.* 2016). Hermeneutics arose as a robust method to interpret religious text; it is now used widely to interpret nonreligious texts (Guest *et al.* 2012). The focus of hermeneutics in its narrow sense, religious texts, was to uncover the original meaning or reality inherent within the text (Smith *et al.* 2009, Guest *et al.* 2012). As this method became more widely used it also embraces the interpretation of experiences that are communicated verbally and then transcribed (Annells 1996, Smith *et al.* 2009, Austgard 2012). This wider approach encompasses trying to understand an individual's world, their being in the world, and the way meaning of their world which is communicated through different forms of communication including language (Gadamer 1976, Annells 1996, Austgard 2012).

Using hermeneutics in this way brings an interpretative understanding to a particular matter, the interpretation forms a central part of this understanding including the impact the narrative has upon the interpreter (Gadamer 1976, Austgard 2012, Guest *et al.* 2012). This interpretative process of trying to understand an individual's meaning of an experience or phenomena effectively brings hermeneutics and phenomenology together (Gadamer 1976, Annells 1996, Fleming *et al.* 2003, Smith 2007, Debesay *et al.* 2008, Austgard 2012).

The work of Schleiermacher has influenced IPA in emphasising the need to careful pay attention to the precise meaning of an individual's experience while at the same time acknowledging the individual nature of this experience (Smith *et al.* 2009). As an example, text or language will follow certain rules and will have a general meaning, however the use of language by the speaker will not only convey a general meaning it will also convey a unique meaning, one that it is embedded within the speaker's experiences (Smith *et al.* 2009). There are no specific rules on how to use Schleiermacher's approach within IPA, Smith *et al.* (2009) views its use as an art form rather than a scientific pursuit, with the potential of the researcher truly knowing the participant's experience. The value of this approach for IPA according to Smith *et al.* (2009) is that it anchors the process of the analysed experience back to the individual's unique meaning even when themed to a larger data set and connected to the relevant research literature.

Gadamer's work builds on the work of Heidegger and like Heidegger emphasises the ontological viewpoint of radical relativism, this viewpoint is based on the idea that reality is a multiple construct, with its form and content being dependent on the individual (Heidegger 1927/2010, Gadamer 1976, Annells 1996, Smith *et al.* 2009). Heidegger as a reaction to Husserl's ideas moved away from the notion of knowing an individual's experience to focusing on understanding an individual's relationship with this experience (Heidegger 1927/2010) (Fleming *et al.* 2003). In addition, Heidegger's phenomenological approach is also hermeneutic, when the researcher facilitates the phenomenon to appear the process of examining and analysing the phenomenon is where the interpretative or hermeneutic part of the process begins (Smith *et al.* 2009). Gadamer's work within a Heideggerian perspective specifically focused on the relationship between the interpreter and the interpreted (Gadamer 1976, Fleming *et al.* 2003, Smith *et al.* 2009, Austgard 2012). Gadamer's interest in this relationship was not to develop a set of rules or a prescribed way of working instead it was to highlight the importance of the researcher being self-aware (Gadamer 1976, Fleming *et al.* 2003, Smith *et al.* 2009, Austgard 2012). This notion of researcher self-awareness necessitates the researcher to be aware of the assumptions and knowledge they already possess or being aware of their fore-understanding (Gadamer 1976, Fleming *et al.* 2003, Smith *et al.* 2009, Austgard 2012). Fore-understanding is knowledge that is historical in nature and has been accrued and processed, when the researcher is trying to understand a phenomenon they bring this type of knowledge to bear (Fleming *et al.* 2003, Smith *et al.* 2009, Shinebourne 2011).

As an example the researcher in this study is an experienced mental health nurse who will fore-understand using coercion within an acute mental health context. It is important to recognise the relationship between a researcher's fore-understanding and the researcher making sense of a new phenomenon is dialogical, if this dialogical relationship is not managed carefully the voice of the researcher's fore-understanding can inhabit the voice of the phenomenon (Smith *et al.* 2009). The potential impact being the researcher relying on fore-understanding can pre-understand the phenomenon and jump to conclusions about the phenomenon without having real understanding due to not allowing the true voice of the phenomenon to come through (Gadamer 1976, Fleming *et al.* 2003). Gadamer's intention is not to influence the researcher in way that they become pre-occupied with the elimination of fore-understanding and pre-understanding when encountering a new phenomenon rather Gadamer's intention is to engender an awareness of the potential impact of this type of knowledge (Gadamer 1976, Fleming *et al.* 2003, Smith *et al.* 2009, Austgard 2012).

A central part of the hermeneutic method is the hermeneutic circle and within IPA the hermeneutic circle is viewed by Smith *et al.* (2009) as a 'useful way to understand method' (p. 28). According to Smith *et al.* (2009) the hermeneutic circle is based on and has been continually developed by a number of hermeneutic philosophers such as Heidegger, Gadamer, and Schleiermacher. In essence the hermeneutic circle is interested in the whole of an experience which includes its relationship to its constitute parts (Smith *et al.* 2009). To understand the whole of the experience, the researcher has to understand the constituent parts of the experience, and to understand the 'parts' the researcher has to understand the 'whole', this circular process should also be dynamic and analytical (Smith *et al.* 2009). Smith *et al.* (2009, p.28) provides the following modified example of how the part and the whole dynamically interact;

The part	The Whole
A word	The sentence the word is in
An extract	The complete transcript
The interview	The research project
The specific experience	The complete life story

The meaning of the word as a 'part' will only become understandably clear to the researcher as they move through the hermeneutic circle to the 'specific experience' and back again (Smith *et al.* 2009). When using the hermeneutic circle, the researcher has to be careful not to think of it as a linear step-by-step process, instead it is iterative where the researcher will move backwards and forwards across the data as they generate a sense of understanding and meaning (Smith *et al.* 2009). Another major influence within IPA is idiography, Smith *et al.* (2009) describes idiography as 'being concerned with the particular' (p.29). This is different from a nomothetic approach where research findings are generalised to a wider and given population (Smith *et al.* 2009, Shinebourne 2011).

As there is a commitment to what Smith *et al.* (2009) calls the particular meaning the analysis stage of the research pays careful attention to detail, ensuring the analysis is 'detailed, thorough and systematic' (p. 29). Using this approach even with small sample groups produces large amounts of rich data, on this basis IPA sample groups tend to be small with a focus on purposeful selection (Smith *et al.* 2009). Typically, even a single case study is highly detailed with a careful in-depth exploration of the individual's lived experience (Smith *et al.* 2009). Where the research sample involves more than one individual each case is still explored at this highly detailed level and only after this phase has been completed will the researcher start the process of discovering and identifying themes across the sample group, these group themes are then re-considered within an individual participant context (Smith *et al.* 2009, Smith 2011). Always considering the individual perspective embeds IPA within both the idiographic and hermeneutic with an outcome of providing a detailed analysis of an individual's lived experience (Shinebourne 2011). In addition, Smith *et al.* (2009) highlights that IPA's focus on the idiographic is attuned with Heidegger's view that an individual's experiences are of their world and relational to that world; unique to the individual. This idiographic approach is the cornerstone of IPA, however the researcher has the latitude to link these findings to the relevant research literature where 'shared commonality' is identified within that literature (Shinebourne 2011, p.23).

To ensure the idiographic is not lost when sharing the findings of a study the researcher is encouraged to capture the unique perspective of the individual by providing an interpretative commentary, supported by the literature, that is 'interwoven with participant extracts' (Shinebourne 2011, p.24). To initially examine and explore an individual's lived experience the researcher will use research questions that facilitate this process, generally these questions (Smith *et al.* 2009) will be take the form of a series of open questions, for example;

  ➢ What is the meaning of depression to individuals who have the condition?
  ➢ What is it like to experience mental distress?
  ➢ How does a nurse make sense of looking after a service user?

When working with a group of participants it is important that the participants have a particular 'common' lived experience, the participants remember the experience, and it has value within their everyday life (Smith *et al.* 2009). This lived experience may feel like a whole, however Smith *et al.* (2009) highlights this whole is composed of units of experience, when connected they construct an experience which has value to the individual. As an example Smith *et al.* (2009) uses the analogy of pebbles on the beach, to explore this idea of a unit of experience in the real world I will use my activity within the here and now as an illustrative example. As I type, I am aware of my fingers on the keys of the keyboard and how difficult I find this activity. I start to realise that my typing is engendering feelings of frustration, my brain feels as if it is working quicker than my fingers, I know what I want to say, however it is taking time to convey my thoughts into typed words.

This is a unit of experience; how does this unit have significance in my life as a valued experience? As I take a break from typing I realise this frustration relates to my childhood memories of school. From the age of 11 until I left school I disliked school especially the activity of writing. My handwriting was viewed by my English teacher as poor and I would be constantly reminded that this was the case. These experiences have had a significant impact, I avoided writing until computers were in more common usage. As frustrating as using a keyboard can be, I find using a pen more frustrating. Moving through these units of experience; using a keyboard, writing, my relationship with my school days; they become connected and interconnected through the meaning they have to me, and then as a whole they become a lived experience of value or significance (Smith *et al.* 2009). The role of IPA provides a method that supports the researcher to meaningful engage with the participant in way that facilitates the participant to reflect on their experience, or in the words of Smith *et al.* (2009); '*to reflect on the significance of their experience*' (p.3). At the same time the researcher is endeavouring to make sense of this significance (Smith *et al.* 2009, Shinebourne 2011).

3.3. <u>Sense making</u>

Making sense of a participant's experiences is based on the interview as an engagement process, it is also based on a detailed examination of the production of 'thick interpretative accounts by a small number of participants rather than a thinner report of a larger sample group' (Hunt and Smith 2004, p.1001). In addition, IPA's systematic approach to this interpretative process affords the researcher the opportunity to both examine each individual case on its own and then make general claims supported by detailed extracts from the individual participants accounts (Dean *et al.* 2005, Eatough and Smith 2006, Osborn and Smith 2006, Smith and Osborn 2007). It is important to note this process IPA is tempered by 'how the participants make sense of their own experiences, a form of 'insider research that connects the researcher with this intimate knowledge' (Davies *et al.* 2010, p.142). IPA in essence views the participant 'as an experiencing, meaning making, embodied and discursive agent', on this basis IPA is concerned with 'unravelling the relationship between what the participants think, say and do' (Eatough and Smith 2006, p.485). Eatough and Smith (2006, p.485) highlight that within this approach, 'cognitions are not isolated separate functions but an aspect of being-in-the-world', therefore cognition is not detached reflection but in fact part of our basic attitude to the world'. By using this approach within this study the researcher has the opportunity 'fore-ground' the participant's (mental health nurse's) subjective experiences, to understand how the participant interprets those experiences, and finally to explore and understand how the participant 'constructs' meanings in relation to their interpretation of their experience (Smith and Osborn 2007, p.520). As this study focuses on exploring the mental health nurse's ethical meaning/experience of using sanctioned acts of coercion it is important that the participants have the relevant lived experience and it has value and meaning as a lived experience; a purposive sample (Smith *et al.* 2009, Shinebourne 2011, McQueen and Turner 2012, Maguire *et al.* 2014, Fox and Diab 2015, Smith *et al.* 2015).

Exploring and making sense of others lived experiences is the central methodological focus of this study, however as part of a critical approach to research other methodological approaches were considered (Langdridge 2007, Willis 2007, Flick 2011). Lived experiences do not happen in a vacuum, a research approach has to be flexible enough to acknowledge that these experiences are influenced by a wide a range of contextual and complex factors, these include changes to a person's job role, whether they feel valued to name a few (Willis 2007, Smith et al. 2009). Taking this real world influence into account will ultimately assist the researcher to better understand the participant's meaning of their experience, an experience that is embedded with the world the participant inhabits (Langdridge 2007, Willis 2007, Smith et al. 2009, Shinebourne 2011). In the process of understanding the participant's meaning of their experience the researcher needs to use a human dimension to uncover this meaning by using self in an interpersonal and dynamic way (Tomkins and Eatough 2013b, Tomkins and Eatough 2013a, Parahoo 2014). The underlying assumption of this world view is that meaning is located at a human level, naturalistic paradigm, rather than as an absolute truth, therefore reality is seen as being constructed by the individual (Krauss 2005, Parahoo 2014). Whereas the positivist paradigm or the traditional scientific world view sees reality in terms of an objective reality that can be discovered and verified and is not a construct of the individual (Krauss 2005, Parahoo 2014).

Working within the naturalistic paradigm requires the researcher to not search for a truth or reality rather to focus on understanding the participant's experience and the value and meaning the participant places upon that experience (Krauss 2005, Parahoo 2014). The challenge for the researcher who is not used to this way of working is to let go of the objective and in turn free themselves to explore the participant's experiences in a richer and more in-depth way (Langdridge 2007, Willis 2007). Part of letting go is to accept that reality may not exist independently of human behaviour and that knowledge is not necessarily objective and value free (Krauss 2005). There is also a commitment to accept that this type of approach is data rich even though the sample group may be relatively small, and the interpretative phase is a reflexive journey rather than a statistical exercise (Krauss 2005, Willis 2007, Tomkins and Eatough 2013b, Tomkins and Eatough 2013a). While designing the study it was generally accepted that a naturalistic methodology would be used, however a 'mixed methods' approach was considered, this is where approaches from both the naturalistic and positivist paradigms are used (Krauss 2005, Flick 2011).

This process of exploring other methods and approaches was contextualised by how will the chosen approach best suit the study's aim of understanding the participant's experiences from their perspective (Flick 2011, le May and Holmes 2012). It was recognised at this stage that a survey could have been combined with face-to-face interviews, the survey would cover a larger sample group and the interviews would explore identified issues in more depth (Flick 2011).

The weakness of this 'mixed methods' approach is it would reduce the data-richness and it would not fully fulfil the aim of the study to understand the participant's own unique perspective (Willis 2007, Flick 2011). Flick (2011) highlights that a mixed methods approach should only be chosen if it enhances the study rather than limits the study's aims and scope.

Obviously there are many naturalistic research approaches which include phenomenology, ethnography and grounded theory as naturalistic methods of enquiry (Willis 2007, Flick 2011). Taking either an ethnographic approach or a grounded theory approach implies the researcher would be concerned about the social context of the participant's experiences, in contrast by taking a phenomenological approach the researcher is primarily interested in the participant's own interpretation of that experience which may or may not include an interpretation of their social context (Willis 2007, Flick 2011). When weighing up which approach to use the researcher has a choice of whether to focus solely on the participant's interpretation of their experience or to also focus on the social context of the participant's experience (Willis 2007, Flick 2011). IPA's strengths come to the fore when the researcher is interested in the 'personal meaning and sense making of an individual's experience', this experience can be shared by others (Smith et al. 2009, p.45). IPA's effectiveness is limited outside of these parameters. When making this choice the researcher's own values play a part (Krauss 2005, Tomkins and Eatough 2013b, Tomkins and Eatough 2013a). As I hold the philosophical belief that the individual's experience is more than the participant's social situation and that this experience is a lived experience embedded within the individual then I leant towards using a naturalistic approach which is phenomenological in nature (Krauss 2005, Willis 2007, Tomkins and Eatough 2013b, Tomkins and Eatough 2013a). I also believed this approach gives me the opportunity to set aside the meaning of the participant's experience as a social construct through the process of bracketing allowing me to understand the participant's experience, their meaning, from a fresh perspective (Heidegger 1927/2010, Husserl 1931/2012, Willis 2007).

In addition, IPA as a phenomenological approach gave me as the researcher the opportunity to explore in great detail a relatively overlooked area of mental health nursing practice. It is acknowledged that the issues of coercion and ethical practice within mental health practice has been thoroughly explored, however, there is little work on the moral decision-making process of mental health nurses using coercive strategies within an 'acute' context (Hem et al. 2016). Taking this into consideration this study aims through the use of IPA as a research methodology to address this knowledge gap by focusing on exploring the mental health nurse's ethical meaning/experience of using sanctioned acts of coercion (Smith and Osborn 2007, Smith et al. 2009). These experiences and subsequent meanings are then be linked to the relevant literature including literature exploring coercion and ethical practice within a mental health context (O'Brien and Golding 2003, Department of Mental Health & Learning Disability 2006, Liegeois and Eneman 2008, Anderson 2011, Duxbury 2015, Hem et al. 2016).

When exploring how individual's reason, in this case ethically reason, which is both an emotional and a cognitive act, IPA as a psychological approach has added value (Cohen 2004, Smith *et al.* 2009). IPA broadly focuses on how people engage with the world and of course it is now being used outside the field of psychology, however as a research method it maintains its psychological essence by being used primarily to explore a person's cognitive inner world which fits well with the notion of reasoning (Smith *et al.* 2009). IPA also acknowledges this exploration of a person's inner world, both cognitive and emotional, has an interpretative element and on this basis provides an explicit interpretative methodology (Smith *et al.* 2009). This methodology will assists me, the researcher, to simply to 'grasp' (Eatough and Smith 2006, p.485) or to understand from the participant's perspective what it is like (cognitively) for a mental health nurse within an acute context to have to ethically reason through coercive situations (Smith *et al.* 2009). IPA also acknowledges the context of the phenomena, which in this case has to acknowledge that coercive acts within mental health nursing are not only complex acts happening in real time but they are as much based on 'tacit knowledge' as rules and policies (Mckie and Swinton 2000, Welsh and Lyons 2001, Cohen 2004, Smith *et al.* 2009, Hem *et al.* 2016).

3.4. Reflexivity and Validity

To be a reflexive researcher it is essential when using a qualitative approach such as IPA the researcher recognises they are not detached from the production of knowledge as in this approach they are a co-producer of knowledge (Langdridge 2007). Langdridge (2007) defines reflexivity as; *"… the process in which researchers are conscious of and reflective about the ways in which their questions, methods and very own subject position might impact on the psychological knowledge produced in a research study"* (Langdridge 2007, pp.58-59). Based on the work of (Langdridge 2007, p.59) I, as the researcher, have used the following prompts to engender my reflexivity:

➢ *Why am I carrying out the study?* As a mental health nurse with a vested interest, I am interested in how mental health nurses reason and work through what can be quite difficult situations. How do they make sense of these situations? I am not sure as the literature is vague and there are only a few studies related to this area within a UK context.

➢ *What do I hope to achieve?* A better understanding of the ethical dimension of mental health nursing practice, what works and what does not work, what can be learnt.

➢ *What is my relationship to the topic being investigated?* I am an 'insider', a mental health nurse and someone who has worked for many years with mental health service users who have been in acute mental distress. I can also clearly identify and emphasise with the participants' experiences

➢ *Who am I?* I am a middle-aged white male from a working class background. My main influence upon the topic I am studying is having a need to make a difference, to improve the care mental health services user and learn lessons that can improve care in the future.

➢ *How do I feel about the study?* There is an external pressure to complete the study and obtain a doctorate. I feel more pressured by wanting to do a good job and accurately reflect my findings

➢ *How will my subject position influence the analysis?* I am interested in how nurses ethically reason. My assumption is that they do this in a structured way or they should if they do not

➢ *How might the outside world influence the presentation of my findings?* As this is an understudied area there is little influence at the moment

➢ *How might the findings impact upon the participants?* The findings do not appear to be harmful, however I am aware that disclosing and talking about stressful situations needs to be handled sensitively

➢ *How might the findings impact upon me and the outside world?* The personal impact would the completion of doctorate. The external impact I hope is to learn lessons and improve future care delivery.

These prompts are not a recipe to be followed and they do not sit in isolation, they have been used throughout the research process to ensure that I spend time to reflect and then learn, which includes being internally prompted to revisit a theme or a journal article (Langdridge 2007). Reflexivity is a personal journey which is about creating a reflexive attitude and continually asking questions that challenge potential underlying preconceptions at every point of the research process (Malterud 2001, Langdridge 2007). It is important to be aware of and manage these preconceptions as; *"A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions"* (Malterud 2001, pp.483-484). The concern is that these preconceptions create a 'bias', if this happens this outcome is viewed as undesirable (Malterud 2001). Bias and preconceptions are not necessarily the same thing Malterud (2001, p.484) argues that within a qualitative research context a '*preconception only becomes a bias when the researcher fails to mention it'*. Different researchers will approach a study situation from different positions or perspectives. This might lead to the development of different, although equally valid understanding of a particular situation under study (Langdridge 2007).

Rather than viewing preconceptions as a problem to be solved the phenomenological perspective views preconceptions as adding a richness to the research process, this richness of understanding is accrued through the researcher being reflexive (Malterud 2001, Langdridge 2007). This view is particularly important in qualitative research where the researcher is an 'instrument' of the research undertaken (Shinebourne 2011). A challenge that arises in IPA during the double hermeneutic process relates to the researcher while making sense of the participants making sense of their world ensuring their own preconceptions do not unduly influence this process (Shinebourne 2011).

This issue is not so much the influence that the researcher's preconceptions have, it is more about the researcher being aware and identifying the impact of this influence (Shinebourne 2011). By systematically working through this potential issue, which includes engaging in peer review, the researcher can better account for any influences present throughout the research process (Shinebourne 2011). Smith *et al.* (2009, p.189) views this as moving through 'layers of reflection', starting with 'pre-reflective reflexivity', being barely consciously aware of an experience, to finally in the last stage of 'deliberate controlled reflection', being able to mentally replay an experience and then being able to analyse this experience in depth. On this basis the aim of the IPA researcher should be to develop a reflexive attitude where deliberate controlled reflection becomes an important part of their practice (Malterud 2001, Smith *et al.* 2009). Beyond this personalised aspect and as a potential challenge, reflexivity can also become part of an academic discourse where the researcher's views and insights are viewed as expert moving away from the participant as expert (Langdridge 2007). To disrupt this effect the researcher should write in multiple voices with a focus on capturing the voice of the participant as expert, hence the emphasis on intertwining the participants narrative with both the relevant literature and the researcher's insights (Langdridge 2007, Smith *et al.* 2009, Shinebourne 2011).

Langdridge (2007) highlights that the qualitative researcher should follow best practice when utilising a particular approach and in doing so an external judgement on the validity of the findings can be made. This external judgment should take into account that IPA does not subscribe to a specific criteria rather its focus is on working within a particular way; a process which has common features (Langdridge 2007, Smith *et al.* 2009). According to Langdridge (2007, p.111) the analysis stage would include the following common features;

1. Reading and re-reading the transcript
2. Identifying emerging themes
3. Clustering themes
4. Creating an ordered table of themes

Once each case has been examined in detail, shaped by these common features, the researcher moves onto identifying themes that are 'common' to all the transcripts (Smith *et al.* 2009). This process should be systematic, it also has to be flexible;

"Flexibility is important when moving from case to case as there will be times when it is necessary to start again and completely rework themes or abandon those that appeared relevant with one case but not others. This process is cyclical and iterative, continually returning to the data to check meaning and confirm interpretations"

(Langdridge 2007, p.111)

Using common and easily identifiable features is a specific example of working in a way that can externally be seen as being valid (Smith *et al.* 2009). Validity can also have broader features such as; context sensitivity, commitment, rigour; transparency, coherence, and impact (Yardley 2000, Shinebourne 2011). Within IPA sensitivity would include the researcher providing a robust rationale for their choice of this methodological approach and in addition demonstrating sensitivity to the nature of the participant's lived experiences throughout the research process (Shinebourne 2011). Also the researcher would need to show commitment to IPA's idiographic principles including demonstrating that the examination of the participants lived experiences is congruent to the context of the research (Shinebourne 2011).

Rigour should be demonstrated through a thorough approach to the data collection and analysis stages, both these stages should pay careful attention to detail and completeness (Shinebourne 2011). The presentation of the research has to be coherent with the description of each stage of the research, it also has to be transparent and accessible (Shinebourne 2011). In addition, there has to be a coherent sense of flow which begins with the research question, to the underpinning research methodology, onto how the data was collected, and then finishing with the method of analysis (Yardley 2000, Smith *et al.* 2009, Shinebourne 2011). To assist the researcher to maintain coherency Shinebourne (2011) signposts the researcher to a useful tip from Smith *et al.* (2009, p.41) which provides guidance for first time researchers; '*the reader is trying to make sense of the researcher making sense of the participants making sense of their experience'*. The point being made is the researcher when writing up their findings should be consistent and coherent which includes considering 'what style and what voice' (Smith *et al.* 2009, p.41). This advice fits into the notion of impactful research, is this piece of research 'interesting, is it important and is it useful', something Smith *et al.* (2009, p.183) believes IPA should 'aspire to'. Smith *et al.* (2009) also highlights that the researchers work should be auditable, preferably by an independent auditor, where all the research materials are systematically stored and kept for this purpose.

3.5. <u>From methodology to method</u>

IPA provides a robust theoretical framework one that is both systematic and flexible, which is underpinned by three theoretical approaches; phenomenology, hermeneutics, and idiography. IPA through these theoretical approaches places value on how meanings are constructed by individuals within their real world. IPA as a phenomenological approach will ensure this study robustly explores in fine detail a relatively understudied area of mental health nursing practice. In addition, ethically reasoning is in part a cognitive act; the strength of IPA is it is used primarily to explore a person's cognitive inner world, which fits well with the act of ethically reasoning. Therefore, IPA will assist me, the researcher, to understand from the participant's perspective what it is like to ethically reason when applying coercion within an acute mental health context. The following chapter will describe in detail how IPA as a research methodology was used in action.

Chapter 4: Method

4.1. <u>The choice of method</u>

This chapter building on the methodology chapter describes in detail how the chosen method, IPA, was used in this study. Making clinical decisions which are ethical are part and parcel of working as a nurse including working as a mental health nurse (Hall 2004, Roberts 2004, Cutcliffe and Links 2008, Dierckx de Casterle et al. 2008, Nursing & Midwifery Council 2015a). The professional code of conduct for nurses, an ethical framework, interestingly only mentions the term 'ethical' once and in relation to publicity, however terms with explicit links to ethical theory such as; duty, outcome, standards, values, principles, and behaviour; are mentioned throughout (Robertson et al. 2007, Robertson et al. 2007a, Robertson and Walter 2007a, Robertson et al. 2007b, Robertson and Walter 2007b, Robertson and Walter 2007c, Nursing & Midwifery Council 2015a). The code is used as a professional covenant (Coady 2009) with the expectation that the nurse will always act in accordance with the code. The challenge for the nurse is ensuring they apply the code to their practice while at the same time acknowledging that the code does not provide a comprehensive set of rules that can solve every situation or indeed be used in every situation (Nursing & Midwifery Council Professional Advisory Service 2008). The code in essence is a framework of rules and ways of working which the nurse has to interpret and make sense of within a particular clinical context. The nurse also has to be aware that if they get their interpretation wrong they risk censure. In other words, they have to justify their actions in accordance with the code. Being able to interpret not just the code but also being able to rationally justify a decision and a corresponding action is dependent on possessing effective ethical reasoning skills (Smith 2016).

Ethical reasoning does not happen in a vacuum, we tend to think it is an entirely rational process, however such factors as the emotional context of the situation and having the time to make a considered decision have a substantial impact (Dierckx de Casterle et al. 2008, Bortolotti 2015). These practical considerations imply that for the nurse to be an effective ethical reasoner they have to be both a top-down ethical reasoner and a bottom-up ethical reasoner; follow the rules while at the same time factoring in the practical nature of their decisions (Cohen 2004). These practical considerations also have to be situated within the practice of mental health nursing which includes recognising; mental health nursing has a state sanctioned coercive element, the very nature of classifying mental health distress is value-laden, and nursing individuals who are in acute mental health distress is a complex and emotionally difficult endeavour (Fulford 2008, Currid 2009, Duxbury 2015, The King's Fund 2015). In addition, the topic of ethical reasoning within a mental health nursing context is under-studied, the effect being there is very little guidance for mental health nurses who aspire to be effective ethical reasoners (O'Brien and Golding 2003, Roberts 2004). These factors have shaped the choice of the methodological approach; the topic area being under-researched and the complex nature of the topic area (Smith et al. 2009).

4.2. <u>From methodology to research questions</u>

Reasoning in all intents and purposes is an inner world experience, something which is difficult to determine externally without asking the person (Cohen 2004, Smith *et al.* 2009). On this basis the chosen approach has to involve a guided conversation and one that assists the researcher to explore the participant's inner world (Smith *et al.* 2009). It is accepted this inner world is idiographic, unique to the person, the researcher's role is to explore and interpret this inner world by following a clear and robust interpretative methodology (Smith *et al.* 2009). IPA meets these requirements and in a way that through the interview process the researcher can make sense of the relationship between what participants think, say and then do, this connects the researcher with the participant's internal world in action (Eatough and Smith 2006, Davies *et al.* 2010).

The aim and the corresponding sub-aims or objectives are congruent with using an IPA approach to explore the topic area especially with the focus on understanding the participants experiences and their understanding of those experiences (see chapter 1, sections 4 and 5) (Smith *et al.* 2009). With the primary research aim focusing on making sense of these experiences this led to the following primary research question; 'how do mental health nurses who within their practice have used sanctioned coercion make ethical sense of their decisions and actions?' Even though the question is open it was arrived at by thinking about the kinds of areas that needed to be explored through the interview process (Smith *et al.* 2009). This included questions such as; could you tell me about your experience of using coercion; how did you feel at the time; how did you make ethical sense of this experience? In reality these questions are only a guide, a framework to promote homogeneity throughout the in interview stage (Smith *et al.* 2009). In practice the interview process consisted of open and occasional probing questions (Smith *et al.* 2009) these focused on the following common areas:

- ➢ Experiences
- ➢ Relationships - treatment
- ➢ Acuteness
- ➢ Wards
- ➢ Coercion - persuade, pressure, control
- ➢ Choice
- ➢ Treated
- ➢ Ethics, morals, unethical, duty, rules, good, bad, right, wrong, rights
- ➢ Risk – locked doors, protect
- ➢ Team
- ➢ Reason

These areas in the first instance were framed by the research aims and question, however as the interview process was an open process the participants could and would focus on areas they wished to explore in more detail with minimal prompting by the researcher (see appendix 5) (Smith *et al.* 2009). Some of the participants required minimal prompting to enter into a discussion whereas others required more prompting. Knowing when to prompt was in part dependent on my skill as a mental health nurse and also having undertaken relevant researcher training, this skill included knowing when to prompt and knowing when to be silent (Smith 2014, Lofland et al.2006). To ensure I was not totally reliant on these skills I would offer the participants the opportunity to give practice examples when they had made a point. This approach engendered a fuller discussion in each of the interviews (Smith et al. 2009).

4.3. <u>Method in action</u>

The ontology of this research approach focuses on describing the mental health nurse's ethical experiences of using sanctioned coercion (Smith and Osborn 2007, Rooney 2009). During this process the participants were offered an opportunity to provide a 'rich and detailed account' of these experiences (Smith *et al.* 2009, p.56). The role of the researcher during this process was to undertake a detailed investigation of the participant's experiences' by entering into 'dialogue where questions are modified depending on the participant's responses' (Smith *et al.* 2009, p.57). In practical terms this dialogue took the form of individual audio-taped semi-structured interviews, the advantage of using individual interviews especially within phenomenological research is they can provide a rich source of descriptive data (Langdridge 2007). These interviews focused on facilitating participants to talk in detail about their experiences and where required minimal prompts were used in the first instance to help the participants focus 'their attention on a specific situation or event' (Smith and Osborn 2007, p.521). These prompts were also used to enable the flow of the dialogue and to assist the researcher in clarifying the participants' perceptions and their feelings (Davies *et al.* 2010).

An initial concern at the start of the interview process related to the participants knowing I was a mental health nurse, an insider researcher, and would this have a negative impact upon the interview process. On reflection this was not the case, I made sure that my role was to facilitate the discussion rather than have a professional-to-professional discussion (Lofland et al. 2006). A couple of ways I 'reduced my impact' was to used my prompt list as a way of reminding me to bracket, I also encouraged the participants to provide examples when talking about their experiences which gave the discussion a more participant-centric focus (Smith et al. 2009). The schedule for the interviews was shaped by the need to 'facilitate a comfortable interaction' this devised schedule aimed to minimise both the researcher's and the participants anxiety (Smith et al. 2009, p.59). The interviews primarily started with an opening question, one that allowed the participant to '*recount a full descriptive account*', follow-up questions were then used, they were phrased in such a way that they did not assume an answer, taking a neutral stance where possible (Smith et al. 2009, p.59).

These interviews were around an hour in length and on occasion slightly longer, and took place where possible in a quiet setting with the aim of minimising any interruptions (Hunt and Smith 2004, Huws and Jones 2008). The setting chosen was away from the participant's places of work, it was easily accessible and I ensured we would not be disturbed throughout the interview process (Lofland et al. 2006).

As the focus of an IPA study is to provide a detailed and rich analysis of each case then sample sizes are small (Osborn and Smith 2006, Huws and Jones 2008, Davies et al. 2010). The rational for this approach to sample size is based on the premise that IPA is an idiographic mode of inquiry where sample purposiveness and analytical depth is more important than size (Smith et al. 2009). On this understanding IPA studies can be conducted on a sample sizes such as a one participant case study (Smith et al. 2009). Smith et al. (2009) articulates that; "There is no right answer to the question of the sample size" (Smith et al. 2009, p.51). Analytical depth as a mediating factor in determining sample size is characterised by a acknowledging that each case selected has to be analysed in detail and therefore the sample size is in essence governed by the level of analysis, the deeper the analysis the smaller the sample size. As a way of guiding new researchers Smith et al. (2009) and Reid et al. (2005) recommend that a sample size of three is a useful sample for a Masters level project and for a doctorate between four to ten participants. The expectation at doctorate level is that there is more time to engage in a deeper level of analysis (Smith et al. 2009). To ensure this study addressed analytical depth as a mediating factor, a sample size of six participants was chosen after supervisory input (Smith et al. 2009). Another mediating factor is the emphasis on a purposive sample and on this basis the six participants were recruited from a mental health trust with the intention they would have the required experiences (Smith and Osborn 2007, Smith et al. 2009). The inclusion criteria (Dean et al. 2005, Smith et al. 2009) was;

➢ At least six employed registered mental health nurses, three male and three female if possible
➢ Who have recent experience of managing coercive situations with service users in acute mental health distress
➢ Voluntarily agreed to participate in at least one recorded interview

An email flyer was used to recruit the participants; the email flyer provided a brief description of the study (see appendix 2). Individuals who were interested in participating in the study contacted the researcher directly were given further information (see appendix 3). The researcher selected participants who met the inclusion criteria, participants who did not meet the inclusion criteria would not have been selected (Huws and Jones 2008). However, the six respondents who responded first met the inclusion criteria, once these six participants were selected; an email was sent out to confirm the recruitment phase for the study had been completed. In addition, if the six respondents recruited had not represented an equal gender split – equal opportunity, I would have considered recruiting more participants and then selecting six participants from this larger pool of respondents.

Taking this approach may have been more difficult within a general nursing context than a mental health nursing context as historically male nurses, in terms of numbers, are better represented within mental health nursing than adult nursing (Nolan, 1993). In addition to the sample group fully meeting the inclusion criteria all the participants had at least 10 years post-qualifying experience. Four participants had worked in 'acute' hospital and community settings, two participants had only worked in 'acute' hospital settings. Through my previous and current work roles, I knew all six participants due to my attendance at various practice-focused meetings and events. Nonetheless, I had not worked directly with any of the participants so I was not aware of any details regarding the way they practised as mental health nurses. Mental health nursing can be a 'small world' and I was mindful methodologically the 'little I knew' had to be bracketed throughout (Smith et al. 2009). On reflection, I recognised that knowing the participants more than I did may have been more of a challenge especially if I knew of any ethical concerns relating to their practise. To ensure that I bracketed throughout I used a reflective diary. The use of this diary started from when I devised the study through to completing the study including the writing-up the study. The main issue teased out of my reflective musings related to knowing the participants was that I was surprised by the way they ethically reasoned. I assumed it would be would be more linear and prescriptive. This assumption arose from my academic practise rather than my clinical practise and was influenced by my use and knowledge of linear ethical reasoning models (section 6.7 – researcher's reflections).

The main ethical issue that arose from this study was the need to protect the participants involved in the study and to ensure that they were not exploited, to guarantee all the required protections were in place ethical clearance was applied for and granted (see appendix 1) (Smith and Osborn 2007). The ethics approval allowed scope to interview the participants through multiple interviews and also to include more than six participants if required. In reality methodological considerations moved the study away from multiple interviews and the need to have a bigger sample size. Once 'university' ethics approval was granted, a mental health provider organisation was contacted to gain approval to approach and recruit their staff to the study. After a process of checking the research proposal the organisations approval to access their staff was granted including the sending of a recruitment email via a designated 'gatekeeper'. The participants via this email were signposted to contact me directly. The ethics process also included thinking about such specific ethical issues as listening, providing a safe place, and consent and confidentiality (Langdridge 2007, Smith and Osborn 2007).Listening is an ethical issue where it relates to using this skill to encourage a participant to talk about their experiences especially where difficult emotions may arise. Being sensitive to any difficult emotions while interviewing is important as is providing the participants the opportunity to be skilfully de-briefed, to avoid a conflict of interest this opportunity for de-briefing was offered not by the researcher but through a local debriefing service (see appendix 3) (Langdridge 2007, Rooney 2009). Additionally, to ensure I could always focus on listening appropriately the interviews were audio recorded (Smith et al. 2009).

Taking account of this emotional context lead to the research being conducted in a safe place where not only geographically the participant would feel safe but also they would feel emotionally safe (Langdridge 2007, Lofland et al. 2006). On this basis the interviews were conducted away from the work environment. The issue of consent relates to providing the right information and obtaining informed consent at the start of the research process, requirements of the ethical approval process (see appendices 3 & 4). As an additional measure throughout the research process I kept negotiating consent with the participants by keeping them fully informed of the progress of the research project (Hunt and Smith 2004). Confidentiality was managed through the use of anonymity for both the participants and the issues they may talk about which meant giving the participant the opportunity to check that anything written cannot in anyway identify them (Smith et al. 2009). In addition, the recorded extracts of the interviews were kept securely and then destroyed after transcription (Rooney 2009). The transcription process was done manually, not unusual in IPA, and took about 9 hours per interview (Smith et al. 2009).

Moving onto analysing the interview transcripts Eatough and Smith (2006, p.485) highlight 'it is not possible to directly access the participant's experiences' therefore to give meaning to the participant's experiences the researcher has to engage in an interpretative activity in which 'the researcher is trying to make sense of the participants trying to make sense of their world'. This process of analysing and making sense involved 'two stages of interpretation, or a double hermeneutic' (Huws and Jones 2008, p.100). During this process the researcher was aware that they were attempting to make '*sense of the participants making sense of their experiences*' and in doing so their own '*thinking and understanding*' would come into play (Huws and Jones 2008, p.100). This thinking and understanding were not viewed as biases but as vital components or preconceptions, which the researcher needed to be aware of during the analysis stage (Huws and Jones 2008). To assist in this reflexive process when engaging with the participants accounts the researcher preconceptions were identified and noted (Langdridge 2007). The verbatim transcripts of the semi-structured interviews served as the raw data from which each case was analysed (Hunt and Smith 2004, Dean et al. 2005, Eatough and Smith 2006, Smith and Osborn 2007, Huws and Jones 2008, Davies et al. 2010) through the following four stage process;

1. A close interpretative reading was undertaken where initial responses to the text are annotated
2. These initial notes were then translated into emergent themes and recorded
3. The themes were then further analysed, super-ordinate themes and subordinate themes with identifying information were recorded
4. After each case had been analysed a cross-case analysis was undertaken and any resulting cross-case patterns were recorded

This record of themes and patterns were 'transformed into a narrative analytic account' which is supported by verbatim extracts from each participant (Smith and Osborn 2007, p.521).

It was recognised during this process that IPA is not a prescriptive approach but a set of flexible guidelines, these guidelines were adapted accordingly as the research process progressed; **see figure 4**, which provides an illustrative example (Eatough and Smith 2006). Once the data was analysed the literature was revisited with a more in-depth consideration, Eatough and Smith (2006) emphasise that; *"... it is only later that the emergent analysis is examined in light of the extant literature and at this stage theoretical relationships are established, as in IPA it is not the case that the analysis is driven by theoretically derived categories"* (Eatough and Smith 2006, p.485). In practice it was acknowledged by the researcher that I was aware of the literature within this area, therefore during the analysis stage this knowledge was bracketed (Smith et al. 2009). The analysis stage clearly followed the four stage process above, however it was more inductive and iterative than just following a four stage process (Smith et al. 2015). The interview transcripts were read a number of times, first as a whole and then line by line, throughout this process themes emerged and relationships between themes were noted (Smith et al. 2015); **see figures 5 & 6**. During the analysis of the transcripts my reflective diary was updated and used to assist in the process of bracketing, but also to aid learning, 'why had I focused on this issue rather than another' (see section 6.7 – researcher's reflections) (Smith et al. 2015).

In addition a transcript along with superordinate theme table was given to a member of the supervisory team as a peer reviewer to independently theme, notes were then compared and any preconceptions identified, this learning was looped back into the analysis process (Smith et al. 2009).

Five superordinate the were generated from the analysis stage;

➢ The Practitioner
➢ Values
➢ Clinical Practice
➢ Coercion
➢ Ethics

The following chapter will explore these findings and themes in more depth including paying particular attention to the researcher's reflections.

Figure 4: an illustrative example of the four stage process

Stage one - first reading

Yes it's not about what I personally want to do, it's for the greater good if you will, its in their best interests and you would always, because you are in a position where people come into to hospital and they are unwell, you have to justify that is was in their best interests. You wouldn't do anything that wasn't or wasn't deemed to be in their best interests. You know you wouldn't stop somebody from leaving if, you know, if they were informal and they wanted to go out and they had no self-harm ideas, they weren't going to harm anybody, the risks were low, if you prevented that person from leaving then it is not in their best interests. So you wouldn't do that but if they were informal and they wanted to go out and kill themselves then you would stop them because you have got to act in their best interests, you have got a duty of care as a nurse to do that. Yes, so it's for their interests.

Stage two - emergent themes

Unwell allows the mental health nurse to act. Acting has to be justified which uses the best interests argument. Cannot act without justification. Risk is a part of this process. Risk can be harm to self or others. Being informal is also a factor, this legal status may be overridden. Acting in these circumstances is a duty of care – ethical dimension.

Stage three - Individual participant themes

Themes	Page/Line	Key Words
Ethical Decisions	*2.33*	*they are unwell*
best interests	*2.42*	*duty of care*
greater good	*2.43*	*Informal*
Situational factors and risk		*risk*
Risk determines level of coercion		*best interests*
		not personal
		Justification

Stage four - Superordinate themes for the group

Themes	Page/Line
Reluctant use of power	
.... I don't like that, that's not part of the job that I enjoy....	*1.3.84*
..... we are saying we are trying to persuade a service user to do a certain thing or a course of action	*2.1.18-19*
It's a bit like a power play....	*3.1.37*
Sometimes we have to coerce people to take medication if they are detained under the act and it is prescribed such as depot medication	*4.2.38-40*
.... it's not about what I personally want to do, it's for the greater good...	
Using the word coercion seems a bit strong but yes sometimes we have to make people do things they may not want to do at that particular moment in time	*5.2.33*
	6.3.106-107

81

Figure 5: an example of themes emerging from a participant's transcript

Participant Transcript Excerpt

I don't believe, it is quite difficult, because I only know my own practice, erm, my own practice I don't think I use coercion, erm, maybe I do, or maybe it is something I will discover, I don't think I do, erm, I try to work with people. And certainly very much around giving people the choice of what they think is best, sometimes I have got to make a decision they don't like. I recently had a patient who was not compliant with the conditions of their community treatment order and I had to go out and serve notice that the patient was going back into hospital, which I didn't like doing, and he didn't like me doing it. It ended up as a police matter, and there was all that, and it leaves a bad taste in the mouth, because I don't like that, you know. I would have rather got to a situation where we could have resolved it in a better way, but it was not to be, the patient would not meet me half way, and, you know, the patient would not let me in etc. Erm, the patient didn't want any medication at the time which would have helped and has been since proved that when the patient takes it they are stable. He wouldn't meet me and leaves a bit of a bitter taste in the mouth, because I don't like that, that's not part of the job that I enjoy, I see it as a bit of a failure if someone goes into hospital.

Emerging Themes on 1st Read

Coercion is forcing a service user to do something against their will

Because the MH nurse believes it is in their best interests

A common practice

Failure

Not a nice thing

Reluctant use of power

Researcher's Comments

Coercion is forcing somebody to do something against their will and because you want them to do it

Very precise language

Core part of their practice

Coercion is a last option, choice being the first option, but it may be something that has to be done in certain circumstances

Though a core part of their practice clearly uncomfortable with coercing, pausing has increased and use of the term – 'a bad taste in the mouth'

Coercion is to be avoided, personalises its use as uncomfortable and a failure

Figure 6: an example of a superordinate themes table – individual participant

Themes	Page/Line	Key Words
Self		
Experienced but not forthcoming	1.7	Years
Coercing		
Coercion is about getting a service user someone to do something the nurse wants them to do	1.24	Paternalistic
Coercion are nursing interventions	1.29	making them better, for their own good
Mental health nurses are sanctioned to be coercive where required	2.53	responsibility
The level of coercion is determined by the service user's response	3.69	depends on the situation
Coercion is not a nice word	3.78	trick someone
Persuasion is part of coercion and a nicer word	3.79	respect
Coercion can be an implied threat rather than an actual happening	3.97	we are going
Coercion can have a positive outcome	8.261	feel safer
Restrain is a coercive option, but always the last option	10.311	try and de-escalate
Knowing when to coerce is a dilemma	10.333	Sometimes
Trying to maintain a therapeutic relationship and being empathetic reduces the need for coercion	11.355	I would always worry
Coercion is about common sense, your own beliefs	11.370	dilemmas you have
Ethical Decisions		
There are in the best interests of the service user	2.33	they are unwell
Best interests are about the greater good not the nurse's personal preference	2.42	duty of care
Situational factors can determine best interests	2.43	mental health problem
Risk determines how coercive you need to be	4.118	risk assessment
Ethical nurses protect service users and stop them coming to harm or harming others	5.170	Doing the best for somebody
Being ethical is a process, it is not always about the outcome	6.177	we couldn't have done anything else
Acting for people who are in mental distress is a duty of care	6.190	lost their autonomy

A duty of care is absolute but the person determines what that duty of care should be	6.200	ultimately to protect that person
Following rules can be a strong drive, but rationally a person can decide not to follow the rules	7.231	my duty of care to patients overrides
Ethical reasoning is part of clinical decision making	7.237	balancing risks
Clinical Decision-making Risk and how the service user responds are mediating factors	3.70	risky
Be therapeutic at all times is essential	3.90	trusted you
Controlling others is not comfortable	4.109	it's necessary
A duty of care is an obligation to act	4.123	I can't let you
Control can be an illusion, you don't always know what a person is thinking	4.130	Instinct
Teams are supportive and protective	5.156	a multidisciplinary approach
Acting and how you act is dependent on the personality of the person	5.162	cautious person
Not knowing information about a service user can affect the way deal with a situation	6.185	best of our knowledge
Decision making is based upon weighing up all the options and risk	7.235	I had known
Decisions have to be rational and they have to be justified	8.246	justifying yourself
Your own experiences are a powerful form of evidence	9.278	I know day to day that it works
Being in control and maintaining control is vital	9.298	it's not a nice side
Knowing a person can reduce the potential for violence	10.317	using your relationship
Positive risk taking is part of building therapeutic relationships	13.407	necessary to build that trust
Values Treat people how you want to be treated		
Treating people well is based on your own values and beliefs	12.378	respect for the person
Best practice is respecting the person and using your	12.380	I believe in karma
common sense and listening and being influenced by the service user's experience	12.393	remember me in a good way

Chapter 5: Findings

5.1. The superordinate themes

This chapter will present in detail the findings of the study. Smith et al. (2009) provides guidelines to support the writing-up of the analysis stage, however Smith highlights that;

"*Just with every other stage of IPA there is not a single right way to up an IPA analysis. Writing is a creative process, and authors, just like participants, have voices which will come out in the constructing of the account.*"

(Smith et al. 2009, p.108)

This creative process may include writing the analysis first and after writing up the analysis completing the other chapters of the study, and after writing these chapters returning to reconsider the analysis section (Smith et al. 2009). To makes sense of what could be potentially a never ending process Smith et al. (2009) does offer the following advice; "*And wherever one starts, good writing almost always involves drafting and redrafting – one's analysis and argument will deepen and become clearer as one works*" (Smith et al. 2009, p.108). Taking this advice into consideration the writing up of this study started first with the analysis stage and then the other chapters were drafted which included re-visiting the literature in more depth (Smith et al. 2009). In addition, Smith et al. (2009) recommends that the researcher not experienced in using IPA split the findings and discussion into separate chapters, this is the case with this study. The purpose of this findings chapter is to account for the common themes, how these themes were arrived at, and how they have been interpreted without at this stage relating them to the relevant literature (Smith et al. 2009). This chapter presents the five superordinate themes generated from the analysis stage; The Practitioner, Values, Clinical Practice, Coercion, and Ethics (Eatough and Smith 2006).

These superordinate themes are presented as a table (see table 2) and are supported for the purposes of the table by partial text extracts (Smith et al. 2009). This table is the final table and was agreed after a dialogue between the researcher and the independent checker who is a member of the supervisory team (Smith et al. 2009). The superordinate themes frame the 'commonality' of experience between mental health nurses who were participants in this study (Smith et al. 2009, Shinebourne 2011). These themes are used to structure this chapter with careful attention being paid to how each superordinate theme arose out of the analysis stage (Smith et al. 2009, Shinebourne 2011). To provide the reader with an insight into this process a reflective commentary is provided for each superordinate theme and corresponding sub-themes (Smith et al. 2009). This reflective commentary which is interwoven with the relevant participant text extracts is a refined version of the researcher's reflective endeavours accrued during the analysis stage. These text extracts reflect the presentation in the superordinate theme table, however more detail is provided than is provided in this table.

In addition, a selected presentation of these text extracts is then provided in the discussion chapter where the superordinate themes are embedded within the relevant theories and literature (Smith et al. 2009). To maintain the personal or phenomenological soul of these extracts pseudonyms are used to distinguish who said what (Smith et al. 2009).

5.2. <u>Superordinate theme I - the practitioner</u>

This superordinate theme arose out of the following common sub-themes;

- ➢ Being an expert
- ➢ Enjoying your current role
- ➢ Mental health nursing is complex and challenging
- ➢ Good role model

Being a practitioner and *being an expert* is not surprisingly related to how the participants identified themselves as mental health nurses. Having the skill to be a mental health nurse was easily identifiable what was more difficult to describe was how these skills were used within their day-to-day practice. Susan when talking about her experiences clearly identified skills they had accrued over time;

"I was actually building on skills around relationship building, brief interventions and solution focused therapies."

However, there was an acknowledgment of a more difficult to describe part of mental health nursing practice. Alice described this as instinct;

"Well they would and again it goes to that what mental health nurses call an instinct, it's something you can't quite put your finger on."

This use of instinct relates to the challenge of not knowing what a service user is really thinking and on this basis the nurse has to make an educated guess. This guess appears to be based on the nurse's knowledge and skill, and their knowledge of the service user and their circumstances. When Alice was talking about using instinct which was framed by a particular incident it genuinely felt like that they had guessed their way through the situation. In addition, the use of skill and instinct can be limited by the environment the practitioner works within. Bill describes their recent experiences of being on an acute mental health ward and in their opinion the ward was understaffed and due to this understaffing certain day-to-day tasks were not being delivered. These tasks included spending time with the service users on the ward and also having the time, for example, to take service users off the ward to go to the local shops.

Bill located this understaffing issue within acute mental health wards as not being the place you would choose to work in;

"Erm, because I know what is like, I think we have gone to far the other way in the sense that we have had to have cut-backs and all these changes, and change is good nobody is arguing with that but sometimes we have got to stop and look about what we are actually doing. And with the cut-backs and its cutting, cutting all the time, ward space and beds, we not got the space to put people, added to that they are cutting back on staff, so you haven't got the staff available to actually do the job they were trained to do."

When interviewing Bill it also felt as if he was disapproving of the way care is currently being delivered on acute mental health wards, it was not a case of blaming anyone instead it was a case of really not liking to go onto these wards, a personal preference. Being a mental health nurse was not just about professional identity, personal identity was also important such as being a 'people person'. Mick highlighted his reason for choosing to be a mental health nurse;

"Came into nursing in 1989 and started my training at an old institution on the outskirts of the city. I had gone into it with very little knowledge about nursing; I did not know there was such a thing as a nursing assistant at the time, I was the only one in my intake who did not realise that as I did not have any family in the profession. I previously had done voluntary work as I was interested in working with people."

This interest stemmed from undertaking a role prior to entering nursing which also had a 'people person' element. Choosing to work with people in this way also involved being willing to learn from these encounters. Jeff mentions a complex incident in detail which is remembered because Jeff felt he learnt from it;

"I wouldn't say it was the first encounter with an ethical thing as ethics is involved in everything we do every day but it is the first time we sat down and actually explore that and read around it and I actually wrote up that incident as a reflective incident."

Being a practitioner is not without its challenges this includes *enjoying your current role* which is not the necessarily the same as enjoying being a mental health nurse. Most times the participants enjoyed their roles;

"I'm happy, and I'm enjoying it."

Jeff clearly enjoyed their current work role and was full of enthusiasm when interviewed. Jeff's enjoyment related to learning new and interesting things within their current work role. However, Sophie had mixed feelings about her current role, Sophie enjoyed nursing, however she did not enjoy the types of service users she was working with and some of the challenges they posed;

"It is challenging role and certain aspects I still enjoy some of the challenges I don't enjoy as much."

Mick highlights the difficulties inherent with being a mental health nurse which can impact upon enjoyment; the demands of the job and the high emotional intensity. For Mick;

"It feels, Yes, It is the hardest job, I thought being a manager in the community *was a hard job but this is very difficult the amount of range of demands and the intensity of emotions that go with it comparing it to the community."*

Sometimes being a hard job relates to being placed in a work role that was not chosen. Susan highlights;

"It's not really a job I would have chosen to do I was never really that interested to be honest but it does have some good points."

Susan was speaking about her current work role rather than being a mental health nurse, due to service changes Susan was moved into her current role. Being in a role that was not chosen appears to create extra challenges. All of the participants moved from role to role, sometimes working in areas they would not have chosen to work within. This is important when considering how 'hard the job' is especially when working with people in acute mental distress. As a mental health nurse with similar experiences I can identify with this viewpoint. Feeling comfortable within a role also relates to the notion of being experienced which links to the notion of being expert. Being experienced in one role can feel like being an expert, being inexperience in a new role can feel like being a novice.

Mental health nursing is complex and challenging and to manage this complexity safely the mental health nurse has to have the required skills and knowledge and according to Jeff;

"I used a breakaway technique, members of staff came along and I stood back, you probably take a minute or two but I think experience counts here, you say to yourself look here, you know it's not a big individual that's coming at you here, you are looking, you know, the likelihood of someone coming around to do you again you are trying to keep your emotions in check but you are conscious of that, your first minute or two your adrenalin, you are scared and you are frightened but you are trying to get your emotions back in control."

This sense of being experienced also relates to knowing the work environment, knowing the service user and recognising similar situations. Jeff gives an example of being attacked by a service user, he recognised the situation as a situation where restraint could occur, however even though Jeff was under a great deal of stress he had the presence of mind to break away safely from the situation and then de-escalate the situation without using 'restraint methods'. Jeff could not say why he acted in the way he did at that moment in time, retrospectively Jeff could rationalise and justify his actions. During the interview Jeff gave a long and detailed explanation, however, he hesitated when trying to articulate his thinking during the incident. Jeff was very clear about his emotions, Jeff was scared. Experience can only go so far especially when dealing with the uncertain situations. Sophie talks about having to deal with service users who are in acute mental distress, demonstrating risky behaviours, and new to the service;

"What I find frustrating sometimes when we have people come in who have never been in before especially if they go down the mental health route we sometimes get very little information which at times can be very frustrating it can also be depending on how they come in and aroused they are, some people you do not know their history, you do not know their potential and managing that situation when they first come in it is like you are judging how they are acting and behaving. It's a judgment call, a typical example; the other night I got a new admission in a young person who had never been an in-patient who had contact with services in the community."

Sophie calls this making a judgement call which is based on having potentially very little useful information. During the interview it felt like Sophie had a standard way of acting and intervening in this type of situation which became more personalised and informed as Sophie got to know the service user. Even without knowing a service user the nurse may be called upon to make a judgement, which in this type of situation feels again like an educated guess.

Alice links guessing to instinct especially where the nurse is not 'lucky' and does not know the service user. However, even if a nurse knows a service user Alice makes the point that they may not really know them;

"It is really difficult mental health, it's not black and white you can't look inside peoples head you have got to go from how they are acting what they are saying, if you are lucky what you know of them, if you know them before."

Knowing a service user is not just about 'factual' information it has to take into account the emotional distress the service user is in. Mick highlights;

"In in-patients some people are here against their will the intensity of resentment that can bring and just that their life situations that have brought them here means they are at a difficult stage of life and they are often in a much more fraught state."

Managing people in this fraught state requires the nurse to provide an emotional response. Bill calls this being 'touchy feely' something that was a key part of mental health nursing practice which may or may not be missing in terms of contemporary practice;

"It's about you treat other people and how you react to what they are. So, you know, it's not touchy feely, nursing isn't touchy feely anymore, but, it's, I suppose touchy feely in that way."

According to Bill 'touchy feely' is where the nurse identifies with the emotional distress of the service user. During the interview Bill talked about how scary it must be to 'hear voices'. It felt that each participant during the interview process was trying to constantly balance the 'factual' and 'emotional' aspects of their practice. Almost trying to be seen externally as nurses who uses facts while recognising that their practice is an emotional endeavour at a human and personal level. Responding in a way that considers facts and emotions feels like doing the right thing which includes being the right person or being a *good role model*. Alice talking about treating people in the right way and grounds this view in treating people how you would want to be treated. Treating people in this way for all the participants is wider than being a nurse it also relates to how you treat people generally;

"You have always got to do the best by people whether it's in work or outside work If you really do want to help people."

Alice links this view to the notion of 'karma' if you treat people badly it can come back and haunt you. An example is given where a nurse who has been disrespectful to a service user and has been punched, there is element of the nurse deserving their punishment. Mick links being a mental health nurse with a type of person and a type of behaviour, some people are engineers and some people are nurses. According to Mick to be a nurse they have to be caring and they have to demonstrate 'their caring' at all times;

"They might be a cool customer but as long as they are observant of other people and interested in them, they might have a different style of care and not sentimentalise how they care, they can show

it in other ways and that is fine, but if people are, drift into being cynical or uninterested or disdainful of the people we are caring for then that is not acceptable."

Being caring is also about wanting to really help people in acute mental distress;

"If you really do want to help people then you will try to persuade them to take their medication, go into hospital, not to spend large amounts of cash on stuff they don't really need and you'll do that because you understand that at that point in their lives they are not able to make an informed judgement about what they should or shouldn't do."

This wanting to help according to Susan is where the mental health nurse intervenes in a way that both helps the service user to recover and also keeps them safe. Treating people well and being caring has an ethical dimension;

"The mother was involved in the service user's care and treatment, that is the first time I've ever sat down as a team and had a discussion, ethics came up but I will be honest my education in ethics is very limited as many nurses would say, though I read around the topic, you know benevolence doing good, but deception was the big issue here."

When Jeff was talking about a difficult situation which had an ethical and legal dimension, Jeff was aware of the language of ethics, however Jeff was concerned about doing the right thing rather than knowing about ethical theories. During the interview it felt has if ethical theories were something that were studied rather than having a practical application. And yet at the same time Jeff clearly acknowledged doing the right thing was the same as being ethical which for Jeff meant following a right process, problem solving, and achieving a right outcome which was acceptable to all parties.

In addition to following a right process Sophie highlights that doing the right thing required a commitment to both doing the right thing, and also justifying your position, which in effect means being the right kind of person;

"Yes, I always felt and hope I am the kind of person where people can come up to me and say what is your reasoning behind it and say for example why did you do that way, the reason why you did it this way and not this way."

Sophie describes an example where it might be easier to give a service user medication rather spending time working through the service user's distress, however it is not the right thing to do so Sophie did not give the service user this medication. It is not just a case of saying; no, it is a case of saying why they are saying; no.

91

This is set within the context of other staff not saying; no, and Sophie feeling they had to justify their position to those staff as well as explaining her position to the service user.

5.3. Superordinate theme II: values

This superordinate theme arose out of the following common sub-themes;

- ➢ Trust and honesty
- ➢ Treating people how you would like to be treated
- ➢ Being person-centred

Being the right kind of person includes having the right values the most important being *trust and honesty*. Bill highlights;

"Erm, we are the people they rely on to provide support in a number of different ways not just with their mental health, and if we, erm, the first thing you have got to do is be honest, so if someone asks me a question and I don't know the answer don't blag."

This is within the context of building a long-lasting therapeutic relationship. Developing this position Susan outlines a scenario where a service user who was in acute mental distress was not allowed to leave the ward. The service user was frustrated, however this was managed by being honest and explaining why they were not allowed to leave the ward;

"If you're honest with people they're more likely to work with you I think."

Trust is also part of the process of building a therapeutic relationship;

"Yes, but I felt in that situation is was necessary to build that trust."

Establishing trust can mean taking a risk. Alice described an encounter where she took a risk and allowed a service user to touch her. Alice did not clearly know the service user's intentions which transpired later, the service wanted to check that they were human. By taking this risk the service user changed their negative feelings towards Alice and became more comfortable in Alice's presence. On probing further Alice admitted she was slightly wary and little a bit scared during the encounter, however Alice thought it was worth taking the risk to establish trust. Mick views values as the cornerstone of ethical practice;

"Ethics, the underpinning values about which you form your judgements, so, part of the reason why I have difficulty answering is that most people don't think day to day about ethically their stance, their ethical outlook which they may not be aware of."

This includes making clinical judgements that are ethical and lead to the mental health nurse doing the right thing. Mick describes doing the right thing in terms of not doing the wrong things, bullying, disrespecting, and intimidating service users. In addition, Mick also sees doing the right thing as preventing others doing the wrong things. Doing the wrong thing has a contextual element for example telling lies and being deceitful are wrong things to do. And yet there are circumstances where it may be in the best interests of the service user to be deceitful. Jeff highlights this issue when talking about covert medication;

"Obviously the individual is different from the managerial perspective, its deceit, in its simple form it is deceit, it is not telling lies but it is deceiving the patient."

This is where medication is given covertly, for example being given in food without the service user really knowing it is there. By not telling the service user, Jeff saw this as not telling lies, however Jeff was clear it was deceitful. Doing the right thing and being ethical emanates from *treating people how you would like to be treated*. Bill was adamant;

"It's not a key thing for me, it's the most important thing in this profession is being treated how you would like to be treated."

This position was interestingly supported by an everyday scenario; a person waits in for the 'gasman' and they do not turn up which creates stress and bother. Bill clearly saw this as not acceptable, people generally should not be treated in this way. Bill then linked this scenario to nursing and the viewpoint that care delivery should be measured against what we would accept for ourselves and our relatives. There was a sense that unacceptable and acceptable practices could be determined by what we, the nurse, at a personal level would accept for ourselves. It could be argued that this approach is a 'common sense approach';

"It's common sense and its respect for the person and I always think and for myself I think you always treat people how you want to be treated yourself."

Alice relates this viewpoint to always trying to be fair even in the most difficult circumstances such as using restraint techniques. This sense of fairness is mediated by thinking about how would I feel if I was in situation and how would I wanted to be treated. Alice also relates this view back to the idea of 'karma' which feels almost like if you do not treat people fairly something bad will happen to you in the future.

It is acknowledged that even if you treat people fairly it does not mean they will agree with the action you took. Susan is more explicit in linking treating service users in this way to being ethical;

"Well treating people like you want your own relatives to be treated, that is what ethics is about."

This view of ethics is about fairness, it also about protecting the vulnerable. Susan talks about protecting service users when they are at their most vulnerable, even if they do not want to be protected, this is about acting in their best interests. As the service user becomes less vulnerable or starts to become well again, the nurse becomes less paternalistic, always looking to hand control back to the service user. Susan views control for control sake as the wrong thing to do - unethical. Mick embeds treating people ethically within a framework approach;

"So I suppose an ethical example might be something like treating people, like everyone has a right to life, which is enshrined in the human rights act, in ethics we refer to that like the right to family life, the right to life and that is something we make reference too."

This approach starts with rights and values enshrined generally within society and then is linked specifically to the care of people in acute mental distress. Mick views people in acute mental distress has having the same rights as people who are not in acute mental distress. What mental distress changes is the notion that society has more of an obligation to care for people who are clearly 'mentally unwell'. This care should ensure that the person's dignity is maintained throughout. By trying not to be in control for control sake and using 'how would I feel in this situation' as a meditator of care this stance relates to *being person-centred*. This can be a challenge as being a mental health service user can convey certain differences especially when a service user is in acute mental distress and demonstrating risky behaviours. However, Bill tempers these differences by always acknowledging that even if a person has a mental disorder label;

"it doesn't make them any different, no difference, you are a person first and foremost."

The example Bill used relates to how you are treated if you have a medical condition, you should be seen as a person not a medical condition. There is a sense here that acute mental distress is a medical condition, to be treated as you would treat any medical condition. This treatment is not just about physical intervention such as giving medication. It is according to Bill based on 'using empathy' to establish a therapeutic relationship, once this relationship has been established various forms of treatment can then be effectively delivered.

Alice describes person-centred care as the 'best' care which is the type of care they aspire to deliver;

"I do think and I am not saying I am perfect or a wonder nurse, I always tried to do my best and the best is respecting the person and its common sense."

Care can be seen as being the best care if it respects the person. Alice does not go into great detail, it is almost as if anyone would know what best care looks by describing it a common sense. It is highlighted that the providing a good environment and building therapeutic relationships leads to best care and good care outcomes which includes a reduction in serious incidents. Respecting the person includes respecting their choices;

"At the end of the day I always felt that people aired their views about single sex wards and the government had a response, I remember mind campaigning and you've got to respect people's choices, because I have seen many situations with females on mixed wards and they were left very vulnerable, but that is democracy, you know people choose and they have their own opinions about that."

This includes respecting choice even if you think the person has made a bad choice. Jeff talks about respecting choice even they do not agree with the choice the person has made, however they will intervene if the person is a service user and they are putting themselves at risk or leaving themselves vulnerable. This viewpoint illustrates the difference between respecting choice within an everyday context and respecting choice within a mental health nurse-service user context. Sophie is clear;

"I wouldn't say I break the rules as such obviously the patient is the priority and what they want is the priority but understanding there are certain guidelines you have to go by, and make them aware that certain things you can and can't do."

There is a caveat, the rules of care which may restrict what the service user can and cannot do, if the service user's choice potentially breaks the rules, then the nurse cannot help them in their course of action. This issue relates back to the mental health nurse's duty to keep people in their care safe and/or protect them, however this does not mean service users in this situation should be seen as less than 'non-service users';

"I think that just because someone has problems with their mental health and may lack capacity they are no less human beings and probably need to be protected, the rules I suppose protect the patients when they're at their most vulnerable."

Susan sees the rules as a way of protecting people who are vulnerable which in their scenario example relates to someone who is an acute mental distress and lacks capacity. This need to protect should not dehumanise the person in anyway. Being able to recognise and mitigate the potential negative impact of restricting choice is dependent upon the skill of the mental health nurse;

"I suppose that is down to each individual to have that self-awareness to pick upon the signs of that person, whether that other person feels engaged in a free debate or if they have been cornered and are now being in effect forced to do something."

The key skill according to Mick is being self-aware when engaging with a service user in this type of situation. This includes recognising that the nurse role holds a great deal of power within the mental health nurse-service user relationship.

5.4. Superordinate theme III: clinical practice

This superordinate theme arose out of the following common sub-themes;

- ➢ Acute mental health is not a place
- ➢ Team working
- ➢ Being a clinical decision maker
- ➢ Options are influenced by risk
- ➢ A duty of care is an obligation to act
- ➢ Being therapeutic at all times is essential
- ➢ Weighing up all the options

The original intention of the project was to focus on acute mental distress within purely an acute mental health ward context, however, services have changed dramatically since 2011 and acuteness is now being managed in a variety of different services; *acute mental health is not a place*. Bill highlights these changes;

"You know, we do deal with people in the acute phase in the community."

Bill had worked in a variety of settings and was adamant that acute mental distress is not just managed on the wards. Bill emphasised if acute mental distress was managed effectively in the community there was no need for admission to a ward, hospitalisation could be avoided. Bill also talked about these changes in terms of a reduction in 'ward beds' and on this basis individuals discharged from hospital were not always well, but well enough to be discharged if community services could manage their condition.

There is also a sense that people can be in acute mental distress without the need for services to be involved;

"As an example if people start doing things like they are paranoid and they start tampering with the gas pipes and that is extremely dangerous that can kill them and wipe half the street out so then society I think has the right to step in and say no you need to come into hospital and get treatment for that but if that illness takes the form of writing countless letters to politicians and the Queen and various people and building strange things in the back then as long as it is not hurting anyone else then it is their right to be ill without that interference."

Mick was discussing the idea that a diagnosis of mental disorder was not a reason for admission to mental health services. Where services need to be involved was where there was a certain level of risk. This level of risk could be a risk to self or others. Mick talked about an individual diagnosed with schizophrenia who has delusions and there may not be a need for services to be involved. However, if they started to tamper with the gas supply putting themselves and others at risk there was a clear need for services to intervene and if required restrict the person's freedoms. If their activities only include writing thousands of letters to a person and they are not threatening in tone, there may still be a need to intervene but not in a way that restricts their freedoms. This requirement to intervene is also mediated by having a duty of care;

"If somebody was standing on a bridge ready to jump then I would intervene you know to stop them, to try and stop them but it wouldn't be my responsibility, do you know what I mean"

For Alice this duty of care has a specific responsibility. If someone was try to kill themselves Alice would intervene where it was safe, however they do not feel they have a responsibility to intervene. If that person was in Alice's care there is a responsibility to intervene, which is a duty of care. This duty of care within mental health nursing is framed by the therapeutic relationship irrespective of the setting;

"When people do become unwell in the community and you have that relationship with them you can support them at home by suggesting that they do things that you both know they enjoy or that work."

Susan views 'time' as being an important part of this relationship. Within the community setting the mental health nurse appears to have more time to establish this relationship. The mental health within the community may be in constant contact with a service user for years, whereas the nurse on a ward may only work with the service user for a few weeks or months.

As services have change and boundaries between the wards and the community have blurred there is a need for these two settings to work together in way that feels to the service users as an integrated approach. The important part of this way of working is *team working*. This can be a challenge;

"Just the whole way of working is completely different, you have community consultants then there is like an acute services consultant so they are like two completely separate teams really."

Susan is talking about the structure of service feeling like it contains two completing different teams, the community teams, and the in-patient service teams. Where the two teams communicate effectively it feels more integrated, when they do not it feels like two separate teams. A potential negative impact due to a lack of communication is the service user moves from one team to another the relationship with their nurse has to begin from the start, which includes gathering knowledge from the service user that the other team may already have gathered. Changes in service can have an adverse impact;

"Ahem because there is not enough staff, you know, and this is a Trust wide issue isn't it, ahem we have got less beds, less staff."

Bill links a lack of staff on acute mental health wards to staff not being able to spend enough time with service users while they are on an in-patient on the ward. There is also a further link to a lack of beds which Bill describes as being a factor in their being more people in acute mental distress being nursed in the community rather than on a ward. Bill who is now working in the community views the wards as a bad experience for both staff and service users. Mick describes these difficulties as inevitable when you have to manage;

"It is, it is not always easy to do in terms of the right judgement because to some degree when you have 66 people in a small brick box there is going to be lots of problems with how carers react to each other and there has got to be some form or sense of regulation of how people will behave to some degree, but I think what I rather staff did is make individual judgements about circumstances so not saying the rule at 1 o'clock in the morning the TV is off and I am locking this lounge off and you are all going to bed I would rather they responded individually and at night times when it is appropriate to say can't party all night and should try to go to bed but if one person has got insomnia and is wandering around the ward can't the nurse in charge make a judgment for them and let them go and watch TV as long as it is quiet, something like that."

This dynamic of having so many people in a confined space with limited access to outside space can lead to tensions between all groups of people working and living in this space. This includes staff making up rules just to control this dynamic, from an outside perspective these rules can appear unfair. Where teams appear to function more effectively it is where they adopt a multidisciplinary approach;

"I think nowadays it is more of a multidisciplinary approach."

Alice describes an incident where the team on the ward were considering whether to give a service user leave. Alice was not keen as they felt the service user was still a suicide risk. The majority acknowledged this viewpoint, however the team as a whole decided to take a therapeutic risk and grant the service user leave. At the time Alice thought it was the wrong decision but was willing to go with the majority decision, on reflection Alice now believes the team made the right decision. This change is based on the outcome, the service user did not harm themselves. Jeff makes the point that team disagreement can be a good thing;

"The service user to leave, the service user was homeless, there were concerns raised so we got together, there were opposing views on the team about the service user and so let's get the capacity assessments done that is what they are there for, the psychiatrist looked at the service users history and spoke with the service users mother, the mother was unhappy if service user was allowed to leave with the service user having nowhere to live."

When dealing with a situation of a service user potentially making an unwise decision the team could not agree on the course of action. The team recognised that they had a duty of care and that as a team they did not agree with the service user's decision. However, they also recognised after a long discussion the service user did not lack capacity and was making a reasoned decision. The outcome being the team had to respect the service user's decision irrelevant of whether it was an unwise decision. Reflecting and seeking other opinions where possible is not an uncommon practice;

"I think about it afterwards and talk about it with the team."

This includes reflecting post-incident. Sophie describes this as a common practice especially after using restraint techniques. These reflections tend to focus on did I do the right thing, using restraint, could I have done things differently. If there was no other option available there is a sense of; I have made the right decision. Mental health nurses are making complex clinical decisions on a daily basis.

Being a clinical decision maker involves exploring different options;

"We needed to explore the options the options available to him, I'm not saying on a personal level that I am uncomfortable with that, on a professional level, you know, you have a discussion, you debate the issues, and see what the best option available for our patient is."

Jeff is describing a process of exploring the options as a wide ranging discussion where the consensus of the majority is respected. This process follows this format where time is not an issue. Having time is not just about acting quickly in an emergency it is also about not having time due to workload pressures;

"*it's not enough time to really understand what they're going through and helps them, and I just get them back on medication and stable and out again.*"

Susan highlights the role of mental health nurse on an acute mental health ward is limited to getting a service user fit for discharge. Which may just involve giving the service user prescribed medication and only being able to support them at a superficial level. Susan compares this to working in the community where a service user may be in crisis and they have more latitude to rearrange their workload to work with them in more depth, a more talking therapy approach. During the interview it felt as if Susan was frustrated by this way of working on acute mental health wards, it was not a way of working that they either enjoyed or felt was the right thing to do. Their response to this way of working was to leave and work in another setting. When making decisions within the context of someone being in acute mental distress there is an overwhelming need which was highlighted by Alice to minimise harms;

"You wouldn't want to see someone trying to kill themselves or harm someone else."

In these circumstances acting and intervening to minimise all types of harms is important and so is according to Sophie the need to provide an explanation;

"I if feel that they don't look like they need it I will have a discussion with the person and say give me the reasons why you feel you need it, not just because you want it and it's been prescribed, I have a duty of care to explain why I have used it and it has to be in your best interests."

And sometimes there is a sense of regret which does not fade even if the right decision was made;

"Um, he was someone who was in the group of bullies and sometimes he dropped out so it was a complex set of relationships, but on reflection I did think it had been the right decision an enough time had elapsed to think I hope the individual had done that for some other reason."

Mick when dealing with a particular incident believed he acted in the right way, however there was a sense of regret due to the service user killing themselves after discharge. Making clinical decisions requires the nurse to explore all the options ultimately these *options are influenced by risk*. Once these options have been explored it is only then the service user's freedoms are explicitly restricted, the nurse feels more at peace with their decision;

"Yes I mean, I would feel comfortable if that was the options left to us to do, we have explored all the options. This man needed to have his medication or he would deteriorate quite quickly, he was on anticonvulsant type medication."

Jeff sense of being comfortable relates to being able to say all the options have been explored and they are able to provide justification for their actions, to give covert medication. For the mental health nurse everything they do within their practice is influenced by the need to manage risk;

"It is risk that separates it out, yes"

Jeff describes a scenario where if it was not for the service user being risky he would not have intervened. Alice relates identifying and making sense of risk to a robust process;

"Well its necessary when anybody has to go out or anything you are constantly risk assessing the situation and themselves, so it's a necessity to have risk assessment of the basis of everything that you do and what you base your judgements on"

Assessing risk is not just a tick box process it is something the mental health nurse is constantly aware of and at all times. Assessing risk according to Sophie is a process that assists the nurse in keeping a service user safe;

"I would say I'm concerned about the safety; a lot of them want to go because they want to harm themselves, a lot of them will say they want to hurt themselves such as jump off the flyover, they going to go home and kill themselves, they are going to hang themselves or they're going to slit their wrists."

Susan highlights that once risk is identified then the mental health nurse usually as a team member acts;

"Because of his presentation, being very agitated and potentially risky, the team agreed to stop his leave."

The *duty of care is an obligation to act* especially where a service user is identified as being at risk;

"The crunch time comes if somebody who is known to be suicidal starts expressing suicidal ideation or they have started harming themselves then you have got to start for their own sake taking some other intervention whether it be getting the crisis team in or look at hospitalisation."

Bill is describing a process whereby this obligation to act based on risk can lead to restricting freedoms, determining factors are actual, the service user has harmed themselves and/or others, or there is the distinct possibly that something will happen if the nurse does not intervene. Alice relates this process to the specific context of an in-patient ward where a service user can be prevented from leaving the ward through the use of a locked ward if they appear to present a risk to self and/or others. To justify this intervention to the service user or the wider world the information from the risk assessment process would be referred to throughout;

"Look saying to someone look last night you were saying you wanted to kill yourself, you have had ideas that you wanted to hang yourself and now you are asking me that you want to go out, you seem very down, you seem very flat in your mood, you know I've got a duty of care to you, I can't let you go out when you saying that to me and the behaviour you were displaying."

Restricting freedoms even when robustly justified is not a comfortable position to be in;

"The whole idea for me, all my experiences of physical restraint, there has been lots and at a personal level I hate doing it but if I have to I will, if it is required to over the issues of health and safety balancing that against patients autonomy and squaring the ethics of all of that is very difficult."

Jeff relates this feeling of being uncomfortable to how he would feel if his freedoms were restricted, Jeff used such terms as; dehumanising and degrading. Making the right decision to restrict freedoms is difficult when there is little time to make a considered decision, this can happen when a risky situation arises with little apparent warning.

Knowing the right decisions to make in these fast-paced decisions is based on experience;

"I think is that quick the decision sometimes, it does come with experience knowing when to do it I'm not going to say that there aren't times when maybe that was a bit quick to make that decision."

However, Sophie does suggest that sometimes in hindsight there is sense of did we act to quickly. This acting to quickly relates to the use of physical restraint and also the decisions of others in the team who can influenced the decision to restrain. Sophie was adamant from their perspective that restrain is a last option with all other options being explore first including verbal de-escalation techniques. Mick provides a reminder that the nurse is accountable for their practice even when part of team and on this basis;

"We have a duty commensurate with that particular job that you are holding and you have an ethical duty to not to simply deal with the people that clamour around us, that may be people more senior to you or colleagues, but to make sure you are aware of what is actually happening with the most vulnerable people you are responsible for and make sure that they are getting a good and fair responsive treatment from the service."

Even in the most difficult of circumstances and irrespective of the service user's condition the mental health nurse has to remember that *being therapeutic at all times is essential*. Being therapeutic which includes establishing a therapeutic relationship can determine the type of care provided, it can also increase the amount of options available. On an in-patient ward being therapeutic even when there is intent to be therapeutic can be a challenge;

"There is a lot of noise and there can be a lot of friction between some of the service users especially when we seem to have a high input of service users with an EPD, emotional unstable personality disorder."

Sophie highlights that for the nurse to be therapeutic they have to manage the interactions between all parties that are the ward. This is a difficultly in itself trying to manage around thirty different personalities at any one time, staff and service users. In addition, the environment can be a restricting factor. When a service user is an acute mental distress on a busy ward it can be difficult to give them the appropriate space, one-to-one space, to manage their distress. If more than one service user is in acute mental distress than a lack of appropriate space can limit the nurse's options. Where the nurse has options they can use their relationship with a service user to consider;

"So trying to get their attention, trying to get them in the time, place and person, using your relationship to manipulate that situation in a way again to coerce or persuade them to stop doing

something that might harm them and obviously breaking up furniture and harming furniture, you know, like damaging things."

Alice is describing a situation where a service user on the ward is angry, psychotic, and damaging objects on the ward. As they are not harming others, Alice tries to get their attention, bringing the service user into Alice's reality, Alice then tries to establish a dialogue with the service user with the aim of de-escalating the situation. At the same time Alice has directed the team to get all the other service users to a safe place. Where there is not a threat to others Alice knows she has the time to work with the service user. Alice has also calculated that the service user's anger will diminish over time, so Alice keeps talking. If Alice's feels, an educated guess, the situation is escalating and the service user is a threat to others Alice will consider physical restraint, but only as the last option. Alice calls this approach manipulating, however this approach is viewed as good manipulation because it is aimed at reducing harm. Susan describes a situation where they convinced a service user to change a decision they had made due to this decision creating a high level of mental distress;

"I took her out and walked round the park with her a couple of times talking to her and because we have developed a good relationship over the years I managed to convince her that it was better for her son to know where she was."

The outcome for all parties was a reduction in levels of mental distress. This decision was viewed as an unwise decision, however at first the service user was unwilling to consider other options until working through the issue with Susan who had a good relationship with the service user. This manipulating which aims to 'do good' and is based on agreed ethical values;

"If you are member of this society you have a right to have your life valued and to be taken care of and so the rest of society has the ethic duty, I suppose, to plan to make sure that people don't simply become marginalised and 'bullified' if they are ill and their behaviour is unappealing or unattractive to others."

Mick links any type of nursing intervention with an ethical framework approach, these frameworks, ethical and legal, should guide the nurse towards making an ethical decision. Before intervening the nurse has to *weigh up all the options*, this includes exploring all the options;

"Anything that is affecting the quality of life, you know, and if it is getting to the point where, err, using someone quite recently as an example, there is a person I see who has a bipolar disorder, they diagnosis is bipolar, but its more I would say it's a schizoaffective disorder, and the patient is starting to experience more and more paranoid thoughts, now the patient is a very intelligent and articulate person who have lived with this illness and managed it, the patient has got a lot of physical health

problems as well, and, you know, the patient was at the point of I think being admitted quite recently because the patient was so distressed by it, but because we increased the visits because we worked with the patient and the patient's partner so closely and we looked at options about what we could do, the patient didn't want CRHT because the patient thinks they do not work, by the fact that you get a different practitioner every time and all you do is go over your past history, 7 times in a week if you are seen by seven different people, which is not helping."

Bill describes a situation where a service user was in acute mental distress and hospitalisation appeared to be the only option. However, after a lengthy discussion it was agreed that hospitalisation could be avoided if risk could be managed by increasing the amount of staff support the service user was receiving. This approach appeared to work measured by outcome, the service recovered and risk was contained during their recovery. This individualised approach should not as Mick highlights relate to applying the rules just for the sake of the rules;

"I suppose what I want is people to move away from sets of rules of how or what we expect of the service users that we might coerce them into and move towards a sense of ethics."

Responding not just through following the rules requires the nurse to keep a dialogue going;

"It can be a really quick decision and in a lot of ways it comes down to experience to whether you put hands on or not, I mean more and more you are thinking you do not want to put hands on people, you want to try and use verbal de-escalation, you want to try and encourage people to talk to you as to why they want to go, and just explaining to them we do not want to go down this road, they're a lot of other options, we do not want you to hurt yourself, we do not want you to hurt the staff."

Sophie explains that verbally de-escalating a situation where a service user is mentally distressed and risky requires a two-way dialogue. On this basis the mental health nurse is constantly trying to keep the channels of communication open, once this process stops there appears to be more chance that physical restrain will be the only option. Even though as Susan articulates;

"It should only be ever used as a last option, because it is restrain, and you taking people's liberty away, it is the ultimate act of taking people's liberty way, holding them down."

Alice makes the point that mental health nurses are not mind readers, if communication stops, the service user still appears to risky, and they are not controlling their own behaviour, then the nurse is required to intervene.

This need to intervene is therefore more likely to be based on an educated guess which has to result in establishing control;

"We can't foresee we can't read people's minds or anything so we done our best with the process, we have done our best to the best of our knowledge."

5.5. <u>Superordinate theme IV: coercion</u>

This superordinate theme arose out of the following common sub-themes;

- ➢ Restricting freedoms
- ➢ Reluctant use of power
- ➢ Pressuring and persuading
- ➢ Coercion is based on a duty of care
- ➢ Sensitive coercion
- ➢ Risk a mediating factor
- ➢ Knowing when to coerce is a dilemma
- ➢ Best interests
- ➢ Potentially abusive

Defining what coercion is and is not was a struggle for all the participants, however, *restricting freedoms* was a key tenant including making service users do something they did not want to do;

Coercion to me means forcing somebody to do something against their will, if you for example; 'don't accept this increase in medication then I will put you in hospital', you know, that's coercion."

Bill links this idea of restricting freedoms within mental health nurse practice to the nurse having the power to restrict freedoms. Sophie then links power with having the means to restrict;

"My understanding of coercion is making a service user do something they do not want to do by whatever means is required, whether that is by restraint or through medication, whether it is restricting their movements in some way, not letting them go off the ward."

These means are framed by what society will allow, however there is a recognition that the power to restrict freedoms is more than just an unusual occurrence;

"Coercion is without getting into concepts coercion is every day, I go to work and there is coercive elements every day in my encounters with the people I work with."

Jeff is highlighting that everyday nursing interventions are pressuring a service user to change their behaviour to be or to do things they may not want to be or do. This takes the form of constant pressure. This approach is justified by the best interest argument described by Alice;

"Well such as, I suppose you can look upon it that is quite a paternalistic sort of role in that you are doing something for somebody in their best interests even though they don't think so at the time, because of the nature of their illness."

Susan talks about this use of power as the unpleasant side of mental health nursing practice;

"Making people do something they don't want to do in a bullying way maybe, usually something unpleasant. You don't need to coerce someone into doing something nice do you."

Restricting freedoms can be unpleasant even if justified. All the participants recognise they have the power to restrict freedom, however there is a *reluctant use of power*. Sophie talks about this use of power within a team of mental health nurses in relation to giving discretionary medication as;

"It's a bit like a power play where I made the decision is only up to my discretion and I do challenge that with some staff."

This relates to one nurse wanting to use this power in one way and another disagreeing and wanting to use it in another way. Bill describes the impact of the use of power, in this case the power to send someone to hospital, at an emotional level;

"He wouldn't meet me and leaves a bit of a bitter taste in the mouth, because I don't like that, that's not part of the job that I enjoy, I see it as a bit of a failure if someone goes into hospital."

Even using the term coercion can be sit uncomfortably with the caring aspect of the role, even if it is a necessary part of the role;

"Using the word coercion seems a bit strong but yes sometimes we have to make people do things they may not want to do at that particular moment in time."

Susan reframes coercion in terms of talking a service user into doing something, this reframing is related to feeling that the word coercion has sinister connotations.

Mick highlights where required coercion is a necessary part of the mental health role;

"Sometimes we have to coerce people to take medication if they are detained under the act and it is prescribed such as depot medication."

This sense of not wanting to do it is balanced against the greater good. By coercing where an acutely unwell service user poses a risk is justified by the wider societal need to control and reduce this risk. Alice describes this as not a personal choice;

"Yes it's not about what I personally want to do, it's for the greater good if you will, its in their best interests and you would always, because you are in a position where people come into to hospital and they are unwell, you have to justify that is was in their best interests."

In preference to the term coercion the terms *pressuring and persuading* were used. Susan and Alice respectively describes their preference for the term persuading;

"Persuade, yes, it just feels as if you trying to trick someone and you're not treating them with respect, not respect, but I don't know it feels more I don't know it does not feel as nice as persuade."

"Probably, yes it probably is, because you are still making someone do something they don't want to do but persuasion suggests giving reasons for doing it rather than coercion which suggest just do it because."

Pressuring and persuading felt for Susan and Alice as more acceptable as terms, however pressuring and persuading may carry in the background the threat of restricting freedoms Mick highlights;

"So I would see that as coercion, I think we do it for a valid reason but it's still coercive doing something against their will."

Pressuring and persuading can according to Jeff feel coercive especially where choice has been restricted;

"In that respect I have seen staff speaking to service users, applying sort of pressure, it's not a negotiation it's telling people what to do type of thing."

Sophie relates the use of pressuring and persuading to the nurse's intention. If the nurse's intention is framed by the best outcome for the service user, their approach is least likely to be coercive;

"I think sometimes, it depends on where you're coming from and why you want to persuade them to do something, if you think it is the best for them and you've got reasoning behind you why you think it's best, and for their benefit, and their safety and their health."

However, there is a caveat, the best outcome for the service user is not necessarily the same as what the service user would choose to do. To manage this disconnection between these two points of view Bill highlights the need for the mental health nurse to challenge or pressure in a sensitive way;

"Yea, you do sometimes have to persuade people to do stuff, you know, it might be a better idea if you do something else, you can suggest things I suppose, erm, I like it mainly to be a working relationship you can, you know, the patient has got choices, but sometimes you have got to say; 'well look is that the best choice you are making for your long term recovery needs'."

Using *coercion is based on a duty of care*. It has to follow the rules and it has to be the right thing to do. This duty starts with the service user having a mental disorder being supported by the nurse to recover, as described by Mick;

"I don't know how to phrase this really, basically they are ill and we are intervening to try and help them recover, I suppose."

This need to intervene in this way is reaffirmed by Alice;

"Yes, it's a duty of care."

Sophie and Mick respectively framed intervening as doing it in the right way and following the required rules;

"So you have not got to use any restraint or sometimes any PRN medication, if you've got a good rapport with certain patients who are coming in even though you know they have got potential to be aggressive or doing themselves really bad self harm, if you have got a good rapport with that person and you use the staff in the right way you can negate that happening, you can talk to them, you can distract them, and it works really well."

"I suppose you work within the nursing code of conduct as I said before about respecting privacy, confidentiality, and all that works within that."

Intervening that is coercive may be done in the right way and it may follow the rules, however Susan highlights that even though it is the right thing to do it may be something that the service user does not want to do;

"Stay on medication that they don't want to really be on, you know, they need to go into hospital that they need to stay in hospital."

This not wanting to do it can take the form of actively refusing to go along with the intervention and even if the service user goes along with the intervention it does not mean they would if there was not pressure present. Coercion within a caring context such as mental health nursing practice has to be *sensitive coercion*. This can take the form of minimising harm to all parties, Sophie highlights;

"You do not want to do it because there is always the potential that they might get hurt or a member of staff might get hurt."

Mick talks about it being contextualised by the issue of consent;

"I think we are still aware we are coercing them and what we are doing is not with their consent."

It has to be a last option;

"I would give it orally."

Alice when presented with the scenario of having to enforced medication by injection and then the service user suddenly changes their mind even though the injection is drawn up Alice would still go with the least coercive option in this case oral medication. Coercion has to take into account the human dimension of both staff and service users, Bill describes the need to respect the humanity of the service user;

"They have got the same feelings, the same worries and the same concerns, as you or I have."

And it has to be honest as highlighted by Susan;

"I don't like medication; I always say that to them."

The presence of risk and the type of risk determines the type and level of coercion, *risk a mediating factor* in coercion.

Determining risk is based on knowing the service user, Sophie highlights;

"To my mind it is knowing your patients, it is knowing your patients and it is judging their state of arousal, if you feel that they listen to you and are willing to engage with you and talk with you why they want to go out and what's going on and what's causing the reasons, the thought processes why they want to go."

The assessment of risk is way of determining how to intervene, assessing risk can also carry a threat of coercion which is described by Alice;

"Whereas risk assessment is something you can use to persuade people or coerce people, the results of that risk assessment you can use for doing that, for persuading people, for coercing people."

This relates to something like; according to the assessment information we have if you do not take your medication you know you will become unwell again. The power of assessing and managing risk links to the power to act, Mick discusses;

"It's not the diagnosis that gives us the right to intervene and I thinking more towards the mental health act and it is simply if they are going to harm themselves or others then that gives society under the current law the right to intervene."

Bill and Susan respectively describe harm as risk as;

"Erm, again, if it somebody relapsing, erm, through psychosis, erm, when it starts to affect their quality of life or their not fully self-caring, erm, or it is impacting upon their activities of daily living, erm, or they are starting to experience real problems outside of the house or they are withdrawing back into their home, then have got to start doing something more proactive and start looking at."

"If someone is in a position why they are going to do something that will harm themselves or someone else again the same rules really. At that time, it is the only course of action that will prevent that from happening."

As there is a preference not to coerce *knowing when to coerce is a dilemma*. Alice highlights this dilemma within the context of physical restraint;

"I always used to have the problem of when do go in to restrain them."

Not coercing and not acting can potentially have an emotional impact, in this case Mick is talking about his reasons for acting which involved preventing a service user coming to harm by restricting the freedoms of other service users who were bullying this individual;

"If the individual had killed themselves while I was getting reports that they were feeling bullied and I never would have forgot it in my life."

And Susan felt uncomfortable using restraint though the use of restraint in this situation was without complications;

"Although it was controlled and probably very different to a normal incident I still felt uncomfortable."

For Sophie being coercive can be the culmination of a difficult situation where there is very little information at hand and the nurse's choices are restricted;

"So trying to keep people and the situation safe for everybody was difficult and as we did not have a great deal of information as far as the family were concerned the service user had not had any contact with services so we couldn't really get anything from them to whether the service user had been like this before, if the service user had any aggressive behaviour before that we should be aware of."

Coercion should always be used in the *best interests* of the service user. A starting place is to work with the service user to determine what they think is in their best interests, Bill describes;

"And certainly very much around giving people the choice of what they think is best, sometimes I have got to make a decision they don't like."

However, the nurse has to determine what is in a service user's best interests if they believe the service user is unable to make this judgement they have to act of their behalf. Sophie and Susan highlight respectively that this acting in best interests is based on the best outcomes for the service user and knowing what is best for them;

"I think I understand in my mind it's about thinking about them and the best outcome for them."

"I think you can and I think honesty is the key, to me it is about being honest with people and saying look I know you don't want to do this but at the moment I truly believe it is the best thing for you to do if I didn't think that I wouldn't be asking you do it."

This knowing what is best is accrued through the mental health nurse putting themselves in the service user's place. However, feels like; if the service user was in their right mind what would they want. The nurse is using being in their right mind as a way of making sense of this dilemma rather than being the service user in acute mental distress. This approach is framed against a long term good, the service user's long-term wellbeing, Alice highlights;

"So it might be a case of preventing people from leaving or you are trying to persuade them to stay as a patient or you are persuading them to take medication for their mental state with the ultimate aim of making them better, for their own good."

There was a concern that coercion could be *potentially abusive*. Bill, Jeff, and Susan respectively highlight the following concerns;

"You know, when you get on the ward its not a nice experience being locked in there, I don't think as a patient it's a good experience to be locked in."

"That is a nice way of working with people that came afterwards, restraint is always a big ethical issue for me it can be different things, autonomy, the experience, the degrading experience for people and it's de-humanising."

"It should only be ever used as a last option, because it is restrain, and you taking people's liberty away, it is the ultimate act of taking people's liberty way, holding them down."

These concerns potentially influence the mental health nurse to be cautious in their use of coercion especially coercion in the form of physical restraint. Using coercion has a price to pay, Mick describes the cost;

"You might think that the intervention outweighs the damage it causes to them by bringing them in and making the decision to do it, there is a cost to pay in as much as you are sometimes left with a very angry and humiliated person."

The nurse can become so used to using coercion they become desensitised;

"I have said it myself, look if you don't take this medication we are going to have to give it to you by inject and we really don't want to do that. You know if you don't stay on the ward we are going to have to get you assessed under the mental health act."

Alice is talking about almost running through a script which is used to pressure the service user into taking medication. Even though this script is used in the service user's best interest the participant still feels a sense of regret that they have worked in this way. Sophie highlights she has observed others using coercion in a way Sophie believes is not right;

"Other times you find people using it not in the best way, there could be other ways of using it or dealing with people and dealing with their issues at that particular time, it's about both sides."

5.6. Superordinate theme V: ethics

This superordinate theme arose out of the following common sub-themes;

- ➢ Ethics in practice
- ➢ Right and wrong are relative to the situation
- ➢ Ethical rules
- ➢ Everyday rights and duties
- ➢ Ethical outcomes
- ➢ Ethical decisions have to be reasoned
- ➢ Ethics is multifaceted
- ➢ The character of the nurse
- ➢ Unethical

Understanding ethics is contextualised by the mental health nurses practice; *ethics in practice*. There is a sense that ethical issues feel different in the mental health field compare to physical health, Mick highlights;

"And so, we do it through the NHS, is to try and understand more deeply why people become ill, how it affects them, how can we respond in a way that helps them and maintains their dignity and I suppose ethics have evolved quite quickly in terms of mental health compared to say physical health care so even in the time I have been qualified in 20 years I have seen a lot of change as much as the judgement of people who have got mental health problems is respected far more."

Mick relates this change to the active involvement of service users within the management of mental health service delivery. Mick views this change as a good thing and one that underlines the value of service user involvement. Being ethical is respectively described by Jeff, Sophie, and Alice as doing right and not doing wrong;

"Trying to keep it simple in my mind ethics is concerned about what's right and wrong in situations that informs our practice."

"It's about right and wrong basically, what feels right for the patient and what they say to you and taking on board what they say to you."

"Doing the right thing."

Right and wrong also relates to minimising harm;

"It's like the doctor thing, first do no harm, you know and I think that, erm, is important in nursing as well as, you know."

Mick relates no harm to working in the best interests of mental health service users. Not exploiting their vulnerabilities and being committed to working in a collaborative way. There also has to be an intent not to do harm;

"It's about your intent when you're working with vulnerable people."

Susan describes intent in terms of intending to do 'good' and protect people who may be at their most vulnerable.

Right and wrong are relative to the situation, which includes being relative to the person;

"It's not what is right for me it is what is right for the patient."

"Understanding what their concerns are what their choices are, what might be right for them, you might think might not be the right outcome, but it is what they feel comfortable with and they want to do."

Jeff and Sophie respectively highlight the importance of respecting what the service user wants while at the same time acknowledging what they want and what the service believes is right for the service user may not be the same thing. In this situation the mental health nurse is mediating and trying to make sense of the relative merits of each position and then trying to plot a way forward for the service user. Relativeness is also about understanding that a standard approach will not always work;

"They would welcome you to the ward no matter how ill you were, obviously it doesn't work in every situation, but it makes you feel important which is when you are at your most vulnerable being admitted to an acute mental health ward, you are really vulnerable, but that little personal touch makes you feel a little easier."

Bill discusses the need for the nurse to be person-centred this includes being respectful and courteous especially on a mental health ward which may not be the most welcoming place. Determining what is right in a situation should be based on agreed ethical values;

"That is what I want people to do to sort of look at the 'there and then' situation and try and decide what is safe, fair and respectful and promotes autonomy for that particular situation and not just say the rule we do this."

Mick advocates not only using a values approach to ethics, it should also be framed by the following; fairness, respect, equality, dignity and autonomy. However, the nurse should not use this approach as a fixed rules-based approach. Rules-based approaches do provide a reference point, Bill, Jeff, Sophie, Alice, and Susan respectively highlight;

"Yes, life is governed by rules, you know, and there are certain things within nursing, you know, that are no-no's in nursing."

"Both, it was wrong legally and ethically for that person as a human being it was the wrong thing to do."

"I wouldn't say I break the rules as such obviously the patient is the priority and what they want is the priority but understanding there are certain guidelines you have to go by, and make them aware that certain things you can and can't do."

"Yes if you follow policies which are there to protect you and if you follow policies you cannot go far wrong."

"I think that just because someone has problems with their mental health and may lack capacity they are no less human beings and probably need to be protected, the rules I suppose protect the patients when they're at their most vulnerable."

Rules-based approaches have limitations, they cannot provide an answer to every situation, making ethical sense of a situation requires ethical sense;

"I suppose what I want is people to move away from sets of rules of how or what we expect of the service users that we might coerce them into and move towards a sense of ethics."

Mick is describing a situation where the nurse makes ethical sense of a situation through knowing what is right and wrong at that moment in time.

This knowing is based on the nurse being able to balance the rules against the wishes and wants of the service user. This approach felt like the ability to feel for the right answer which is a challenge when the nurse has to constantly justify their actions; rationalise. This rational approach has to be seen to respect *everyday rights and duties*. The mental health nurse has a specific role which makes them accountable to society, Mick makes the point;

"Yes we are all here as servants in one form or another whatever I do not think any of us are powerful however far you climb up the ladder we are all here as public servants."

This societal role as highlighted by Sophie and Alice is to protect and at times act on behalf of the vulnerable;

"We basically say, yes you are an informal patient but, we have gone down the road and have got locked doors for your safety and protection."

"If they are really unwell you know they may have lost their autonomy by the nature of their illness so you have to act for them, you have that duty of care, makes you do your job."

To do this role well the nurse has to have good social skills and be an effective communicator, Bill has noticed on occasion not all mental health nurses possess these skills;

"How about developing the social skills of the people looking after them."

There is also a mental health specific paradox to protecting which Jeff describes;

"I think so yes let's be honest with you personally yes, but this is deceit without telling lies, really covert medication is about deceit without telling lies."

This highlights what may appear to be unethical in an everyday context may be ethical in a mental health context. Having the right values provides balance in what may be difficult ethical situation;

"And I suppose ethically that is what that is about fairness, you know, being respectful and being fair."

Susan describes a situation where a service user in acute mental distress was refusing medication. The ward team could have enforced the medication which was prescribed instead they worked with the service user to find a compromise. In essence the service user was given the final decision on which medication was to be prescribed.

This approach would not work for everyone, the service user in this situation was knowledgeable about the medication they could or could not take. On reflection the Susan knew she had done the right thing because of the outcome. Knowing as a mental health nurse you have done the right thing can be linked to *ethical outcomes*. Alice and Mick respectively highlight;

"No the former, our duty of care would be to ultimately to protect that person and for that person to have not killed themselves."

"Went off the ward on unescorted leave and went home and hung themselves."

Outcomes may not always be a good measure. A service user killing themselves can be interpreted as the nurse making the wrong decision, however it can also be interpreted as the right decision with the act of suicide being unpreventable. Even when the latter stance is taken there appears to be a sense of regret which possibly comes from needing to intervene and prevent;

"So you will going to weight up, if somebody is saying to me and expressing that they are going to commit suicide I feel quite, and not would say justified but I feel comfortable in doing restraint if I need to."

Sophie discusses this need to intervene if a service user is expressing suicidal ideas, intervening may include restraint. Sophie has a need to intervene, however she was always exploring the options, yes I could restrain, though I would prefer to talk things through, possibly offer medication as well. The nurse is always trying to present options which can look like limited choices, Bill gives an example;

"You have got to give people the choice and say to them, you know; if we look at you past history and we say to you, you know, say for example you're my patient and looking at your history in 2001 you were admitted to hospital and prior to that you stopped taking your medication and in 2003 you were admitted to hospital and you had stopped taking your medication then, 2008 the same thing."

These limited choices are seen as being successful if there is a good outcome which includes controlling risk. Susan describes medication within this context;

"It's not being dishonest just trying to show that there is a purpose and a point to medication sometimes."

This does not mean medication works for every service user, however it is an option. Exploring different options is part of the reasoning process.

Ethical decisions have to be reasoned, they have to be justifiable which can include challenging decisions which do not appear to justifiable;

"Yes, justifying yourself."

Alice describes a situation where she challenged a decision by their manager which she felt would put service users at more risk. Alice's justification for her position was based on being able to present a rational argument. Sophie felt that sometimes it is difficult to challenge institutional practices even practices which appear to be coercive. The example Sophie discusses is the routine use of locking ward doors;

"I would say we have never been given any legitimate reason by management as to why we have done it."

Sophie is not entirely comfortable with this decision, however there appears to be no avenue to challenge it. Mick relates challenging decisions to power, Mick did not agree with a decision and he had the power to overturn the decision;

"I don't care whether he doesn't match your criteria."

Susan highlights;

"Absolutely you don't just do it, you do it if they are going to hurt themselves or refusing to take medication, they can't see at that point that it is better for them to have medication and they are not accepting it and they need it."

This way of reasoning relates to the use of restraint, to restrain the nurse has to have good justification which includes providing evidence that it was the only course of action available. *Ethics is multifaceted* within mental health nursing practice especially in complex situations with no clear outcomes and multiple ethical issues are present. Knowing the service user or not knowing can influence the level of coercion, Sophie and Bill highlight;

"I think some ways it might, I think if you know someone you have a fair idea of how they respond to certain things or how they might behave when they first come in."

"Whereas if you don't know someone then perhaps it's easier to sort of be, I suppose coercive."

119

Mick makes the point that what appears to one thing is something else. This relates to a locked ward door not being a locked door;

"I suppose in my house my door is locked but as I can go I do not see it as a locked door."

In addition, the nurse has to follow the rules until they have to be overridden, Susan highlights;

"Even though I follow policy there are times when my duty of care to patients overrides that."

Susan notes that the legal status of the service user has to also be taken into consideration;

"Now they have to go to a member of staff and ask to be let out and I think there is a difference between being a voluntary patient and being a detained patient, but even with a detained patient they don't need locked doors because they can't go anywhere anyway, if their on a section."

Susan discusses locking ward doors by relating the ethics of using this approach to a service user's legal status. They are comfortable with doors being locked if the service user is detained, if they are not detained using a locked ward door to restrict their freedoms feels wrong even if the service user is not attempting to leave the ward.

The character of the nurse has a part to play in relation to the nurse being ethical or not as the case may be. Bill highlights;

"I think the vast majority of nurses have the same sort of ethics and morals that I do, don't get me wrong, I don't think a lot of people would come into the job otherwise."

Having the right character is incredibly important when working with individuals who are mentally distressed;

"It's very hard sometimes to actually engage them in a conversation where they can reason out why they want to stay on the ward or why want to go and come to a mutual understanding of what the best outcome is going to be."

Sophie describes how difficult it can be engaging with service users who are in acute mental distress.

Mick and Susan respectively highlight that the small things can help such as kindness and understanding;

"I think on most wards you will find service users who will quickly suss out who is kind to them and who is indifferent and outright unpleasant to them."

"So listening to people and understanding their needs from their point of view rather than telling them how it is."

It is important to recognise that the character of the nurse includes personal characteristics;

"But I think generally I'm more of a cautious person any way so I think that is what I am probably reflecting the fact that I am more cautious than other people."

This personal characteristic makes Alice more cautious when managing risk, Alice is more likely to reference to the rules when making decisions. Mental health environments can be difficult places to work within, there are practices that can appear *unethical* or feel unethical. Being coercive even if justified can feel wrong. In this case Susan is discussing locked ward doors;

"I just don't like it; I just don't like the idea of it."

Alice talks about restraint in the frankest terms;

"You could say you are assaulting people because you laying hands on people and I know it is frowned upon but I think it is necessary you can't stand there while someone is punching somebody else, and, and they would be putting other patients at risk."

Sophie views coercion as pointless;

"We find with a lot of our patients there is no benefit in coercing them."

This sense that coercion is pointless relates to coercive measure appearing to work in the short-term, however in the long-term it can escalate risky behaviours which is a direct response to freedoms being restricted. Mental health wards and some of the practices undertaken on these wards are not pleasant and potentially not ethical, as described by Bill, Jeff, and Mick respectively;

"Absolutely, I would not now take anybody onto the wards if I could help it if it was a family member, I would not take them near the wards."

121

"Hey what's going on here, straight away from my experiences I knew this was wrong, what's going on here, morally and ethically this is wrong."

"It is difficult because often people are quite clever at being lazy or difficult."

5.7. <u>Final points</u>

It is important to recognise the superordinate themes and corresponding sub-themes do not sit in isolation. It is easy when reading off a page to look at these themes as a list with sub-lists when in reality they are constantly interacting. This sense of interaction becomes more apparent when re-reading the themes, for example Bill articulates;

"*It's not a key thing for me, it's the most important thing in this profession is being treated how you would like to be treated*"

This clearly resonates with Susan;

"*I don't like medication; I always say that to them*"

Nevertheless, these statements are by different participants sitting in different superordinate theme categories. On this basis it is important the reader like the researcher adopts a suspicious attitude constantly questioning which themes go together, obviously for the researcher there has to be a limit to this suspicion or there would be no thesis (Smith et al. 2009). In addition, it is also important to recognise the participants describe their experiences of ethically reasoning in a complex non-linear way, sharing experiences that are personal to them. Building on the findings contained within this chapter the discussion chapter will embed these findings within the relevant theories and literature (Smith et al. 2009). This process of embedding the findings within the literature involved the researcher undertaking a 'bracketed' literature review as explained in the literature review chapter. Once this literature review process was complete the discussion chapter started to emerge.

Table 2: table of superordinate themes for the participant group

Themes	Page/Line
A. The Practitioner	
Being an expert	
I say nowadays it's much more difficult to staff	1.12.416-417
.... it goes to that what mental health nurses call an instinct, it's something you can't quite put your finger on	5.4.130-131
I was actually building on skills around relationship building, brief interventions and solution focused therapies	6.1.13-14
.... I actually wrote up that incident as a reflective incident. That was illuminating for me to be honest with you....	2.4.127
Which has its difficulties and challenges....	3.1.7
..... I was interested in working with people	4.1.8
Enjoying your current role	
I'm happy, and I'm enjoying it	2.1.9
.... certain aspects I still enjoy some of the challenges I don't enjoy as much	3.1.8-9
It's not really a job I would have chosen to do I was never really that interested to be honest but it does have some good points	6.1.15-17
.... It is the hardest job...	4.1.23
Mental health nursing is complex and challenging	
It's about you treat other people and how you react to what they are. So, you know, it's not touchy feely, nursing isn't touchy feely anymore, but, it's, I suppose touchy feely in that way. .... but I think experience counts here....	1.10.365-367
.... you do not know their potential and managing that situation when they first come in it is like you are judging how they are acting and behaving...	2.6.197 3.5.196-198
...... they are at a difficult stage of life and they are often in a much more fraught state	4.1.28-29
It is really difficult mental health, it's not black and white you can't look inside people's heads.....	5.4.131
On the wards it tends to be a bit like whoever shouts the loudest gets the most attention and the people who need your time more get left	6.1.31-33
Good role model	
.... ethics came up but I will be honest my education in ethics is very limited as many nurses would say	2.4.116-117
.... I always felt and hope I am the kind of person where people can come up to me and say what is your reasoning behind it...	3.1.29-30
..... one of the most important things is to greet that person...	1.13.451
..... but if people are, drift into being cynical or uninterested or disdainful of the people we are caring for then that is not acceptable	4.9.336-337
You have always got to do the best by people whether it's in work or outside work	5.12.380-381
If you really do want to help people	6.5.161-162
B. Values	
Trust and honesty	
..... it is not telling lies but it is deceiving the patient	2.3.96
.... the first thing you have got to do is be honest	1.1.27
If you're honest with people they're more likely to work with you I think	6.5.157-58
..... the underpinning values about which you form your judgements....	4.5.151
.... I felt in that situation is was necessary to build that trust	5.13.407
Treating people how you would like to be treated	
It's not a key thing for me, it's the most important thing in this profession is being treated how you would like to be treated	1.8.263-264
So I suppose an ethical example might be something like treating people, like everyone has a right to life, which is enshrined in the human rights act, in ethics we refer to that like the right to family life, the right to life and that is something we make reference too	4.5.154-157

It's common sense and its respect for the person and I always think and for myself I think you always treat people how you want to be treated yourself	5.12.378-379
Well treating people like you want your own relatives to be treated, that is what ethics is about	6.5.160-161

Being person-centred

it doesn't make them any different, no difference, you are a person first and foremost	1.10.346-347
..... you've got to respect people's choices....	2.2.57
... obviously the patient is the priority and what they want is the priority	3.3.100-101
I suppose that is down to each individual to have that self-awareness to pick upon the signs of that person.....	4.2.75-76
.... I always tried to do my best and the best is respecting the person and its common sense	5.12.389-390
.... they are no less human beings and probably need to be protected....	6.5.173-174

C. Clinical Practice

Acute mental health is not a place

.... we do deal with people in the acute phase in the community	1.2.51-52
I'm a staff nurse in acute mental health....	3.1.4
..... as long as it is not hurting anyone else then it is their right to be ill without that interference	4.4.143-144
If somebody was standing on a bridge ready to jump then I would intervene you know to stop them, to try and stop them but it wouldn't be my responsibility, do you know what I mean	5.2.51-53
When people do become unwell in the community and you have that relationship with them.....	6.2.39-40

Team working

Ahem because there is not enough staff, you know, and this is a Trust wide issue isn't it, ahem we have got less beds, less staff	1.7.225-226
..... so they are like two completely separate teams really	6.2.68-69
I think nowadays it is more of a multidisciplinary approach	5.5.155-156
there were opposing views on the team	2.7.249
I think about it afterwards and talk about it with the team	3.5.162
..... 66 people in a small brick box....	4.10.364

Being a clinical decision maker

..... on a professional level, you know, you have a discussion, you debate the issues, and see what the best option available for our patient is	2.4.136-137
.... I have a duty of care to explain why I have used it and it has to be in your best interests	3.2.50-51
.... but on reflection I did think it had been the right decision....	4.7.238
You wouldn't want to see someone trying to kill themselves or harm someone else	5.2.53-54
it's not enough time to really understand what they're going through and help them, and I just get them back on medication and stable and out again.	6.1.24-26

Options are influenced by risk

.... I would feel comfortable if there was the options left to us to do, we have explored all the options	2.4.141-142
I would say I'm concerned about the safety; a lot of them want to go because they want to harm themselves....	3.4.151-152
Yes there the major issues....	1.8.269
It is risk that separates it out, yes	4.4.146
Well its necessary when anybody has to go out or anything you are constantly risk assessing the situation and themselves, so it's a necessity to have risk assessment of the basis of everything that you do and what you base your judgements on	5.4.109-111
Because of his presentation, being very agitated and potentially risky, the team agreed to stop his leave	6.5.154-155

A duty of care is an obligation to act

...if somebody who is known to be suicidal starts expressing suicidal ideation...	1.5.179-180
.... I've got a duty of care to you, I can't let you go out....	5.4.123

..... I hate doing it but if I have to I will, if it is required to over the issues of health and safety......	2.6.205-206
I think is that quick the decision sometimes, it does come with experience knowing when to do it....	3.5.170-171
..... to make sure you are aware of what is actually happening with the most vulnerable people you are responsible for and make sure that they are getting a good and fair responsive treatment from the service	4.7.229-231
<u>Being therapeutic at all times is essential</u>	
..... there can be a lot of friction between some of the service users....	3.3.58
So trying to get their attention, trying to get them in the time, place and person, using your relationship to manipulate that situation...	5.10.316-317
.... and because we have developed a good relationship over the years I managed to convince her...	6.2.59-60
If you are member of this society you have a right to have your life valued and to be taken care of.....	4.5.164-166
<u>Weigh up all the options</u>	
.... we looked at options about what we could do...	1.8.283
...... you want to try and encourage people to talk to you as to why they want to go, and just explaining to them we do not want to go down this road, they're a lot of other options...	
.... I would rather they responded individually...	3.5.181-183
We can't foresee we can't read people's minds or anything so we done our best with the process, we have done our best to the best of our knowledge	4.10.368-369 5.6.184-185
It should only be ever used as a last option...	6.6.204

D. Coercion

<u>Restricting freedoms</u>

.... that's coercion. You know, getting somebody to do something they don't really want because you want them to do it	1.2.67-68
..... coercion is every day, I go to work and there is coercive elements every day in my encounters with the people I work with	2.1.14-16
My understanding of coercion is making a service user do something they do not want to do by whatever means is required.....	3.1.11-12
I suppose it's to some degree if anyone is here against their will....	4.1.32
..... I suppose you can look upon it that is quite a paternalistic sort of role in that you are doing something for somebody in their best interests even though they don't think so at the time, because of the nature of their illness	5.1.24-26
Making people do something they don't want to do in a bullying way maybe, usually something unpleasant. You don't need to coerce someone into doing something nice do you	6.3.103-104

<u>Reluctant use of power</u>

.... I don't like that, that's not part of the job that I enjoy....	1.3.84
..... we are saying we are trying to persuade a service user to do a certain thing or a course of action	2.1.18-19
It's a bit like a power play....	3.1.37
Sometimes we have to coerce people to take medication if they are detained under the act and it is prescribed such as depot medication	4.2.38-40
.... it's not about what I personally want to do, it's for the greater good...	5.2.33
Using the word coercion seems a bit strong but yes sometimes we have to make people do things they may not want to do at that particular moment in time	6.3.106-107

<u>Pressuring and persuading</u>

In that respect I have seen staff speaking to service users, applying sort of pressure, it's not a negotiation it's telling people what to do type of thing	2.1.26-27
I think sometimes, it depends on where you're coming from and why you want to persuade them....	3.1.19
So I would see that as coercion, I think we do it for a valid reason but it's still coercive doing something against their will	4.2.44-45

Probably, yes it probably is, because you are still making someone do something they don't want to do but persuasion suggests giving reasons for doing it rather than coercion which suggest just do it because	6.4.113-115
Persuade, yes, it just feels as if you trying to trick someone and you're not treating them with respect, not respect, but I don't know it feels more I don't know it does not feel as nice as persuade	5.3.78-80
... the patient has got choices, but sometimes you have got to say; 'well look is that the best choice you are making for your long term recovery needs'	1.3.89-91

Coercion is based on a duty of care

I don't know how to phrase this really, basically they are ill and we are intervening to try and help them recover, I suppose	4.3.107-109
..... if you have got a good rapport with that person and you use the staff in the right way.... Yes, it's a duty of care	3.6.223-224
I suppose you work within the nursing code of conduct as I said before about respecting privacy, confidentiality, and all that works within that	5.2.59
Stay on medication that they don't want to really be on, you know, they need to go into hospital that they need to stay in hospital	1.9.323-324
	6.4.122-123

Sensitive coercion

You do not want to do it because there is always the potential that they might get hurt or a member of staff might get hurt	3.4.140-141
I think we are still aware we are coercing them and what we are doing is not with their consent	4.3.90-91
I would give it orally	5.11.349
They have got the same feelings, the same worries and the same concerns, as you or I have	1.13.447-448
I don't like medication; I always say that to them	6.4.133

Risk a mediating factor

To my mind it is knowing your patients, it is knowing your patients and it is judging their state of arousal....	3.4.135-136
It's not the diagnosis that gives us the right to intervene and I thinking more towards the mental health act and it is simply if they are going to harm themselves or others then that gives society under the current law the right to intervene	4.4.131-133
.... when it starts to affect their quality of life or their not fully self-caring, erm, or it is impacting upon their activities of daily living....	1.5.183-184
.... risk assessment is something you can use to persuade people or coerce people, the results of that risk assessment you can use for doing that, for persuading people, for coercing people	5.4.118-120
If someone is in a position why they are going to do something that will harm themselves or someone else again the same rules really. At that time it is the only course of action that will prevent that from happening	6.7.226-228

Knowing when to coerce is a dilemma

..... I never would have forgot it in my life	4.7.240-241
I always used to have the problem of when do go in to restrain them	5.10.323-324
Although it was controlled and probably very different to a normal incident I still felt uncomfortable	6.6.217-218
.... what makes you illness worse or better, how can I support you to do this and this....	1.3.103-104
So trying to keep people and the situation safe for everybody was difficult...	3.6.209

Best interests

And certainly very much around giving people the choice of what they think is best, sometimes I have got to make a decision they don't like	1.3.73-75
I think I understand in my mind it's about thinking about them and the best outcome for them	3.1.22
.... I truly believe it is the best thing for you to do....	6.6.195-196
..... most vulnerable people you are responsible for...	4.7.230-231
So it might be a case of preventing people from leaving or you are trying to persuade them to stay as a patient or you are persuading them to take medication for their mental state with the ultimate aim of making them better, for their own good	5.1.26-29

Potentially abusive	
.... it's not a nice experience being locked in there; I don't think as a patient it's a good experience to be locked in	1.12.428-430
.... restraint is always a big ethical issue for me it can be different things, autonomy, the experience, the degrading experience for people and it's de-humanising	2.6.231-233
Other times you find people using it not in the best way....	3.2.42
.... there is a cost to pay in as much as you are sometimes left with a very angry and humiliated person	4.3.97-98
I have said it myself, look if you don't take this medication we are going to have to give it to you by inject and we really don't want to do that. You know if you don't stay on the ward we are going to have to get you assessed under the mental health act	5.3.97-100
it is the ultimate act of taking people's liberty way, holding them down	6.6.205-206

E. Ethics

Ethics in practice	
It's like the doctor thing, first do no harm, you know and I think that, erm, is important in nursing as well as, you know	1.9.330-331
Trying to keep it simple in my mind ethics is concerned about what's right and wrong in situations that informs our practice	2.2.62-63
It's about right and wrong basically.....	3.3.92
.... I suppose ethics have evolved quite quickly in terms of mental health compared to say physical health care....	4.5.170-171
Doing the right thing	5.5.166
It's about your intent when you're working with vulnerable people	6.5.161
Right and wrong are relative to the situation	
...... obviously it doesn't work in every situation....	1.13.456
It's not what is right for me it is what is right for the patient	2.3.69
.... what might be right for them...	3.3.94
That is what I want people to do to sort of look at the 'there and then' situation and try and decide what is safe, fair and respectful and promotes autonomy for that particular situation....	4.11.379-381
Yes, even if people had run off	5.8.242
Ethical rules	
Yes, life is governed by rules, you know, and there are certain things within nursing, you know, that are no-no's in nursing	1.9.314
.... it was wrong legally and ethically for that person as a human being it was the wrong thing to do	2.3.87-88
..... understanding there are certain guidelines you have to go by, and make them aware that certain things you can and can't do	3.3.101-102
.... the rules I suppose protect the patients when they're at their most vulnerable	6.5.174
I suppose what I want is people to move away from sets of rules of how or what we expect of the service users that we might coerce them into and move towards a sense of ethics	4.10.372-374
Yes if you follow policies which are there to protect you and if you follow policies you cannot go far wrong	5.7.209-210
Everyday rights and duties	
How about developing the social skills of the people looking after them	1.11.403-404
I think so yes let's be honest with you personally yes, but this is deceit without telling lies, ...	2.3.99-100
..... we are all here as public servants	3.3.109
If they are really unwell you know they may have lost their autonomy by the nature of their illness so you have to act for them, you have that duty of care, makes you do your job	4.7.226 5.6.189-191
.... I suppose ethically that is what that is about fairness, you know, being respectful and being fair	6.6.181-183
Ethical outcomes	
You have got to give people the choice....	1.4.147
.... if somebody is saying to me and expressing that they are going to commit suicide I feel quite, and not would say justified but I feel comfortable in doing restraint if I need to	3.4.154-155

Went off the ward on unescorted leave and went home and hung themselves	4.7.235-236
…. our duty of care would be to ultimately to protect that person and for that person to have not killed themselves	5.6.200-201
it's not being dishonest just trying to show that there is a purpose and a point to medication sometimes	6.6.199-200

Ethical decisions have to be reasoned

….. affecting the quality of life….	1.8.275
I would say we have never been given any legitimate reason by management as to why we have done it	3.3.110-111
I don't care whether he doesn't match your criteria	4.6.200-201
Absolutely you don't just do it, you do it if they are going to hurt themselves or refusing to take medication….	6.7.222-223
Yes, justifying yourself	5.8.246

Ethics is multifaceted

Whereas if you don't know someone then perhaps it's easier to sort of be, I suppose coercive	1.14.495
I think some ways it might, I think if you know someone you have a fair idea of how they respond to certain things or how they might behave when they first come in	3.6.216-217
I suppose in my house my door is locked but as I can go I do not see it as a locked door	4.11.397-398
Even though I follow policy there are times when my duty of care to patients overrides that	5.7.230231
…. I think there is a difference between being a voluntary patient and being a detained patient….	6.7.236-237

The character of the nurse

I think the vast majority of nurses have the same sort of ethics and morals that I do, don't get me wrong, I don't think a lot of people would come into the job otherwise	1.14.491-492
It's very hard sometimes to actually engage them in a conversation….	3.4.144-145
…. who is kind to them….	4.9.316
but I think generally I'm more of a cautious person any way so I think that is what I am probably reflecting the fact that I am more cautious than other people	5.5.161-163
So listening to people and understanding their needs from their point of view rather than telling them how it is	6.6.191-192

Unethical

Absolutely, I would not now take anybody onto the wards if I could help it if it was a family member, I would not take them near the wards	1.13.465-466
…. straight away from my experiences I knew this was wrong, what's going on here, morally and ethically this is wrong	2.3.84-85
We find with a lot of our patients there is no benefit in coercing them	3.7.266-267
I just don't like it; I just don't like the idea of it	6.7.238-239
It is difficult because often people are quite clever at being lazy or difficult	4.10.353-354
You could say you are assaulting people because you laying hands on people and I know it is frowned upon but I think it is necessary you can't stand there while someone is punching somebody else, and, and they would be putting other patients at risk.	5.9.289-291

Chapter 6: Discussion

6.1. The key discussion points

The intention of this chapter unlike the findings chapter will be to link the overall themes with the relevant theories and literature (Smith et al. 2009). To maintain the phenomenological essence of the study there is an on-going commitment to value the participants' rich emotional experiences by making reference to the participants' insights through selected extracts (Eatough and Smith 2006, Smith et al. 2009, Shinebourne 2011). Similar to the findings chapter the original transcription texts are the source for these insights and consistent pseudonyms are used throughout. Furthermore, it is acknowledged this chapter will always be a complex dialogue between the literature, the participants insights, and the researcher making sense of the participant making sense of their experiences (Smith et al. 2009). To focus this dialogue, again similar to the findings chapter, the superordinate themes provide a structure for this chapter. The discussion section (Smith et al. 2009) aims to engage in this dialogue by considering whether; the findings illuminate or problematize the literature, the existing literature illuminates the study's findings, and are there are there unexpected findings, if so, how do these findings link to the literature?

Linking the literature to discussion was a cyclic process, which started with a bracketed review of the literature, the initial process produce the research proposal and identified the knowledge gap. After the analysis stage generated the superordinate themes, a fuller literature was undertaken and during this stage, the discussion chapter started to emerge hermeneutically (Smith et al. 2009, Boell and Cecez-Kecmanovic 2014). This knowing was bracketed during the writing of the findings chapter and revisited once it was time to write and refine the discussion chapter. In addition, to providing an in-depth analysis of the findings the discussion chapter is also an opportunity to evaluate what has been learnt from engaging in the study (Smith et al. 2009). To address what the researcher has learnt this chapter contains a section on the researcher's reflections. The conclusion chapter addresses other considerations including identifying the strengths and limitations of the study and discussing the implications for practice and future research.

6.2. The practitioner

The mental health nurse uses different ways of knowing when managing coercive situations; knowing includes 'feeling for the right solution', which involves the use of tacit knowledge, also known as intuition. Accordingly, the participants have developed their knowledge over a number of years and in different ways. Currently mental health nurses are expected to be degree educated at the point of registration, however this was not always the case, until the last few years the minimum requirement at the point of registration for pre-registration nursing programme was at diploma level (Nursing & Midwifery Council 2010). After registration there is an expectation the mental health nurse will continue to professionally develop, this development can be undertaken through both informal and formal learning (Nursing & Midwifery Council 2015a).

This learning feeds into the mental health nurse's reasoning endeavours at a moment in time or within a given situation; Jeff articulates;

"You are thinking of the service user and also their physical issues and stuff. Do we really need to do this?"

This brief and simple question is part of a self-questioning process which is used to elicit a 'storehouse' of knowledge to further in this case Jeff's learning (Welsh and Lyons 2001, Crowe and O'Malley 2006, Jasper and Rolfe 2011). During this process of learning the mental health nurse is accessing different forms of knowledge which they have engaged with including tacit knowledge (Welsh and Lyons 2001). This learning builds upon their pre-qualifying and post-qualifying activities which the mental health nurse converts into usable knowledge or knowing (Welsh and Lyons 2001). This knowing corresponds to the ways of knowing identified by the work of Carper (1978); empiric, esthetic, personal, and ethical. These ways of knowing interact and are shaped by the practitioner's individual experiences of being a practitioner, they in turn shape the mental health nurse's own understanding of their practice (Benner 1982, Welsh and Lyons 2001). To be expert the mental health nurse has to be reflexive while at the same time have a high level of skills underpinned by the four ways of knowing (Carper 1978, Benner and Tanner 1987, Hardy *et al.* 2002). The challenge with using all four forms of knowing is that empiric knowing tends to be the most valued way of knowing (Welsh and Lyons 2001). This value has arisen through advent of evidence-based practice (EBP), which is the dominant form of scientific knowledge within healthcare (Gournay 2009). On this basis the mental health nurse is more likely required to use this type of knowledge to justify the clinical decisions they make (Gournay 2009). The limitation of this approach is that empiric evidence is not always readily available in every situation and where it is available it may not be adequate for the needs of the mental health nurse who may be making a complex and real-time decision (Welsh and Lyons 2001). For example evidence-based practice is based on using the best evidence available, which includes on a sliding scale the systematic review of Randomised Control Trials (RCTs) down to the testimonies of clinical experts (Gournay 2009). This evidence is generalisable and gives the mental health nurse an idea of what they should do however it does not give the nurse all the solutions to all the challenges they may face. In situations where time to react can be limited, as highlighted by Jeff, making a decision and acting is more instinctual;

"At that moment the service user attacked me, and within a seconds of that happening the service user grabbed me by the throat. So my time to react was to use a breakaway technique .... in a few seconds other members of staff arrived."

The limits of empiric knowing is not surprising even though Gournay (1995) has been dismissive of other forms of knowing, however there is an acknowledgement there are gaps in the body of knowledge that need filling. For Gournay (1995) only scientific knowledge which uses rational and objective methods can fill these gaps whereas for Franks (2004) scientific knowledge cannot claim to be the absolute truth. And yet if we consider how risk should be assessed there is an expectation that all four forms of knowing are used (Welsh and Lyons 2001, Wand 2011, Coombs *et al.* 2013). Using tacit knowing is a common phenomenon; however it does not always hold the same value as empiric knowing which in healthcare is underpinned by evidence-based practice (Benner and Tanner 1987, Welsh and Lyons 2001). It is evident that as experienced nurses all the participants use tacit knowing or intuition to address clinical problems that are complex, have no clear outcomes, and are in real time (Welsh and Lyons 2001). However, when reflecting after a significant event has occurred the participants provide an intellectualise rationale which attempts to link their actions to the relevant rules and/or evidence-base (Welsh and Lyons 2001, Hardy *et al.* 2002). Tacit knowing is situational and relativist which becomes functional through the mental health nurse reflecting on action in a structured way, during what is usually an on-going activity the mental health nurse converts tacit knowing into a more usable form (Polanyi 1958, Welsh and Lyons 2001). Welsh and Lyons (2001, p.304) describe this conversion process as a process of building a virtual 'tacit knowledge store', in addition this 'store' is underpinned by the mental health nurse's empiric knowing. This store of tacit knowing is then activated by the mental health nurse reflecting-in-action (Schön 1983) and then pattern matching (Crook 2001); knowing a situation. This knowing a situation is also about knowing people, Sophie highlights how this knowing works in practice;

"To my mind it is knowing your patients, it is knowing your patients and it is judging their state of arousal, if you feel that they listen to you and are willing to engage with you and talk with you why they want to go out and what's going on and what's causing the reasons, the thought processes why they want to go. Some of them you can verbally de-escalate and they will come away and talk to you, others no matter what you say to them or how you try to get to the reasons why they want to go they will still go to the degree where you have to use C and R."

As tacit knowing is accrued through the mental health nurse's work with the service user it is framed by the therapeutic relationship and it is dependent on the length of time the nurse has known the service user (Smith 2012a). Bill provides an example of the importance of 'knowing a service user for a length of time';

"Erm, valuable resource non-medical prescribing I feel in that I know the patients and know them better than the doctors do, as a lot them I see on a regular basis, so my own, erm, caseload of people, erm, most of them I have known at least over ten years. Erm, so they tend to trust me to make a decision around medication more than perhaps they would a doctor."

This therapeutic relationship is the medium for treatment with the service user's story or narrative driving this process (Bracken and Thomas 2005, Hurley and Rankin 2008, Smith 2012a). Mental health nurses will use different types of interventions within the therapeutic relationship, most will be 'talking therapy' focused, however, the mental health nurse is not usually a specialist in a particular talking therapy (Hurley and Rankin 2008, Nursing & Midwifery Council 2010). A key part of this way of working is the requirement to truly listen, which can be a challenge when there is a need to interpret and reinterpret a service user's story with the emphasis on making a clinical judgement (Bracken and Thomas 2005, Smith 2012a). The risk of reinterpretation is that the service user's story is presented in fragments, such as in the case of using an assessment tool, this can mean that the true meaning of the story is lost (Bracken and Thomas 2005). It can also mean this information does not give a full enough clinical picture which can present as a challenge when trying to manage a service user's behaviour; Sophie highlights;

"*It's a judgment call, a typical example; the other night I got a new admission in a young person who had never been an in-patient who had contact with services in the community. This was a slightly different presentation to how the service user was in the community and the service user comes in, it is judging how the service user is going to be and the service user's behaviour escalated, the service users parents were there, and it is trying to judge how you manage the environment around the service user.*"

The type of environment the mental health nurse works in also contextualises effective practice effectively, whether this be the support they receive or whether they have chosen work in a specific environment. This environmental impact does not take away from the participants always trying to be a 'people person' and learning from their practice, however, it illustrates that the role of the mental health nurse is a challenging and complex role with its effectiveness influenced by a multitude of factors. Sophie illustrates;

"*I have to say I'm not happy at this moment in time. It is challenging role and certain aspects I still enjoy some of the challenges I don't enjoy as much*".

These challenges whether it relates to being able to fully listen or enjoying a particular role can impact upon the mental health nurse's effectiveness as an ethical reasoner. To be an effective moral reasoner the mental health nurse has to be 'morally sensitive'. To do this they have to be able to identify the ethical issues at play and they also have to be self-aware which includes having the psychological and social resources to understand, manage, and control their own levels of moral distress (Fulford 2009, De Veer *et al.* 2013).

Coercive situations can be morally distressing and difficult to manage, however mental health nurses are expected to be emotionally intelligent enough to work through these situations in way that all parties are safe (Dierckx de Casterle *et al.* 2008, Bowers *et al.* 2010, Nursing & Midwifery Council 2015a). Jeff talks about managing their emotions when dealing with a distressing situation;

"Of course, afterwards the adrenalin hits you, hairs stood on the back of my neck, someone grabs you by the throat, against the wall, In front of your face. I used a breakaway technique, members of staff came along and I stood back, you probably take a minute or two but I think experience counts here, you say to yourself look here, you know it's not a big individual that's coming at you here, you are looking, you know, the likelihood of someone coming around to do you again you are trying to keep your emotions in check but you are conscious of that, your first minute or two your adrenalin, you are scared and you are frightened but you are trying to get your emotions back in control. Obviously you visualise someone that size with limited mobility, you dust yourself down quickly, and come on, but it only took a minute or two, the other staff got the service user into their room, and I got back into control of the situation."

In addition, mental health nursing has an interpersonal dimension which relates to knowing the service user in a way that it is not just about following the rules it is also about understanding the values inherent within the situation and managing any conflict that arises (Cohen 2004, Woodbridge and Fulford 2004, Fulford 2009). Being distracted whether it is internally or externally can lead to not listening and not paying the right amount of attention, when this happens it is easy to assume certain things about the service user or the situation (Bracken and Thomas 2001, Bracken and Thomas 2005). Sophie highlights the adverse impact of a noisy and conflicting environment;

"There is a lot of noise and there can be a lot of friction between some of the service users especially when we seem to have a high input of service users with an EPD, emotional unstable personality disorder. We have three or four of these service users in, it causes a lot of stress, a lot of anxiety on the ward to have to manage that as well as the other service users, there is a lot of friction between the other service users and these particular service users because there is a lot of input managing their behaviour so you can't give a lot of time to the other service users which can be frustrating for service users and the nursing staff."

One way the mental health nurse deals with internal distractions is to be empathetic and focus on the moment, the task in hand, rather than what may need to be done in the future (Wilkin 2006, Richards *et al.* 2010, Johns 2016). This approach imbues the therapeutic relationship with an ethical dimension, one that the mental health nurse has to make sense of and in a way that meets external expectations (Ford 2006, Nursing & Midwifery Council 2015a).

On this basis the mental health nurse has to be skilled enough to build a therapeutic relationship even in the face of knowing that there may be a chance they will have to employ coercive strategies (Bowers *et al.* 2003, Bowers *et al.* 2006, Bowers *et al.* 2010). All the participants recognise the importance of the therapeutic relationship and within this relationship the nurse's ethical role to keep the service user safe. This process involves making difficult emotional decisions including decisions that that involved the use of coercion (Roberts 2005). It is not managing complexity itself that is a challenge it appears to be managing complexity where there is role dissatisfaction (De Veer *et al.* 2013). This aspect is especially important when considering the nature of the nurse's role within an acute mental health context where the role can be complex and challenging (Currid 2009, The King's Fund 2015). On this basis an inference can be made that being comfortable within a role is an important mediating factor when dealing with ethically difficult situations. In addition to being comfortable within their current role the participants acknowledged 'being experienced' partly helps them to deal with complexity. There is also a degree of making an educated guess; however, this guess has to be justified. Mental health nurses are professionally accountable for their decisions even when dealing with a high degree of complexity (Dierckx de Casterle *et al.* 2008, Nursing & Midwifery Council 2015a).

This educated guess is based on knowing the service user and having a sense of what the best emotional response would be for that individual. There can be a tension between 'being scientific' and 'being emotional', however being a good role model and having the right values appears to be a mediating factor, this includes treating people well. Justifying how you treat people has an ethical dimension; however, it is less about knowing ethical and scientific theories and more about being the right kind of person and having the right skills. Jeff highlights;

"I want to discuss with people different ways of dealing with their anger whether it is punching pillows, whether it is throat plastic cups around, I would discuss different avenues to express that anger."

Mental health nursing practice is different than the practices of psychiatry and clinical psychology. Psychiatric diagnoses, which evidence-based practice within the mental health field is largely based on, does not fit as easily into the practice of the mental health nurse. A fundamental problem with this scientific approach to mental health nursing practice is that this largely 'reductionist approach does not necessarily meet all the requirements of service users with complex mental health needs' (Welsh and Lyons 2001, p.300). A clear example is the way clinical risk within mental health nursing practice is managed, there is a tendency to use risk assessment tools which are seen as being scientific, however part of the process also requires the nurse to know the service user which falls into the realm of tacit knowing (Welsh and Lyons 2001).

Being too reliant on scientific knowing could mean that the non-reductionist richness of the therapeutic relationship is potentially lost (Crook 2001, Welsh and Lyons 2001). Jeff makes the point;

"That is what I want people to do to sort of look at the 'there and then' situation and try and decide what is safe, fair and respectful and promotes autonomy for that particular situation and not just say the rule we do this."

Carlsson *et al.* (2000) highlights that information from the therapeutic relationship can be lost if the way the data is collected is not sensitive to the subjective element of this relationship. On this basis a one dimensional approach to knowing does not help the mental health nurse in situations that are complex and also require a rapid response (Welsh and Lyons 2001, Dierckx de Casterle *et al.* 2008). Perraud *et al.* (2006, p.217) describes the therapeutic relationship as the 'key context for all mental health nursing interventions', there is a caveat in that there is no 'universal consensus on exactly how to frame this relationship'. It is acknowledged this relationship should be person centred, collaborative and based on interpersonal principles (Wilkin 2006, Silverstein 2008). Therapeutic relationship work is also based on empowering the mental health service user, before this can happen the mental health nurse through the skilled use of empathy has to understand the mental health service user's perspective (Reynolds *et al.* 2000, Silverstein 2008). Empathy is a complex term with many definitions, however, empathy is viewed as an important skill used within mental health nursing practice, a skill that is central to the effectiveness of the therapeutic relationship (Perraud *et al.* 2006, Kane *et al.* 2014). The challenge of being empathetic when using coercion is articulated by Alice;

"Yes, because I think you maintain the relationship with the person, if I went into to restrain people I would always worry how that would affect the nurse patient relationship, because if someone restrains you it's got to affect you, you might not remember if you were really unwell, some people have looked back of situations and their never glad you restrained them they acknowledge that they needed that at the time because they weren't in control of what they were doing and they couldn't act for themselves, or how they would normally act so they could understand it. At the end of the day I certainly wouldn't want to be restrained, it must be really frightening, its trying to maintain that relationship."

6.3. Values

The practitioner has to be the right kind of person this also means having the right kind of values. The two key values highlighted by the participants were honesty and trustworthiness. This relates to both possessing these traits and knowing how to use them effectively within the therapeutic relationship (Mckie and Swinton 2000, Radden and Sadler 2008).

Having the right values or in effect character traits is seen as increasing the potential that the practitioner will do good or there will be good outcomes. Doing good based on character traits falls into the realm of the moral theory of virtue ethics, this is where the character of the practitioner is the basis for ethical action (Smith and Godfrey 2002, Radden and Sadler 2008). There is a lack of agreement about what these virtuous traits should be and also how they are attained, however, Smith and Godfrey (2002) highlight that virtuous traits for nurses are situated within the standards of nursing. Looking at these standards it is expected that a nurse has the traits of kindness, compassion, honesty, integrity, and fairness (Nursing & Midwifery Council 2015a). Possessing these traits is not enough, the nurse also has to know how to apply them even in the most difficult situation which includes applying coercive strategies (Armstrong 1999, Armstrong *et al.* 2000, Armstrong 2006). This is a challenge as the mental health nurse has to know when they are being compassionate and fair even if the service user may take a different viewpoint, which can happen in difficult ethical situations (Woodbridge and Fulford 2004). Susan highlights how they make sense of 'honesty as a trait' within their practice;

"Because it keeps them well, I don't like medication, I always say that to them, if I was in their situation having to take medication every day and the powerful medication they have to take as well, I don't think I would be very impressed either but at that period of time it is keeping them mentally well and it is important that they stay on it to ensure they do stay mentally well, like the lady above she started to improve when she went back on her medication and could join in with ward activities and trips and stuff that she likes doing"

As well as knowing the right character traits to use and when they should use these traits the mental health nurse has to also be motivated internally to be virtuous rather than being externally motivated by external rules (Armstrong 2006, Radden and Sadler 2008). In addition to these character traits the mental health nurse has to be able situate these traits within their practice in a way that builds and maintains the therapeutic relationship with a specific focus on being person-centred and empathetic (Mckie and Swinton 2000, Armstrong 2006). Using traits in this way can be a challenge especially where following rules which can be seen to be the right thing to do from an organisational perspective, these rules may send the nurse in the wrong direction and lead them into conflict with the service user (Bowers *et al.* 2010). However, as Sophie highlights you can abide with the rules which includes flexing them where needed if it meets the needs of the service user;

"I wouldn't say I break the rules as such obviously the patient is the priority and what they want is the priority but understanding there are certain guidelines you have to go by, and make them aware that certain things you can and can't do. And working with them to work out the best outcome for them but in a way that's not breaking the rules for anybody. So it's making everyone else aware what's the right choice to make."

Flexing the rules means the virtuous mental health nurse has the flexibility and wisdom respond to each situation on its merits (Gardiner 2003, Bowers *et al.* 2010). Similar to the expert mental health nurse they have the ability to feel for a solution (Welsh and Lyons 2001). This ability to feel for a solution is based on the virtuous mental health nurse's use of their tacit knowing, this type of knowing can be seen as a virtuous character trait (Berg 2008). Possessing ethical wisdom enables the virtuous mental health nurse to be emotionally sensitive and really understand the emotional context of a given situation (Gardiner 2003). In addition, it gives the mental health nurse the latitude to make the right choice, at the right time, and in a way that this choice can also be viewed as being ethical (Gardiner 2003). In essence this way of managing situations in an expert and sensitive way may reduce the occurrences of practices that can be perceived as being unnecessary and possibly abusive (Ryan and Bowers 2005, Chodoff 2009, Bowers *et al.* 2010). Having the right character traits or for some the right values underpins the development and sustainability of the therapeutic relationship (Armstrong 2006). A key value highlighted by the participants is the value of 'treating people how you would like to be treated'. This value in effect humanising the therapeutic relationship it also acknowledges the influence of the human element when making clinical judgements within this context (Woodbridge and Fulford 2004, Fulford 2008). Obviously mental health nursing is a human endeavour one, however it is also an endeavour that is framed by the rules which includes policies, and legal and professional frameworks (Ford 2006).

These rules provide guidance, however a level of interpretation is required which is always dependent on the values and attitudes of the interpreter, in this case the mental health nurse (Coady 2009, Fulford 2009). This is especially important when considering the nature of the therapeutic relationship where the nurse holds the power to coerce (Roberts 2005). This power is both explicit and implicit it also has a 'hanging over your head' potential, if the service user does not conform this power could be used to ensure they conform (Roberts 2005, Cutcliffe and Happell 2009). This is why it important that the mental health nurse recognises the nature and impact this power can have upon the therapeutic relationship, once recognised they must put into place strategies to mitigate its effects (Woodbridge and Fulford 2004, Roberts 2005, Cutcliffe and Happell 2009). One way of doing this is for the mental health nurse to be committed to engage in an open dialogue with the service user which recognises the values inherent within the therapeutic relationship, they must also skilfully takes into account the service users viewpoint (Lamza and Smith 2014). Taking this position requires the mental health nurse to actively pay attention to the service user's viewpoint, frame it within the 'rules' without losing the essence of the narrative, and then make sure the service user's viewpoint is fully represented throughout the delivery of care (Woodbridge and Fulford 2004). It also important not to have a 'catch-all' approach as highlighted by a Susan when talking about the use of locked doors and potential outcomes;

"People who are mentally unwell don't necessarily have to be nursed on a locked ward not everyone wants to run off but they'll probably do it anyway even if the ward is locked."

Another challenge for the mental health nurse is to 'know the service user' and in a way that is ethical, or as highlighted by Carper (1978) using ethical knowing. This knowledge is generated through the mental health nurse constantly engaging in an ethical dialogue with the service user which answers ethical questions in a way that the rules cannot (Carper 1978, Welsh and Lyons 2001). As an example following the rules rigidly can exclude the service users voice especially where a course of treatment is chosen on the basis of what the guideline indicates rather than what the service user wants (Bracken and Thomas 2001, Bracken and Thomas 2005). Treating people in way that you would like to be treated is expressed as a 'common sense' approach, however it can also be seen as an approach based on duties and rights that frames ethical knowing. Susan highlights;

"Well treating people like you want your own relatives to be treated, that is what ethics is about."

This approach is less about ethical theory and more about what you ought to do as a mental health nurse, which is framed by the a professional code (Coady 2009). The code requires interpretation and on this basis the mental health nurse needs to know how the code fits into their practice, bearing in mind there is the caveat that '*the values and principles set out in the Code … are not negotiable or discretionary*' (Nursing & Midwifery Council 2015a, p.2). As with any rules, not just the professional code of conduct, the mental health nurse knowing how to apply them in complex and real time situations can be a challenge (Ford 2006). However, irrespective of this challenge there is an expectation that the code will be applied correctly whatever the situation, if not a sanction may be applied (Nursing & Midwifery Council 2015a). If the nurse is not sure then it is argued they should not act as they could be acting outside of their level of competence;

"Recognise and work within the limits of your competence. To achieve this, you must:
  ➢ *accurately assess signs of normal or worsening physical and mental health in the person receiving care*
  ➢ *make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment*
  ➢ *ask for help from a suitably qualified and experienced healthcare professional to carry out any action or procedure that is beyond the limits of your competence*
  ➢ *take account of your own personal safety as well as the safety of people in your care, and*
  ➢ *complete the necessary training before carrying out a new role."*

(Nursing & Midwifery Council 2015a, p.11)

Rules though not all encompassing provide certain protections, Susan articulates this point;

"I think that just because someone has problems with their mental health and may lack capacity they are no less human beings and probably need to be protected, the rules I suppose protect the patients when they're at their most vulnerable."

The code of conduct does not, as with any code, tell the practitioner what the right course of action should be, this is not a function of the code as there will always be the expectation that the mental health nurse as a trained practitioner will know ethically what to do in the most difficult of situations (Nursing & Midwifery Council 2010, Nursing & Midwifery Council 2015a). Coercive situations can be complex and difficult, being able to use the rules is helpful, however being experienced is also helpful, especially if the mental health nurse has faced a number of similar situations before (Berg 2008). Experience only counts if the mental health nurse is able to assimilate that experience in a way that it becomes useable learning (Welsh and Lyons 2001). Berg (2008) highlights the importance of having the time and space to convert experience into learning;

"Clinical practice is dependent on and embedded in clinical milieus. The quality of clinical practice is dependent on the stimulation and protection of critical reflection and critical dialogue in our clinical milieus, as well as the necessary time and space to integrate thinking and "the feeling of." To build and defend these kinds of milieus is the most important way to secure good clinical practice."

(Berg 2008, p.156)

Treating people as you would like to be treated is also seen as person-centred, however it is also acknowledged that being a mental health service user conveys certain differences. One of these differences relates to making sense of the principle of autonomy within a specific mental health context (Woodbridge and Fulford 2004, Fulford *et al.* 2006, Fulford 2008, Fulford 2009). Whether a service user is deemed not to be autonomous (lack capacity) is based on a set criteria, where the mental health nurse would have to provide evidence that the service user was not autonomous (Beauchamp and Childress 2013). Granted there has to justification, however Sayce (1998) highlights that the decision of whether an individual autonomous and capable of making a decision is a subjective judgement. It is also has a political context in that the mental health nurse is making a decision based on the society's majority view of what autonomy looks like (Barry 1964, Berlin 1998, McGrath 1998, Anderson and Lux 2005).

In addition, the mental health nurse as a societal representative is required to act in the best interest of the service user, best interests being based on the nurse as an expert knowing what is best and on the view that when the service user is well, as a person in society, they would agree with the action taken (Berlin 1998, Berlin 2000, Anderson and Lux 2005). Mick provides the following example;

"That is a different matter altogether with mental illness, they have not done anything wrong, they might have, but any criminal acts aside, then people mentally ill there is no sense they have broken the law, I don't know how to phrase this really, basically they are ill and we are intervening to try and help them recover, I suppose."

Knowing the difference between being a mental health nurse and a service user can be become blurry, this may not be a bad thing especially if it engenders emotional intelligence (Dierckx de Casterle *et al.* 1997, Dierckx de Casterle *et al.* 1998, Dierckx de Casterle *et al.* 2008). Part of being more emotionally aware is understanding the service user's emotional viewpoint, what it is like to be coerced (Gardiner 2003). To understand a mental health nurse has to learn to reflect in a way that takes into account both the rational and emotional dimensions of a 'coercive' experience (Crowe and O'Malley 2006, Cutcliffe and Links 2008, Carson and Lepping 2009). listening to the service users and really listening, being empathetic, is a challenge especially when there is a need to constantly monitor for risk indicators, however a skilled mental health nurse will be able to do both (Pang 1999, Bowers *et al.* 2006, Liegeois and Eneman 2008, Kane *et al.* 2014). Making effective decisions in relation to the management of risk is a dynamic and complex process which should also be person centred (Welsh and Lyons 2001, Eales 2009, Wand 2011). Rules remind and guide the mental health nurse towards staying person-centred, however it is the virtuous character of the nurse that will ensure they live person-centeredness (Armstrong 2006, Christie *et al.* 2008, Radden and Sadler 2008). Susan highlights;

"I once had a lady on the ward who had been mentally stable for years and years, worked and everything, she was doing a very slow and gradual reduction in her medication over seen by the doctor but she became very unwell and ended up in hospital. The Consultant for acute services started her on a medication that she didn't like and didn't suit her, she was very irritable and quite nasty at times but said to me that she had been stable for years on a different type of medication and thought she should go back on that. In the ward round I said to this doctor because he was going to increase the other medication, he agreed to put the lady on the medication she wanted because she knew what worked far better than he did. So listening to people and understanding their needs from their point of view rather than telling them how it is."

6.4. Clinical practice

Acute mental distress was for many years seen as something that was managed on acute mental health wards. Over the last ten years this view has changed dramatically with the advent of more community–based approaches (Hannigan 2014). All the participants have worked in a variety of mental health settings recognise and highlight that 'acute mental health is not a place'. This is not surprising as mental health nurses integrate and use a number of different models of mental distress within their practice (Department of Health 2006a, Department of Health 2006b, Nursing & Midwifery Council 2010). Bill articulates this point;

"*You know, we do deal with people in the acute phase in the community. And you have got to, everybody is different and you have got to deal with everybody in a different way, although care plans might have a set routine, about the nurse if in agreement with yourself well we can look at changing the medication or titrating the medication whatever we need to do, we can look at more input during that period of time. Whatever it needs is what we should be doing in the community while they in that acute phase of illness.*"

This example illustrates that over recent years there has been a drive to adopt more psychological models of mental distress ones that are compatible with an evidence-based agenda (Department of Health 2006a, Gournay 2009, Nursing & Midwifery Council 2010). Another influence is the 'medical model' and the corresponding use of medication, if we take the notion of 'hearing voices' medically this could be conceptualised as auditory hallucinations, which in turn leads to it being conceptualised as a symptom of schizophrenia; a psychiatric disorder (Morrison 2014a). The symptoms of schizophrenia include; hallucinations, delusions, disordered thinking, emotional numbness, flattening of affect and lack of motivation (Morrison 2014a). It also has to be acknowledged that the general view of schizophrenia as represented within the media is of the stereotypical mad and potentially dangerous person, until the end of the nineteenth century what is now known as schizophrenia was categorised within a general category of madness (Porter 2002, Walsh 2009). In terms of current practice mental health nurses would conceptualise the experiences of an individual diagnosed with schizophrenia who 'hears voices' as experiencing perceptual disturbances, however some of their practice would be framed by the medical label (Gournay 2009). Applying a mental disorder label appears straightforward, however 'labelling' in this way can be viewed as being controversial and also stigmatising (Szasz 1960).

It has to be acknowledged that having a mental disorder or being in mental distress, with or without a diagnosis, does not necessarily lead to an admission to acute mental health services, these services become involved when the individual is not coping in a way that is viewed as risky (Romme and Escher 1989).

As an example hearing voices is something everyone experiences to a greater or lesser degree, the more tired we are the more of a chance this will happen, when we fall asleep or when we are just going to sleep. However, if these voices distress us, are constant, impairs social functioning, and we demonstrate 'risky' behaviour, hearing voices cease to be seen as normal behaviour and mental health services may become involved (Watkins 1998). Once this label is used and services are involved 'power' becomes a contextual factor and one that comes into direct play especially if a concerning level of risk is deemed to be present (Roberts 2005).

Bill when asked about risk confirmed it was a mediating factor for admission to hospital specifically when a high degree of risk to self or others was present;

"Yes there the major issues, most of the other problems can usually be dealt with and I think in the community we are especially good at spotting the early warning signs and dealing with them and working with someone to deal with them and the vast majority of people do that quite well. You know, prevention is better than cure, you know."

Mental health nurses do not directly diagnose, however they are part of the assessment process that leads to applying a diagnostic label, in addition, mental health nursing is heavily influenced historically and politically by the medical discipline of psychiatry (Nolan 1993, Nolan 2009). Even so far as mirroring psychiatry's movement from phase to phase, currently psychiatry is in its second biological phase where contemporary practice both medical and nursing is taking a more biopsychosocial view (Fulford *et al.* 2006, Nolan 2009). Certainly psychiatry has had a great influence upon the discipline of mental health nursing, however other influences or theories have also had a significant impact these include; psychodynamic theories, learning theories, cognitive theories, and social theories (Nolan 1993, Nolan 2009). A biopsychosocial view of mental distress provides a more holistic perspective, however applying a diagnosis is predominantly biologically focused, it also starts to explicitly link 'risk' with identified symptoms (Morrison 2014a). Where a service user is given a diagnosis, symptoms are identified which includes paying careful attention to any 'risky' behaviours, these behaviours are then viewed as being directly attributed to the pathology of the identified mental illness (Morrison 2014a).

As an example Redfield Jamison (2000, p.102) highlights that 'all the major studies to date demonstrate on retrospective analysis that 90-95% of individuals who commit suicide also have a 'mental illness'. This link is based on the view that thoughts of self-harm and suicidal thinking are symptoms of depression, in addition, individuals with depression are seen as statistically more likely to commit suicide then individuals who are not 'depressed' (Morrison 2014a). The next step is to treat the diagnosed mental disorder, this treatment is seen as an 'agreed' way to also manage and potentially reduced any identified risky behaviours that are attributed to the disorder (Blows 2011).

Once services are involved through the treatment process a duty of care is activated that pays careful attention to managing risk. The biopsychosocial view of mental distress will continue to underpin the way this care is formulated and then delivered, however the biological theory of mental distress will have the strongest influence and any treatment prescribed will have a biological emphasis such as medication (Coppock and Hopton 2000). As the pathology of a person's mental distress is so intertwined with risky behaviour any treatment is seen as way of managing this risk which includes the 'pressure' upon the service user to adhere to treatment (Morse 1977, Coppock and Hopton 2000). And yet, according to Bill medication is one option of many;

"In my opinion the biggest thing with mental health problems is it is scary, if somebody is experiencing an acute psychosis or they have auditory hallucinations 24 hours a day its scary and that's what's makes people sometimes aggressive and sometimes angry, sometimes suicidal, you know, and its making people understand, you know, that these things can be treated, but it is not always about medication. I would say 60% of my prescribing is not prescribing any medication at all, but saying have you thought of this. I get people coming to clinic and the first thing they will do is say; 'I can't sleep can you give me Zopiclone', well no you try the sleep hygiene programme first, have you tried relaxation. That is about education and it is not always about tablets, tablets are something I think are a valuable resource but they are not the 'be end all' of mental health."

A mental health nurse's practice will be framed by this 'biological view' of mental distress which will include administering medication and monitoring adherence, nevertheless of prime importance during the delivery of care is the therapeutic relationship (Borg and Kristiansen 2004, Gilburt *et al.* 2008, Thompson *et al.* 2008). This relationship is formed during the mental health nurse's initial contact with the service user where an assessment of need is undertaken and any planned actions are agreed (Brimblecombe *et al.* 2007, Coombs *et al.* 2013). The subsequent agreed actions, which are contextualised by a power relationship, are delivered through the therapeutic relationship (Roberts 2005, Gilburt *et al.* 2008). This approach is not unlike most healthcare relationships, the difference being in mental health nursing the therapeutic relationship is both the medium for treatment as well as in some cases the main treatment (Roberts 2004, Gilburt *et al.* 2008, Anderson and Waters 2009). This relationship is a fundamental part of mental health nursing practice, it also has an ethical dimension, where the treater, the nurse, has to be and act ethically (Roberts 2004, Roberts 2005, Cutcliffe and Links 2008). To build the therapeutic relationship the mental health nurse will engage with the service user and their family through the use of reason and emotion (Roberts 2005, Gilburt *et al.* 2008, Strack and Schulenberg 2009). This process is in effect an 'open dialogue', using logic and reason while acknowledging there may to be some difficult emotional decisions to make during the delivery of care (Akerjordet and Severinsson 2004, Roberts 2005, Wand 2011).

These difficult emotional decisions will relate to the nature of emotional distress, they will also relate to the potential need to restrict freedoms and the moral distress this can cause (Akerjordet and Severinsson 2004, Cutcliffe and Links 2008, Thompson *et al.* 2008, Anderson and Waters 2009). In these types of situations the mental health nurse has to be self-aware and emotionally responsive recognising their own and the service user's vulnerabilities especially if the service user is nonautonomous (Lutzen and Nordin 1994, Akerjordet and Severinsson 2004, Weiner 2007, Cutcliffe and Links 2008). Maintaining an open dialogue is the starting point in this process which Alice highlights;

"Say there was a situation where somebody was psychotic, unwell and they started breaking up furniture. So we move people out of the area, kept the patients away, so at the end of the day it's furniture so you think they're not attacking anyone, so you try and talk to them, try and de-escalate the situation.

The challenge for the therapeutic relationship as the medium for treatment is that it has to manage risk within a mental health context while also being collaborative (Hall 2004, Cutcliffe and Links 2008, Liegeois and Eneman 2008, Cutcliffe and Happell 2009). This is a balancing act where the mental health nurse always intends to be collaborative and person-centred, this becomes more difficult when working with high risk behaviours as the therapeutic relationship can become more controlling and confining (Hall 2004, Roberts 2005, Cutcliffe and Happell 2009). Managing a service user's acute mental distress can present a number of complex challenges, service issues including a lack of staff or a lack of the right facilities can add to this complexity (Bowers *et al.* 2005, Department of Mental Health & Learning Disability 2006, Currid 2009, The King's Fund 2015). A reduction in staff resource may mean there are less staff to spend time with a service user and potentially prevent problems before they arise (Department of Mental Health & Learning Disability 2006, Bowers 2010). Smaller in-patient units have led to an increase service users with complex clinical issues being admitted, in addition community services due to not being able to access in-patient beds readily are having to manage service users with increased levels of acute distress (Currid 2009, Gilburt *et al.* 2014, The King's Fund 2015). Reorganising services can also lead to a feeling of separateness that one service operationally feels like a number of separate services (Gilburt *et al.* 2014).

One impact upon the mental health nurse is that they have to manage the care of service users with ever increasing complex needs while the service they work within is ever-changing and fragmented (Currid 2009, Gilburt *et al.* 2014). Sophie highlights some of the challenges of working within this context;

"Obviously we are sometimes short staffed and when the service user came in we were already had 1:1 obs and people who were a ligature risk and people doing this and that.

So trying to keep people and the situation safe for everybody was difficult and as we did not have a great deal of information as far as the family were concerned the service user had not had any contact with services so we couldn't really get anything from them to whether the service user had been like this before, if the service user had any aggressive behaviour before that we should be aware of. To be able to in some ways be forewarned what the potential was what we have with a lot of our service users"

As an illustrative example of change within mental health services; currently the main ward door on an acute mental health ward is routinely locked, this was not the case thirty years ago (Ashmore 2008). Keeping the ward door unlocked was viewed as an important part of creating an environment that feels therapeutic rather than intimidating (Ashmore 2008, Bowers *et al.* 2010). Door locking was not the norm until the last ten years, in 2010, 42% of ward doors were permanently locked (Bowers *et al.* 2010) by 2015 this figure had risen to 86% (Care Quality Commission 2015). The challenge with permanently ward locking doors is that it can create internal and external conflict, internally - managing risk versus freedom; externally - being therapeutic versus creating a prison environment (Ashmore 2008, Bowers *et al.* 2010). Locked doors are used on the premise they keep mental health service users safe or prevent them from harming themselves or others, it does this by keeping the service user within the confines of the ward giving the mental health nurse a better opportunity to control or prevent any harmful behaviours (Department of Mental Health & Learning Disability 2006, Bowers *et al.* 2010). The difficulty with this view is that locking doors becomes an almost routine approach, something that feels implicit as a coercive measure rather than explicit (Roberts 2005). It also magnifies the perception that it is OK to control service users in acute mental distress as they more likely to be non-autonomous and more likely to need to be controlled (O'Brien and Golding 2003, Roberts 2004, Roberts 2005). It is important to recognise that not having locked wards can also be challenging, Susan articulates;

"When I worked on the wards we had to have staff strategically placed by the door, especially if we were concerned someone was going to try and run off but we were also very good at checks and observations and talking people into staying if they felt like going. On the other hand we did have plenty of people who ran so we tried to catch them at reception by ringing down and getting the doors locked but if not we just had to chase them! I'm not convinced that this is a good idea, especially considering the fact that there was a very busy road where the ward was and people could just run onto it, also because I had a student nurse who ran after a patient, fell off her wedge shoes and broke her ankle"

Having a routine approach such as locked doors is justified as being in the best interests of the service user, preventing harm and being beneficent (O'Brien and Golding 2003).

The weakness of justifying the use of a routine coercive measures on these grounds is that it does not necessarily follow it is legitimate moral justification in every situation (O'Brien and Golding 2003). Coercive measures especially routine measures are indiscriminate, they can be beneficent, they also be abusive (O'Brien and Golding 2003). Another aspect to be considered is the lack of capacity argument where the mental health nurse is acting on behalf of someone who lacks capacity, however capacity fluctuates so lacking capacity can change from situation to situation, and acting on behalf is not necessarily the same as doing what the person would want (O'Brien and Golding 2003). This it is why a wide consensus of opinion should be sought to prevent the abusive use of power, however where coercion becomes part of a daily routine it may also become more acceptable to use (O'Brien and Golding 2003, Chodoff 2009). Alice highlights how they worked through this dilemma;

"Yes it's not about what I personally want to do, it's for the greater good if you will, its in their best interests and you would always, because you are in a position where people come into to hospital and they are unwell, you have to justify that is was in their best interests. You wouldn't do anything that wasn't or wasn't deemed to be in their best interests. You know you wouldn't stop somebody from leaving if, you know, if they were informal and they wanted to go out and they had no self-harm ideas, they weren't going to harm anybody, the risks were low, if you prevented that person from leaving then it is not in their best interests. So you wouldn't do that but if they were informal and they wanted to go out and kill themselves then you would stop them because you have got to act in their best interests, you have got a duty of care as a nurse to do that. Yes, so it's for their interests."

Mental health nurses are professionally required to seek the views of others within the team especially when facing complex and difficult decisions (Nursing & Midwifery Council 2015a). On a day-to-day basis mental health nurses will have to make these decisions in real-time where there is not always the time to consult widely (Welsh and Lyons 2001). Even during these situations the mental health nurse will consider the options available, if possible explore and test out each option, with the most coercive option being the last option (Welsh and Lyons 2001, Prinsen and van Delden 2009).

6.5. Coercion

Being coercive is not a comfortable experience and it can engender moral distress in some cases! Defining and make sense of 'what coercion is and is not' was a struggle for the participants and at times thinking about coercion created discomfort. As a starting point Bill defines coercion as;

"Coercion to me means forcing somebody to do something against their will, if you for example; 'don't accept this increase in medication then I will put you in hospital', you know, that's coercion. You know, getting somebody to do something they don't really want because you want them to do it."

For all the participants the key components of coercion were restricting freedoms and making a service user do something they did not want to do were. Not feeling comfortable when applying coercive strategies was another common issue even when the best interest's argument was in play. Bill and Alice highlight;

"I don't believe, it is quite difficult, because I only know my own practice, erm, my own practice I don't think I use coercion, erm, maybe I do, or maybe it is something I will discover, I don't think I do, erm, I try to work with people. And certainly very much around giving people the choice of what they think is best, sometimes I have got to make a decision they don't like."

"Coercion (long pause), is there whereby you are asking people to comply with something?"

Coercion in its broadest sense is viewed as an everyday practice, which Jeff articulates;

"Coercion in psychiatry to me is, I remember it as physical chemical and psychological, I suppose nowadays there are other dimensions such as technological issues being involved as well. The mechanical, thankfully I have not been involved in the mechanical that is more America. There is a debate between us and the Americans over that. Coercion is without get into concepts coercion is every day, I go to work and there is coercive elements every day in my encounters with the people I work with."

Coercion, containment, and persuasion are used as terms in everyday mental health nursing practice to mean the same thing, the restriction of a service user's freedoms (Roberts 2005). The focus of these strategies, which come in different forms, is in essence to prevent the service user from harming themselves and/or others (Bindman *et al.* 2005, Department of Mental Health & Learning Disability 2006). Preventing harm and managing risk is a clear intention however this intention cannot be separated from restricting freedoms as a consequence (Roberts 2005). Restricting freedoms can be overt such as the 'forced use of medication and/or restraint, it can also be more hidden such as applying pressure to take medication with a potential threat that more overt measures will be used if the service user does not acquiesce (Roberts 2005, Verkerk *et al.* 2008). Jeff highlights;

"I have seen staff speaking to service users, applying sort of pressure, it's not a negotiation it's telling people what to do type of thing."

Restricting freedoms or coercion is not just a mental health issue the use coercion has been widely debated within a political and legal context (Anderson 2011). Within this context coercion is described as a way of getting individuals to do or not to do something with the impact of diminishing an individual's freedoms (Anderson 2011).

Coercion includes the threat to restrict freedoms which is similar to applying pressure where freedoms come with conditions or are abridged (Carr 1988, p.65). For coercion to be justified it has to be authorised by society, this authorisation can come in the form of agreed rules such as the law (Anderson 2011). On this basis coercion can be viewed as the official and authorised use of force which is used to prevent harms mainly to others, however within a mental health context it is also used to prevent self-harms (Ripstein 2004, Fulford 2009). The implication within a mental health nursing context is coercion has to be sanctioned and justified, it has to be used in accordance with the rules otherwise it is not sanctioned and justified (Ripstein 2004). However, sanctioned coercion as discussed by Ripstein is within a 'criminal and an ordinary member of the public context' where the justification of coercion relates to preventing harm and punishing those that have caused harm, this is not typically the case within a mental health context (Ripstein 2004). Alice articulates how these differences influence her actions as a mental health nurse and as an ordinary member of the public;

"Do you mean me going out with Joe public say on a Saturday? If somebody was standing on a bridge ready to jump then I would intervene you know to stop them, to try and stop them but it wouldn't be my responsibility, do you know what I mean? You wouldn't want to see someone trying to kill themselves or harm someone else. Say it was on the ward and two patients got into a fight and you go in and separate them whereas if you I was out on the street and two people got into a fight I would not go and separate them."

In addition, this general view of coercion does not explore in depth the use of coercion with individuals who are viewed as irrational, which can include individuals in diagnosed with a mental health condition who may on occasion lack the ability to be autonomous (Radden 2002b). Of course not all people with a mental health condition lack the ability to be autonomous, however, even if they are autonomous and at the same judged to present a risk the mental health nurse may have the authority to use coercion (O'Brien and Golding 2003). Authority is the mental health nurse having the power to coerce, this power can only be used in certain circumstances, in this case within a mental health context (Carroll 1991). This power can take the form of force which includes someone being physically restricted or threatened with the use of force (Carroll 1991). Manipulation is also a form of power where a service user is manipulated in doing something the mental health nurse or service wants such as staying in hospital or taking medication (Carroll 1991). Persuasion is similar in that inducements are offered, i.e. if you, as a service user, do something as asked by the mental health nurse this will look better and you may be discharged quicker (Carroll 1991).

Persuasion also involves the provision of information in a way that the suits the coercer rather than the coerced, it is also contextualised by the provider of the information, in this case the mental health nurse, i.e. 'in my expert opinion you need to stay on the ward' (Carroll 1991).

What is important to recognise is that mental health nurses will use these forms of coercive power not in isolation but as multiple forms (Carroll 1991, O'Brien and Golding 2003). The mental health nurse will not always recognise these multiple forms as coercion, which is highlighted by Bill when talking about bargaining;

"I would not say, no try this and you can have tablets, I would say try this as a first line because it is better for you in the long run not to have more tablets on top of the tablets you are taking. If however it doesn't work we could consider tablets. I don't if that is coercion I think that is bargaining, it could be classed as coercion, I suppose it depends how you look at it"

The use of coercive power is again usually justified as being in the service user's best interests; making a decision for someone else, that it is the best one for them (Joyce 2010, p.7). Legally best interests can be viewed as a;

"… method for making decisions which aims to be more objective than that of substituted judgement. It requires the decision maker to think what the 'best course of action' is for the person. It should not be the personal views of the decision-maker. Instead it considers both the current and future interests of the person who lacks capacity, weighs them up and decides which course of action is, on balance, the best course of action for them."

<div align="right">(Joyce 2010, p.7)</div>

Within a mental health nursing practice context Bill views best interests as long-term approach which can have positive outcomes;

"Yea, I suppose in that sense it is, but, I think it is coercion in a more positive way in that you are persuading them from having just more tablets, because, you know Zopiclone is addictive.
You know, these drugs only work for a short time so you need more to get the same effect and its, you know, if you are saying to the patient well I would rather not give you them let's try something else first, then I suppose we are saying it's my suggestion, and maybe there is an element of coercion, but I really think it is working in the best interests rather than you know."

Alice make a further point that working in the best interests of a service user is a role expectation not a personal interest;

"Yes it's not about what I personally want to do, it's for the greater good if you will, its in their best interests and you would always, because you are in a position where people come into to hospital and they are unwell, you have to justify that is was in their best interests. You wouldn't do anything that wasn't or wasn't deemed to be in their best interests."

O'Brien and Golding (2003) highlight that mental health nurses routinely use the best interest argument to justify the use of coercion. The weakness of this approach, firstly relates the best interest argument being used 'as a catch-all', and secondly the mental health nurse is not always aware of what elements of care are coercive (O'Brien and Golding 2003). There is a general tendency to view coercion as being only restraint whereas O'Brien and Golding (2003) highlight that 'any use of authority by the mental health nurse to override the choices of the service user' is coercive (pp.68). O'Brien and Golding (2003) also assert that coercion can only be only justified where;

> ➤ The service user is nonautonomous
> ➤ The harms prevented outweighs the harms caused by the coercive strategies
> ➤ The least coercive intervention which promotes good or prevent harm is used

This approach specifies the use of coercion and moves justification away from a catch-all approach, however knowing whether a service user has capacity, the potential outcomes of situation, and which is the least coercive strategy is a not as 'rational' as it appears (Fulford 2009). The difficulty with a rational approach is that mental health nursing practice has both rational and irrational moments, mental health nursing practice and coercive incidents can be fast-paced, complex and emotional experiences (Olofsson and Norberg 2001, Welsh and Lyons 2001). Post-incident a nurse's reflections have an emotional element, however talking about how the incident was managed it can appear objective and rational, as if everything was quite straightforward (Crowe and O'Malley 2006, Freshwater 2011). Partly this process is due to mental health nurses being trained to reflect post-incident and as time progresses they will then reflect on those reflections; rationalising their rationalisations (Hummelvoll and Severinsson 2001, Gould and Masters 2004, Kuiper and Pesut 2004, Crowe and O'Malley 2006, Jasper and Rolfe 2011).

If we consider an example of a service user who wants to go home, they are actively trying to leave a ward, they are want to self-harm, and they appear to lack capacity. Post-reflection the mental health nurse may justify their actions by talking about acting in the best interests of the service user i.e. keeping them on the ward will keep them safe, it will then be easier to treat their mental health condition, and being in the right place for treatment will in the long-term provide better health outcomes (Sumner 2010). In addition, the fine detail of talking about how they as the mental health nurse acted may highlight that they tried to persuade the service user to stay on the ward, it may then go on to explore other interventions used which are dependent on how the service user responded, other interventions may have included door-locking and restraint (Roberts 2004, Roberts 2005, Hoop *et al.* 2008).

There may be a reference to the emotional dimension of the incident, which may highlight the need for emotional sensitivity, what might be missing the further way in time you move away from the incident is the rawness of the emotional distress and how difficult it was for the mental health nurse to their manage emotions effectively within this type of incident (Akerjordet and Severinsson 2004, Valdesolo and DeSteno 2006). Alice in a general way captures elements of this rawness;

"Well it is, like you say your adrenalin goes, if like you are in the office and you hear the alarm and you think oh god what am I running to sort of thing. Ahem but if you went in and somebody was being attacked you would just go and do it, but it's not a nice side and it's not something you want to do but it's something that is necessary."

This emotional dimension is not something the mental health nurse can ignore as it can have an adverse impact upon the effectiveness of the therapeutic relationship (Akerjordet and Severinsson 2004). In addition, restricting freedoms is not only distressing for both the mental health nurse and service user it can also create conflict within the relationship, conflict that will have to be sensitively and ethically managed as the relationship move forward (Woodbridge and Fulford 2004, Eizenberg *et al.* 2009, Fulford 2009, De Veer *et al.* 2013). Rationalising the use of coercion is useful when needing to be seen as rational and reasoned, however the mental health nurse also to be emotionally intelligent in a way that maintains the relationship through an open dialogue which shows understanding of how distressing coercion can be, irrespective of how it is justified (O'Brien and Golding 2003, Woodbridge and Fulford 2004, Roberts 2005).

Ethically coercion has to be in the service user's best interests it also has to be based on a duty of care, these duties are shaped by the rules, it also has to be the right thing to do (Chodoff 2009, Coady 2009, Nursing & Midwifery Council 2015a). The rightness and wrongness of using coercion makes it an ethical issue especially in the light of it might be 'right' for the nurse, however it may be unwanted by the service user (Ryan 1980, Ripstein 2004). At a general level Ripstein (2004) highlights that coercion interferes with normal freedoms in a number of ways, the most relevant to mental health nursing practice include; 'interfering with a person's capacity to pursue their ends, and forcing a person to adopt an end that is yours but not theirs' (pp.21). On this basis, coercion becomes an ethical issue as it interferes with an individual's freedoms. In addition, a coercive act can become a moral duty especially where an individual is vulnerable including lacking the ability to be autonomous then there is an expectation, best interests argument, that someone acts on their behalf, however it must be exclusively for the benefit of the individual (Ripstein 2004). Acting in this way can re-framed coercion within a mental health nursing context as beneficent coercion, this form of coercion will recognise the issue of consent, it will also be mediated by the presence of risk (Beauchamp 2009, Beauchamp and Childress 2013).

It has to be acknowledged that not all coercive measures used within mental health nursing are for the benefit of the individual, some measures may be for the benefit of a community such as a ward community. These would include ward rules and of course locking doors. The weakness of justifying the general and routine use of a coercion in this way is that again it does not necessarily follow that it is ethically justifiable (beneficent) in every situation (O'Brien and Golding 2003). Routine measures are indiscriminate, for one service user they can be beneficent and yet at the same time for another service user they may not be beneficent (O'Brien and Golding 2003, Ashmore 2008). Jeff gives the following example of how an indiscriminate rule of limiting the use of the ward TV was applied;

"A member of staff changed the TV channel over while the service user was watching TV and told the service user to go to their room. So there was coercion for you, you know, the service user responded verbally back to the member of staff, the member of staff went over and stood up right in front of the service user."

Another ethical justification of beneficent coercion relates to the service user lacking capacity, they deemed to be nonautonomous, however capacity can fluctuate from one situation to another, this means that for coercion to be beneficent coercion it has to sensitive to these fluctuations (O'Brien and Golding 2003, Tuckett 2006, Liegeois and Eneman 2008, David *et al.* 2010, Joyce 2010). In summary beneficent coercion is ethically justifiable with the caveat; it has to be based on a duty of care, it has exclusively benefit the service user, and it has to be individualised rather than indiscriminate (O'Brien and Golding 2003, Ripstein 2004). If not, it can be seen as abusive, Jeff follows on from the 'TV' example above;

"So, the service user went up, you know, they clashed. It should never have happened to be honest with you; we looked at that situation obviously the next day and the behaviour. I was the named nurse for the service user, had not known any aggressive behaviour with this service user, again behavioural analysis are ABCs looked at this here. We were very sorry for the service user that this ever happened, the service users mother came and spoke to the unit manager and myself, why did this happen, and quite rightly so. This matter was investigated and there was action taken over this to be honest with you."

To be individualised coercion has to be sensitive to individual need, not an unrealistic expectation within the caring context of mental health nursing practice (Crowden 2003, Wilkin 2006). As with most things in healthcare when dealing with people and complex situations what works in one situation may not work in another, coercion is no different (Gilburt *et al.* 2008, Ohlenschlaeger and Nordentoft 2008, Strack and Schulenberg 2009, Kilbride *et al.* 2013, Kapur *et al.* 2014).

A key factor in being sensitive is the mental health nurse fully considering which form of coercion is right for that service user in that moment in time (Gilburt *et al.* 2008). Therefore, the mental health nurse as the treater has to be sensitive to the individual nature of a situation to ensure the form of coercion chosen is indeed beneficent (Tuckett 2006, Wilkin 2006). Mental health nurses should through the skilled use of the self be sensitive to the individual context of care to enable them to respond in the right way (Wilkin 2006). Responding or being emotionally sensitive in this way is dependent on being rational, evidence-based, and being emotionally intelligent (Akerjordet and Severinsson 2004, Hurley and Rankin 2008). The main way that mental health nurses is emotionally sensitive is through the use of character traits delivered through the therapeutic relationship (Armstrong 2006). Being emotionally sensitive within this relationship is not just about the right character traits it also about using these traits to make the right decision, in other words being discerning and being wise (Hursthouse 1999, Armstrong *et al.* 2000, Gardiner 2003, Armstrong 2006, Robertson and Walter 2007b, Radden and Sadler 2008). Alice provides an example of she maintains her emotional sensitivity through the therapeutic relationship;

"Yes, because I think you maintain the relationship with the person, if I went into to restrain people I would always worry how that would affect the nurse patient relationship, because if someone restrains you it's got to affect you, you might not remember if you were really unwell, some people have looked back of situations and their never glad you restrained them they acknowledge that they needed that at the time because they weren't in control of what they were doing and they couldn't act for themselves, or how they would normally act so they could understand it. At the end of the day I certainly wouldn't want to be restrained, it must be really frightening, it's trying to maintain that relationship."

6.6. <u>Ethics</u>

For the mental health nurse understanding what constitutes being ethical is shaped not primarily by rules, it is shaped by personal and professional values (Department of Health 2006a, Cooper 2009). Bill and Jeff highlight;

"To be ethical you have got to be, it goes back to your nursing skills, erm, you are not a bully or abusive to people, you don't discredit the gender, religion, whatever, there beliefs. Erm, working in I suppose an honest and trusting way, you don't force your values on people, and to me that's what ethics is about really. It's about working within the boundaries, within the rules of your profession, you don't accept money from people, you don't give them favouritism or anything like that. That's within the boundaries of ethics, you know."

"Trying to keep it simple in my mind ethics is concerned about what's right and wrong in situations that informs our practice. I mean, that is my simple understanding of ethics, what is right and wrong, that is what we need to consider"

In addition, this ethical dimension is contextualised by the practice of mental health nursing which is a pragmatic pursuit (Cohen 2004, Roberts 2004, LaFollette 2007).

Acting ethically requires the mental health nurse to understand their practice, its context, and what they can and cannot do, which includes knowing the rules (Ford 2006). Mental health nurses may not always recognise that the decisions they make have an ethical dimension, however this does not mean that in deeds and action they are not ethical (Han *et al.* 2010, Lutzen *et al.* 2010). Knowing what is ethical can become lost or hidden within the process of making a clinical decision, however it may become apparent on reflection (Dierckx de Casterle *et al.* 2008, Carson and Lepping 2009, Widdershoven *et al.* 2009). Reflecting in and on action are a key parts of a mental health nurse's practice, they are also a key part of being able to make reasoned decisions including ones that are ethical (Schön 1983, Cohen 2004). Where the ethical element becomes hidden relates to the mental health nurse not knowing what ethics are, how this relates to ethical theory, and how it relates to their practice (Roberts 2004). It is evident that mental health nurses know right from wrong, which ends are good, what duties they should adhere to, and what constitutes a good character (Bloch and Green 2009). What they might not know is that it ethics; *"... has a philosophical home in the discourse of moral philosophy, the study of conduct with respect to whether an act is right or wrong, to the goodness and badness of the motives and ends of the act"* (Bloch and Green 2009, p.3). Jeff provides a practice example where he clearly knows right from wrong, however there is only a tentative link to ethical theory;

"A service user there was admitted to the ward, for a quickly the service user had severe cognitive limitations following a road traffic accident, the service user when more medically stable was admitted to the ward. The service user had very poor capacity and poor awareness of their surroundings. I came on duty one time and someone was giving the service user their medication and they were giving it in their food, their weetabix, it was a bank member of staff who was unqualified, I discovered this. Hey what's going on here, straight away from my experiences I knew this was wrong, what's going on here, morally and ethically this is wrong.

Interviewer - *Did it feel wrong or was it wrong in terms of the rules?*

Jeff – *Both, it was wrong legally and ethically for that person as a human being it was the wrong thing to do."*

The participant it did not articulate which rules, only that is was wrong. Mental health nurses may also not know professional codes of conduct are shaped by normative ethical theories, however they will understand what is required professionally, this understanding is reinforced through the revalidation process (Sumner 1967, Smith 2012b, Nursing & Midwifery Council 2015a). Revalidation aims to provide a robust system of re-registration which ensures the nurse keeps up-to-date, maintains safe and effective practice, and learns through engaging with other nurses (Nursing & Midwifery Council 2015b). During this process is the nurse is required to reflect on their practice and then continually improve this practice in a way that it is framed by the NMC code of conduct (Nursing & Midwifery Council 2015a, Nursing & Midwifery Council 2015b). By promoting good reflective practice that is framed by the code of conduct there is an expectation that the nurse will learn good habits and ones that will often than not lead to good practice outcomes (Fesmire 2003, Nursing & Midwifery Council 2015b). Building good habits is a foundation for good practice, however mental health nurses still have to be skilled in dealing with uncertainty where facts may be values turned into facts, and outcomes even good outcomes may be against a service users will and ultimately restrict their freedoms (Woodbridge and Fulford 2004, Fulford 2008, Fulford 2009).

The overriding concern when reasoning through these types of decision is keeping the service user safe or minimising harm, which is a professional duty (Gostin and Gostin 2009, Wand 2011, Nursing & Midwifery Council 2015a). However, knowing what duties, good outcomes, and right character and motives look like in practical terms requires skilled interpretation which is intertwined with reflection in and on action (Schön 1983, Kuiper and Pesut 2004, Sumner 2010). This skilful interpretation is synonymous with ethically reasoning as a pragmatic process. Sophie highlights;

"*I would say I'm concerned about the safety; a lot of them want to go because they want to harm themselves, a lot of them will say they want to hurt themselves such as jump off the flyover, they going to go home and kill themselves, they are going to hang themselves or they're going to slit their wrists. So you will going to weight up, if somebody is saying to me and expressing that they are going to commit suicide I feel quite, and not would say justified but I feel comfortable in doing restraint if I need to. Just to ensure their safety and the opportunity to talk with them and find another way of dealing with what is causing to act in this way.*"

Reflecting in and on action is not just a rational process it also requires the mental health nurse to be self-aware in way they are take into account the emotions that are inherent within a situation where they have the power to control another person (Akerjordet and Severinsson 2004, Roberts 2005). Using this power can impact upon the therapeutic relationship in a way this relationship can become more controlling and less collaborative even if neither parties within the relationship want this to happen or are able to stop it from happening (Roberts 2004, Roberts 2005).

Even if the mental health nurse mediates this use of power by following the rules, the rules may require the nurse to control when they would prefer not to control, thus creating ethical conflict (Woodbridge and Fulford 2004, Fulford 2009). Ethical conflict also arises from expert interpretation of a situation, the mental health nurse as the expert may decide on one course of action, the service user may disagree and want to take another course of action (Fulford 2009). As an example, a mental health may want to prevent a service user from self-harming, the service may want to self-harm as a way of coping, if they tell the nurse they want to self-harm they will be persuaded not to engage in this act, and if they attempt to self-harm they will be stopped especially within an in-patient environment (Thompson *et al.* 2008, Anderson and Waters 2009). Knowing when and how to use this power is a challenge as Mick articulates;

"*(Long pause) no, I don't know whether there is an exact cut off when it stops being persuasion and moves into being coercion. I think I have had conversations with people where it is not even clinical and you feel you have asked them so many times I can't keep asking them, am I chivvying them, am using the status of the job or the strength of my personality to persuade them to do something they do not want to and then it drifts in to coercion. I suppose I hope that anyone that works in this field reflect on their own self so they know if they are reaching a point whether is something about them whether it is their physical size, personality or the job status means that they are unduly influencing a person's decision and it is no longer just reason and argument. I suppose that is down to each individual to have that self-awareness to pick upon the signs of that person, whether that other person feels engaged in a free debate or if they have been cornered and are now being in effect forced to do something.*"

Going back to the example of self-harm as a coping mechanism, which is seen as a bad thing by the expert and good thing even if this is in the short-term by the service user, ultimately the power to determine the rights and wrongs of the situation rests with the societal expert, the mental health nurse (Woodbridge and Fulford 2004). Being a critically reflective practitioner may not be enough in this situation to reduce ethical conflict another process may have to be used that specifically focuses on reducing ethical conflict in these types of 'power' situations (Woodbridge and Fulford 2004, Fulford 2009). A values-based approach is a process which provides a good process that manages this type of conflict it also engenders an open dialogue between the nurse and the service user that is respectful and person-centred (Woodbridge and Fulford 2004, Lamza and Smith 2014). Using open dialogue that is shaped by values-based approach may ensure that the use of coercion is sensitive and beneficent, Susan illustrates;

Interviewer - "*Going back to coercion, can you be ethically coercive, persuade people in an ethical way?*

Susan – *I think you can and I think honesty is the key, to me it is about being honest with people and saying look I know you don't want to do this but at the moment I truly believe it is the best thing for you to do if I didn't think that I wouldn't be asking you do it. Some people don't like anti-depressants for example but if you explain that it's just a way of helping support them until they become stronger mentally and emotionally to deal with whatever issues need to be dealt then they sometimes feel happier, it's not being dishonest just trying to show that there is a purpose and a point to medication sometimes.*"

Following a good process such has a values-based approach is dependent on the mental health nurse truly listening to the service user and not constantly reconstructing their narrative (Merleau-Ponty 1945/1962, Martinez 2009). It can be difficult to truly listen within busy and complex environments, especially within acute mental health wards (Currid 2009). Having these constraints can lead to reducing the listening time spent with the service user, whereas truly listening requires the nurse to have the time to suspend their assumptions and facilitate the service user to re-tell their story which in itself can be a powerful medium for healing (Bracken and Thomas 2005, Brendel 2006). The process of healing through re-telling is a human endeavour, this process is dependent on human or person centred skills which include being empathetic (Hamilton and Roper 2006, Wilkin 2006). The empathetic mental health nurse will understand the emotional world without any loss of their own self (Knott 2012). Empathic skills include; '*being an active listener, genuinely interested, accepting the person, and being caring and compassionate*' (Smith 2014, p.5). These skills can also be seen as virtues which tie them into to ethical theory, however the mental health nurse may be unaware of this link (Armstrong 2006). Mick talks about the role of caring and its relationship to having the right character;

"*Yes we talk a lot about care, it's hard to really, I don't know if you can teach it, we all know people who are caring and they would be caring in whatever facet of their life whether they were a nurse or a teacher or a software engineer they would be a caring as one of those I think. Some people don't have it as much and aren't as warm and I am not when I think about care thinking about that warm personality that some people exude, I think that is a gift and you can't teach people that, but whatever personality someone has got they have got to be solicited to other peoples wellbeing. They might be a cool customer but as long as they are observant of other people and interested in them, they might have a different style of care and not sentimentalise how they care, they can show it in other ways and that is fine, but if people are, drift into being cynical or uninterested or disdainful of the people we are caring for then that is not acceptable.*"

Whether mental health nurses are aware of the role ethical theories play on their practice is debatable, however ethical theories do have a role to play which includes having a direct influence on how the nurse ethically reasons (Cohen 2004, Roberts 2004).

This influence takes the form of a top-down reasoning influence usually through these theories underpinning ethical reasoning frameworks (Cohen 2004). An example of a mental health nursing ethical reasoning framework is the code of conduct for nursing (Coady 2009). Mental health nurses will also engage in bottom-up reasoning, this is where practice will generate a 'moral reaction', which is a situation that occurs and needs to be ethically reasoned through, the solution will invariably be relative to the situation (Cohen 2004, p.61). Mental health nurses as practitioners will engage in both types of reasoning not as a separate pursuit but as combined pursuit where both types of reasoning influence and interplay with each other (Cohen 2004). How effective the mental health nurse's reasoning is will be dependent on their moral development as a mental health nurse and as a person (Cohen and Erickson 2006, Dierckx de Casterle *et al.* 2008). Ethical reasoning is connected with a person's moral development which starts in early childhood (Gross 2015). Predominantly psychological theories of moral development are influenced by the work of Piaget and Kohlberg (Gross 2015). In addition, the mental health nurses moral development will then be supplemented by their pre-registration training and their post-qualifying experiences (Dierckx de Casterle *et al.* 1997, Dierckx de Casterle *et al.* 1998, Cohen and Erickson 2006, Dierckx de Casterle *et al.* 2008). Taking this further development into consideration Dierckx de Casterle et al (2008) suggest;

"Kohlberg's theory, however, needs to be adjusted in relation to nursing care (Dierckx de Casterle´ et al. 1998). The abstract, rigid and justice-oriented ethical concept seems to be inadequate for nursing practice. Because nurses' ethical judgments are often based on the relationship with a particular patient in a particular situation, a more relational ethical concept is needed."

(Dierckx de Casterle *et al.* 2008, p.542)

Dierckx de Casterle *et al.* (2008) position was developed within a generic nursing perspective, however Alice gives a mental health nursing example;

"So if something happens and you had done the best for that person and you had followed the policy they are the important things for me. Saying that I do have another example when I went against that. I was on night duty and three o clock in the morning the fire alarm went off, we had people who would abscond and we had people on observations and protocol or policy was you look where it is and you evacuate the building you know get everybody out that is the policy. So we got everybody up we got them into the dining area where the fire exit was and we did the roll-call, we checked where it was and it was on floor three which was two floors up. So I know it is not on here so we will keep them in here and then obviously the fire brigade were automatically called, but I didn't evacuate and then reason I did not evacuate was because I felt there was a bigger risk if those patients were evacuated onto the car park, we would have people running off and going to kill themselves maybe, a bigger risk to the patients going than staying on the ward when the fire wasn't on the ward.

158

As it turned out the fire brigade came and the fire alarm was going off for two hours it was a fault on floor three, could you have imagined if I let all those people out on the car park for two hours, I did not know it at the time, and then we could not find the keys to turn the alarm off. My manager said to me after I had done the incident form why I had not followed policy and you did not evacuate so I explained my reasons that I felt that there was a bigger risk if I had let the patients go out I knew there wasn't a fire on the ward but not in the building, but I knew there was a bigger risk doing that. Even though I follow policy there are times when my duty of care to patients overrides that."

This example implies that mental health nurses do ethically reason at a post-conventional level where they will use the rules to provide a point of reference in combination with their ability to critically reflect in and on action (Dierckx de Casterle *et al.* 1998, Dierckx de Casterle *et al.* 2008). However, the mental health nurse's ethical reasoning cannot be easily separated from their personal characteristics as again articulated by Alice;

"*I think generally we pretty much worked all the same but I think generally I'm more of a cautious person any way so I think that is what I am probably reflecting the fact that I am more cautious than other people. You have always got a care plan to follow but I would think there are possibly practitioners who would not be as cautious maybe.*"

And yet Alice did overcome her cautious nature as demonstrated in the 'fire alarm' example above. Responding correctly or in Alice's case overcoming her cautious nature is a feature of expert clinical practice where the expert nurse through a process of critical reflection utilises their store-house of practice knowledge to make the right decision (Schön 1983, Welsh and Lyons 2001, Hardy *et al.* 2002). During this process rules have a part to play as a point of reference, top-down ethical reasoning, however without being proficient in bottom-up ethical reasoning the novice nurse may be led in the wrong direction especially in fast moving and novel situations (Carlsson *et al.* 2000, Welsh and Lyons 2001, Berg 2008). The expert nurse finds the right answer through knowing the rules and reflecting on and in action, expertise also embodies the use of virtuous character traits including wisdom which support the nurse to ethically reason at a pre-conventional level (Benner 1982, Benner and Tanner 1987, Dierckx de Casterle *et al.* 1998, Crook 2001, Dierckx de Casterle *et al.* 2008, Bowers 2010). Ethically reasoning in this way does not mean the mental health nurse does not structure the way they ethically reason, it means this process is more of a fluid process rather than a linear process (Cohen 2004, Ford 2006). A linear process of ethical reasoning (Bolmsjo *et al.* 2006, Ford 2006, Smith 2012b) may look like this;

1. Recognise the ethical issue/s
2. Gather the facts and values
3. Consider the rules
4. Look at any underpinning moral theories
5. Consider all options

6. Make a decision and test it
7. Act and reflect on the outcome

The expert mental health nurse will have been trained to think through ethical problems in this way, however due to the uncertain nature of clinical practice they have to be more fluid in their approach (Benner 1982, Benner and Tanner 1987, Cutcliffe 1997, Dierckx de Casterle *et al.* 2008, Nursing & Midwifery Council 2010). This fluidity is dependent on the mental health nurse being supported on their journey towards expertise and once they have arrived being supported to continue their journey. The work of Morrison and Symes (2011) highlights that; *"… the development of expert practice requires a supportive work environment that promotes nurses sharing knowledge and learning from experience"* (Morrison and Symes 2011, p.169). This includes working through the options during the reasoning process in a dynamic way, Susan gives a practice example;

"I think you can, restraint has not been a big thing in my career, fortunately, but I think it is a last resort, restraint. It should only be ever used as a last option, because it is restrain, and you taking people's liberty away, it is the ultimate act of taking people's liberty way, holding them down. But as long as, you know, at that time or at the point where they can understand what is going on or they are receptive to you, you make sure that you speak to them and say we are doing this, because. If you give them a rationale for what you are doing, why you felt it is necessary then I think, not OK, but it is sort of, you have got to do that when you restrain , explain why you are doing this."

In addition, to have the right conditions to engender expert and ethical practice the physical environment also has to be conducive to engendering ethical practice (Currid 2009). Mental health environments can be unpleasant places, they may engender practices that are unethical, and they may be coercion in a way that can be seen to abusive (Hannigan and Cutcliffe 2002, Kress 2006, Kuosmanen *et al.* 2007, Chodoff 2009, Cutcliffe and Happell 2009, Peele and Chodoff 2009, E Landeweer *et al.* 2011). This includes 'bullying' something highlighted by Mick;

Interviewer – *"So in that scenario how did you know that you did the right thing?"*

Mick – *"Ahem, its often difficult to tell because you can't research and have two separate wards and try one.. and, and it making a step and hoping it's worked well. (Big sigh) sadly one on the individuals that was being bullied killed themselves about three weeks later. Went off the ward on unescorted leave and went home and hung themselves. Um, he was someone who was in the group of bullies and sometimes he dropped out so it was a complex set of relationships, but on reflection I did think it had been the right decision an enough time had elapsed to think I hope the individual had done that for some other reason. If the individual had killed themselves while I was getting reports that they were feeling bullied and I never would have forgot it in my life.*

I am pleased that I we had moved the person the individual had identified was harassing them to somewhere else. It's two or three weeks earlier, and I so I am hoping whatever reason they did it was more to do with things in their own life than because of any unpleasant treatment they felt they were getting on the ward. In that case I think after that I felt pleased that if any of the PICU staff question you know this is what happened this is the kind of severity of the problems we are dealing with and do need to step in and do what we can."

6.7. <u>Researcher's reflections</u>

The following reflections have been accrued through the bracketing process and are used to conclude the discussion chapter (Smith et al. 2009). Originally these reflections started at the pre-reflective stage, '*a minimal level of awareness*', scribbles and doodles in my reflective diary (Smith et al. 2009, p.189). Over time these reflections have become more deliberate, critical, and learning focused as the research process has progressed (Smith et al. 2009). As a nurse I am no stranger to the reflective process, however I am a stranger to reflecting within an IPA context. On this basis, I found the following advice useful; "*... 'being phenomenological' involves taking a quality which occurs in everyday life, honing it, stretching it, and employing it with a particular degree of determination and rigour*" (Smith et al. 2009, p.189). This quality Smith et al. (2009) is referring to is pre-reflective reflexivity which is then honed to be deliberate controlled reflection. As a starting place to hone my reflections I first needed to reflexively recognise the experiences I would deliberately reflect on, in this case the analysis stage of my research, this includes not only presenting my rational insights, cognitions, but also recognising the emotions and values related to the experience (Gardner 2014). To continue this level of criticality my reflections acknowledge any underlying assumptions which includes recognising how the social context of the experience has impacted upon my reflexive sense making (Gardner 2014). This process of deliberate sense making is framed by considering the following questions (Crowe and O'Malley 2006):

➢ What are the key issues?
➢ Why have they occurred?
➢ What is their impact?
➢ Are there alternative ways of looking at the issues?
➢ Is there evidence which supports the prevalent view?

It is important to note at this stage that my reflections are part of a reflective loop which started with facilitating the participants to reflect upon their experiences (Smith et al. 2009). On this basis my reflections should not and do not sit outside of the research process, they along with the participants reflections should be seen as an interactive whole (Husserl 1931/2012, Smith et al. 2009). As these reflections as a whole relate to nursing practice there is a determination that they should aid future practice, however, how they aid future practice is ultimately for the reader to decide (Smith et al. 2009, Smith 2016).

During the research process, I was fully cognisant of being a registered mental health nurse who has worked for many years with people in acute mental distress. Over time through my role as an academic, I have rationalised these experiences with an emphasis on good practice. This notion of good practice is located within the relevant literature, clinical guidelines, policies, and ethical frameworks. However, I believe I have a healthy scepticism in recognising good practice is an ideal to aspire to rather than an everyday practical reality. My scepticism engenders a questioning position; I know what good practice looks like in the literature, does it really look like this in practice? In relation to ethical reasoning, I have a sense of what it should look like in practice, what is the pragmatic reality?

Ethical reasoning according to the literature overwhelmingly is described as a rational and linear process. Is this the reality for mental health nursing practice? There is a suggestion that nursing practice at an expert level has a tacit and bottom-up reasoning element. If so, is this the same for the mental health nursing field where coercive power uniquely resides? At the start of the research process my supervisory team highlighted the possibility of the participants unintentionally presenting themselves as being ethical; to be seen to have done the right thing. Interestingly this was not the case, rather there was a sense of constantly wondering whether they had done the right thing, and yet at no time was I asked to confirm whether they had. Externalising this 'wondering' felt like I was being given an insight into an internal process of 'checks and balances', this was not a process focused on regret, yes, there was some regret as if 'fate' had forced their hand after they had exhausted every option. Yet, it was more a case of; if I was in a similar situation what could I do differently? The greater the use of coercion the more the participants questioned themselves, in part this was driven by a strong emotional dislike of the use of coercion. Even the word coercion was disliked; alternative words were sought with persuasion being the preferred alternative. This dislike became stronger when talking about restraint and forced medication. Coercion was also self-personalised; '*I would not like this being done to me*'.
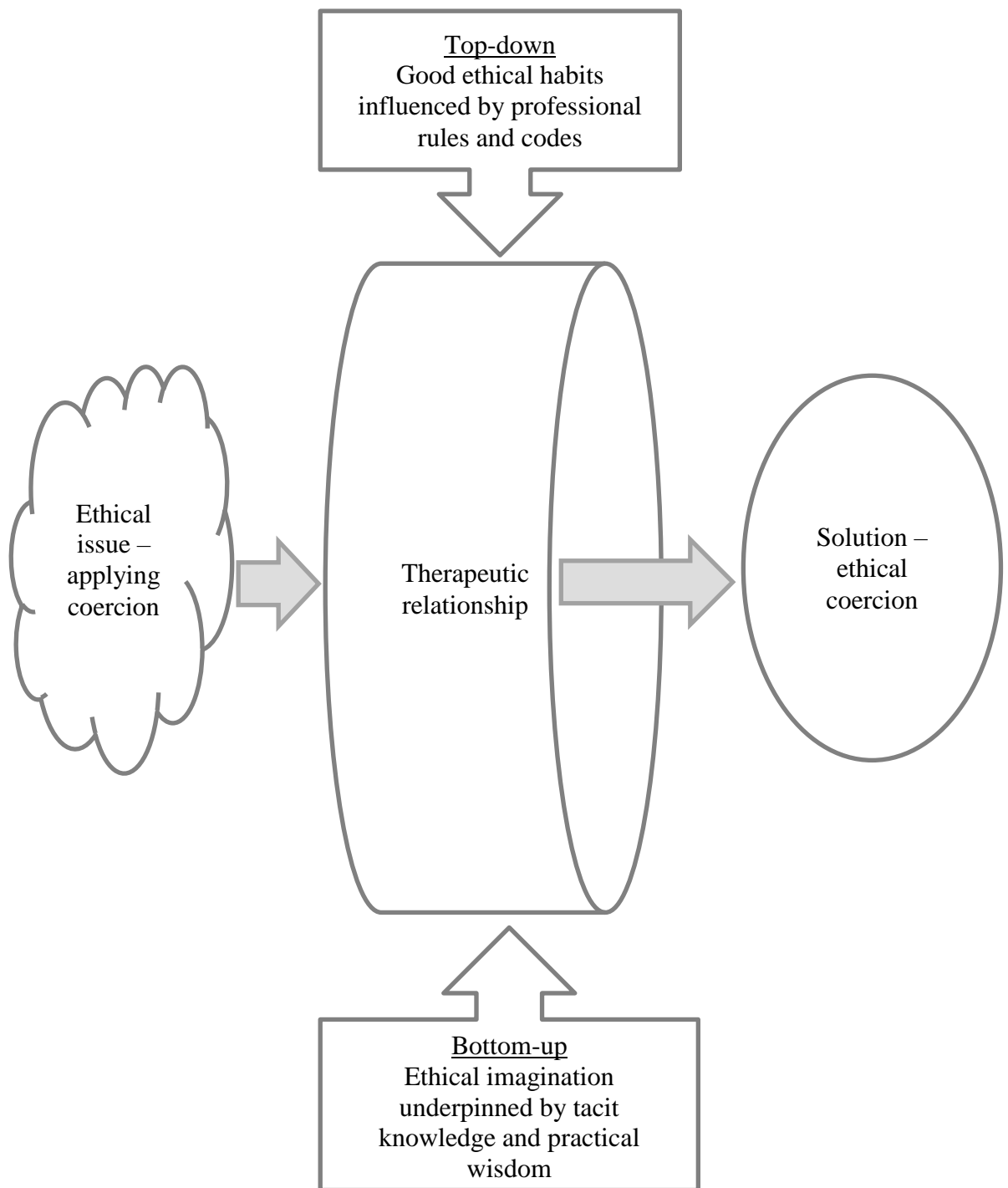
In some ways, this was not surprising as each participant was keen to point out that nursing is a caring profession. It seems coercion does not sit comfortably with this viewpoint, a case of being a 'necessary evil'. Applying learning from one situation to another was not just a cognitive process of recognising patterns; it is also included emotional learning. This type of learning was situated within the therapeutic relationship and included different types of knowing. The most used type of knowing being personal knowing and out of personal knowing then ethical knowing, doing the right thing, was formed. This ethical knowledge was constantly referenced to the rules with the rules being re-interpreted if they were not congruent with this personal knowing. These rules were only briefly mentioned during the interview process, it was acknowledged that they were important, however, common sense ethics appeared to hold a greater sway.

Common sense ethics is shaped by - 'what would I want if I was in their position?' This approach equates to a good nurse is a good person; this includes having the right character and the right values; trust, honesty, and respect being held in the highest esteem. Applying ethical knowing in this way felt relative to the situation, it looks like care ethics and it is articulated through the nurse having 'good habits'. It also relates to the virtue ethics element of care ethics, specifically the use of practical wisdom or phronesis (Hursthouse 1991, Hursthouse 1999, Gardiner 2003). To use practical wisdom, the nurse has to be experienced and know the situations they encounter. All of the participants would fit these requirements as expert practitioners. In addition, they know the rights and wrongs of a situation and how to prioritise their actions. Interestingly they would not necessarily describe this knowing and acting as being ethical, they would describe it as delivering care.

I was surprised by this common sense approach and yet at the same time not surprised. Nursing especially mental health nursing is a complex pursuit. Some situations can be predictable; however, where a person is acutely unwell there is a high degree of uncertainty, which stems in part from the person who is unwell not always knowing what they will do next. To manage risk and control in these situations it appears as if the mental health nurse is constantly trying out different options within the therapeutic relationship, almost constantly experimenting throughout this degree of uncertainty. To ensure they are ethical they look for ethical reference points, usually meditated by the therapeutic relationship, my surprise is that I thought the rules would have a greater say. What I describe as experimenting is more virtual than real, only pursing an imagined solution if it appears it might work and only if it appears to be right and does good; using an ethical imagination (Fesmire 2003). If this process was a model it would not be a linear model, it would have a linear component (top-down reasoning). However, this component would feed into a more holistic way of ethically reasoning (top-down and bottom-up), and it would acknowledge the central importance of the therapeutic relationship as an ethical meditator; **see figure 7**.

The following chapter will conclude the study by teasing out the key points and highlighting the original contribution the study has made in addressing a significant knowledge gap.

Figure 7: modelling how 'acute' mental health nurses apply ethical coercion

Top-down
Good ethical habits
influenced by professional
rules and codes

Ethical
issue –
applying
coercion

Therapeutic
relationship

Solution –
ethical
coercion

Bottom-up
Ethical imagination
underpinned by tacit
knowledge and practical
wisdom

Chapter 7: Conclusion

7.1. Summary of the study

Building upon the researcher's reflections, this chapter will be underpinned by the following broad aims and considerations;

1. To identify what the researcher has learnt from undertaking the study.
2. To tease out the strengths and limitations of the study.
3. Does the actual research process undertaken still relate to the intended aims of the study?
4. What are the implications for practice – mental health nursing practice?
5. What suggestions are there for future research?

Before dealing with each aim through the following sections; methodological considerations and critical reflections, clinical application and implications for existential theory and practice, and future research, an opportunity to summarise what has been learnt will be taken. The superordinate themes will be used to structure the following summary.

When ethically reasoning through coercive situations the mental health nurse as a clinical practitioner uses different ways of knowing, these ways of knowing are akin to the ways of knowing highlighted in the seminal work of Carper (1978). This knowing is based on the mental health nurse's clinical experiences; it is shaped by their formal and informal learning and includes reflecting on their practice. Even though empiric knowing is held in high esteem within healthcare mental health nurses clearly use all the forms of knowing. Due to the nature of mental health nursing practice knowing that emanates from knowing the service user such as personal knowing is used extensively when ethically reasoning. Empiric knowing comes to the fore when there is a need for the mental health nurse to justify their actions, however this does not preclude the use of other forms of knowing where required.

Knowledge, which is tacit, takes a prominent role when working with a mental health service user who is in acute mental distress and there is a high degree of uncertainty. In these situations, the mental health nurse uses evidence-base knowledge but as it has its limits, they primarily appear to use intuition or tacit knowledge. Using forms of knowing in these types of situations is not a process of picking the best form of knowing, all the forms interact with each other, and they are also interactively shaped by the situation itself. This interactive process in turn shapes the mental health nurse's own understanding of their practice and how this knowing can be used in other similar situations. Upon reflecting and rationalising their actions this use of knowing starts to look more rational and logical and potentially looks like empiric knowing, a societally preferred form of knowing. To be able to use the different forms of knowing effectively the mental health nurse has to be competent and experienced they also have to continuously reflect in way that meaningful knowing is generated.

This process includes developing a 'tacit store of knowing' which can be called upon by the mental health nurse from one situation to another (Welsh and Lyons 2001, Matthew and Sternberg 2009). Using this store of knowing from a practitioner perspective looks like; 'I just knew what to do', on rationalising 'knowing what to do' various forms of knowledge are then referenced as a form of justification for the practitioner's actions. This tacit store of knowing incorporates all of Carper's forms of knowing, however the mental health nurse is heavily dependent on the use of personal knowing due to their practice being contextualised by the therapeutic relationship; the medium for treatment (Carper 1978, Hurley and Rankin 2008). In addition, this personal knowing within mental health nursing practice interacts with ethical knowing especially when making clinical decisions that potentially restrict freedoms (Radden 2002a, Radden 2002b, Radden 2004). Enjoying the mental health nurse role and feeling supported has an impact, not feeling valued can inhibit the emotional way the nurse practices, this is especially important when considering the importance of needing to be a 'people person'. To be a 'people person' the mental health nurse has to truly listen and have empathy for the people they care for, they have to be self-aware and they have to be in the moment. Being distracted internally or externally can have an adverse impact upon truly listening; by not listening this can lead to assuming which in turn can lead to conflict within the therapeutic relationship. Being able to truly listening is extremely important when considering the service user in acute mental distress may be struggling to communicate their needs effectively, therefore any useable information they convey is of the upmost value. Not being able to listen or having limited information appears to be a day-to-day reality of working with people in acute mental distress especially if they are on an in-patient ward and/or they are new to mental health services.

As an added layer of complexity using coercion can be distressing, even the use of word 'coercion' evokes a strong emotional reaction. Mental health nurses are expected to be emotionally intelligent enough to work through these emotional challenges, one strategy they use to do is to ground themselves within the empathetic nature of the therapeutic relationship (Johns 2016). The participants articulated this grounding as, 'how would I wanted to be treated if I was in their situation'. In some ways this is a 'mindful' approach to dealing with these emotional challenges, a sort of being in the therapeutic moment (Johns 2016). Being emotionally sensitive ensures at the same time the mental health nurse is ethically sensitive. This almost synonymous connection stems from the professional nature of the therapeutic relationship which places this caring relationship firmly within the ethical domain (Nursing & Midwifery Council 2015a). In addition, there is an external pressure that even in the most difficult circumstances the mental health nurse makes clinical decisions that are ethically justifiable (Nursing & Midwifery Council 2015a).

To be an effective ethical reasoner when making clinical decision the mental health nurse has to be 'ethically sensitive'. Based on linear model of ethical reasoning the mental health nurse has to clearly identify the ethical issue/s.

Due to the emotional nature of mental health nursing practice to 'identify' effectively the nurse has to self-aware which includes understanding their own levels of ethical distress (De Veer *et al.* 2013). In part grounding their practice appears to help even when role dissatisfaction is present, experience is also a mediating factor which includes being able to recognise familiar patterns within a situation. Pattern recognition is a feature of expert practice, which is articulated through the seminal work of (Benner 1982). Identifying an ethical issue and then deciding an appropriate set of actions looks like an educated guess in uncertain and complex situations. This educated guess is also based on knowing the service user (all forms of knowing) and having an experienced sense (expert) of what the best emotional response should be for that individual. The mental health nurse is constantly aware that they have to justify this educated guess and in way that it does not appear to be a guess. This way of reconstructing knowing after a decision has been made may stem from being required to appear to be rational and scientific, however the downside is the non-reductionist richness of this process can be diminished (Carlsson *et al.* 2000). In terms of the participants' narratives the emotional and subjective elements of their reflections only appear to be present when probed for; how did you feel, why did you make that decision? Within a safe relationship, the researcher-participant relationship the participants were comfortable in disclosing this potential hidden dimension but only when prompted.

During this reasoning process there is also a great emphasis on being the right kind of mental health nurse which includes having the right kind of values. The main values highlighted were respect, trust, and honesty. In some ways these values appear to conflict with the use of coercion which in all intents and purposes looked like 'deceit' to the participants. On this basis coercion was reframed by the participants as persuasion which felt less coercive and felt more therapeutic. This sense of being therapeutic even when coercing was important due to this activity being embedded within the therapeutic relationship. Having the right values both as a nurse and as a person was viewed as increasing the potential of 'doing good'. Having the right values was not linked by the participants to an ethical theory such as virtue ethics rather it was seen as being based on 'common sense'. Interestingly there is no general consensus on what the right virtues or values should be, however the participants were adamant that respect, trust, and honesty were the right values a mental health nurse should possess. Being internally motivated rather than just externally motivated to have and use the right values fits with a virtue ethics approach (Armstrong 2006, Radden and Sadler 2008). It was clear the participants used these values in the development and maintenance of the therapeutic relationship. This includes having the wisdom to respond to the individual needs of the service user, which in essence links the rights values to knowing. There was a sense throughout this process that the mental health nurse is constantly feeling for the right solution which fits in with the notion of an educated guess, however it is more emotional and intuitive than an educated guess. Possibly it is where the nurse taps into the irrational, this includes the 'cautious' participant who took a risk on not following the rules because it felt right even though it was out of character.

This approach in retrospect allowed the participant to make the right choice and at the right time, however at the time they did not know their solution would work in reality (Gardiner 2003). It could be argued that the participant was tapping into their moral imagination, working out the right thing to do by imagining the various possibilities, but in quick time (Fesmire 2003, Cohen 2004). Balancing the irrational with the rational is not surprising as mental health nursing is a human endeavour albeit mediated by numerous rules and frameworks. The mental health nurse is therefore constantly working out the right thing to do by using their knowing, which is constantly being shaped by the situation, while at the same time interpreting and re-interpreting the rules. The humanness and values-based nature of the encounter ensures that any interpretation is right for the service user at that time. This includes fast-paced encounters, when the participant was reflecting on an incident where they were attacked; they had the presence of mind to know what they could do and what they should do. 'Could do' was being able to use restraint techniques; 'should do' was tailoring the type of coercion used to suit the individual even if this was a therapeutic risk.

A therapeutic risk can involve doing what is 'tacitly' believed to be best for the service user, however taking this risk may be in conflict with the rules such as policies and procedures. As these rules are there to provide guidance there is a level of interpretation required, conflict arises when the practitioner re-interprets these rules differently than say a line-manager. This process of re-interpretation involves exposing the weakness of the rules which is done by comparing the rules against the best interests of the service user. For the practitioner the best interests of the service user should always come first. This position moderates the use of the power to coerce but only if the nurse recognises the nature and impact of this power (Woodbridge and Fulford 2004, Roberts 2005). Knowing what is best for the service user is generated through the mental health nurse's constant dialogue with the service user, a feature of the therapeutic relationship. This in turn shapes knowing into ethical knowing, knowing what is the right thing to do (Dierckx de Casterle *et al.* 2008). Ethical knowing generated in this way does not exclude ethical rules rather it references them as required, however it is ultimately based on an ethical dialogue (Carper 1978, Welsh and Lyons 2001). In addition, this ethical dialogue is guided by the mental health nurse's ethical values in this case; 'treating people in way that you would like to be treated'. This value is expressed as a common sense moral approach and yet it is capturing the notion that the service user should have same duties and rights as anyone in society, in essence a rights-based approach (Trobec *et al.* 2009). The code of conduct for nursing takes a similar approach by emphasising the need to respect the rights of the service user, is does not say how in detail, it is left to the nurse to make real world sense of the 'how' (Nursing & Midwifery Council 2015a). This approach leaves the mental health nurse with a burden of expectation. They are expected to interpret and apply the rules correctly even in the most difficult circumstances, if after external review they have deemed not to have done so they can be professionally sanctioned (Nursing & Midwifery Council 2015a).

This approach can create further conflict and potentially increase the nurse's ethical distress if the mental health nurse is taking a therapeutic risk which places them in conflict with the ethical rules (De Veer *et al.* 2013). In terms of distress coercive situations can be extremely distressing for all involved parties, further distress can be potentially added when taking a therapeutic risk, dealing with all this distress may influence the mental health nurse to follow the rules even if it is not the best course of action for the service users in their care (Cutcliffe and Links 2008, De Veer *et al.* 2013). This viewpoint has to be tempered by the internal motivation of the nurse to ensure they treat the service user as they would like to be treated even if this creates external conflict. Treating service users in this way is person-centred, however it is recognised being a mental health service user conveys certain differences. One of these central differences is the sanctioned power the mental health nurse possesses to restrict freedoms (Fulford 2009). To use this power there has to be justification and yet at the same time it has to be recognised that there is a political pressure to be seen to control the risk the mental health service user may appear to pose (Johnson 2013). This places the mental health nurse in the difficult position of having to balance the best interests of the service user against the best interests of society as a whole (Berlin 1998). This again creates conflict which stems from needing to be person-centred while at the same being society-centred - a sanctioned ethical agent working on behalf of wider society (Ripstein 2004, De Veer *et al.* 2013). Being emotionally intelligent in addition to being motivated to treat service users in the right way is another way of moderating the effects of this sanctioned power.

The participants' highlight acute mental health is not a place rather it is the level of mental distress the individual is experiencing. Making sense of the distress the individual is experiencing is dependent on the mental health nurses conceptualisation of this distress and the quality of their relationship with the individual (Cromby *et al.* 2013, Chambers *et al.* 2015). Mental health nurses use a number of different models of mental distress within their practice; however, there is drive to ensure these models are compatible with the evidence-based agenda. In doing so, a mental disorder label has become a way of professionally communicating a service user's mental distress (Bracken and Thomas 2005). The challenge with this approach is the phenomenological meaning of the experience can be reconstructed in way that the service user's understanding is lost (Merleau-Ponty 1945/1962). To ensure this is not the case the participants constantly embed their understanding within knowing the service user as partner in the therapeutic relationship. The approach is not without its challenges this relationship is therapeutically focused, however 'power' is a constant contextual factor especially where risk to self and/or others is deemed to be present (Roberts 2005). In addition, the therapeutic relationship is both the medium for treatment as well as in some cases the main treatment. On this basis the therapeutic relationship has to be collaborative and person-centred while at the same time contain clinical risk which includes using coercive strategies.

Balancing person-centeredness against the management of risk leads the mental health nurse into morally distressing territory, especially when considering the routine use of coercive measures within a mental health nursing context (O'Brien and Golding 2003). This routine use is based on a broad definition of coercion which is underpinned by a common justification; 'it's in their best interests'. The participants' practice is shaped by this context; not wanting to coerced, wanting to be person-centred, being required to justifiably coerce, feeling conflicted when coercion is used especially the use of physically restraint.

The inherent ethical weakness of 'routine coercion' which includes locking wards doors is it may appear on the surface to be beneficent, however at a deeper level of analysis it does not necessarily follow it can be ethically justified in every situation (O'Brien and Golding 2003). This is not a surprise as coercion which is routine and indiscriminate provides a catch-all approach which captures the good and the bad or the ethical and potentially abusive. Even ethically justifiable coercion, doing good, can still feel to the mental health nurse as if they have somehow failed. In some ways this is a good thing as it may potentially stop abusive practice; however this is reliant on the nurse maintaining their emotional-ethical sensitivity which in effect becomes as a protective factor (De Veer *et al.* 2013). Another issue to take into consideration is how coercion is defined in practice. Defining what coercion is and is not was a struggle for the participants, part of this struggle relates to not feeling comfortable with the use of term. Lessening the emotional impact includes reframing the term 'coercion' to the term 'persuasion'. Throughout this process of reframing the participants recognised when they were talking about persuasion they were synonymously talking about coercion. They also recognised they had the power to use levels of coercive strategies, from persuading a service user to do or not to do something, to being able to in their best interests physically control the service user. This was viewed as power which is reluctantly used, a safeguard inherent in the use of this power is the least coercive strategy was always preferred. Not being comfortable with thinking about or using coercion relates back to emotional-ethical sensitivity as a protective factor.

An important component of being sensitive is the skilled use of empathy. 'It is not a nice thing to do', 'how would I feel if it happened to me'? Using coercion that is sensitive and therapeutic frames the rightness and wrongness of using coercion in this way as an ethical issue (Ripstein 2004). In addition, coercion has to be beneficent recognising the context of mental health practice which includes being mediated by the presence of risk. Sensitive coercion has to be sensitive to individual needs, a key tenet of the therapeutic relationship; it has to be right for the person in that moment in time. To manage this level of complexity the mental health nurse has to possess expert skills and knowledge, the right values, and they have to be a skilled ethical reasoner. These characteristics do not sit in isolation, they are part of being an expert mental health nurse who reasons at a pre-conventional level (Dierckx de Casterle *et al.* 2008).

Being an expert is built on using all forms of knowing, these forms of knowing are used pragmatically; "*In the every-day sense of the term 'pragmatism' is associated with a matter-of-fact approach to problem-solving*" (Bacon 2012, p.1). For the participants matter-of-fact translates to using your common sense, philosophically this approach equates to valuing knowing through its practical utility rather than its theoretical underpinnings (Bacon 2012, Dewey 2015). This does not mean the mental health nurse is not aware of any theoretical underpinnings or its value, rather they are more focused on how this knowing it all its forms will benefit the service user. It is no surprise that mental health nursing as a 'practical' discipline values pragmatic knowing nor is it a surprise the mental health nurse's ethical reasoning is also built on this pragmatic knowing (Cohen 2004). The mental health nurse will use top-down ethical reasoning given time and space, this includes referencing the ethical rules, less so ethical theories. However, even when having the time and space this top-down reasoning approach usually starts with an ethical problem that is embedded in the nurse's everyday practice, the problem being identified through the nurse constantly being a bottom-up ethical reasoner. If the issue is unresolved, other opinions are sought including considering ethical rules and frameworks in more detail. If the rules provide clear guidance the nurse will top-down reason, if not, they will both top-down and bottom-up reason, which in effect adapts the rules (LaFollette 2007). Where an ethical problem happens in 'quick time' then mental health nurse follows a similar process, the difference being they have less time to externally reference multiple sources of knowledge. By constantly refreshing their knowing the mental health nurse is more likely to do the right thing. This process of refreshing their knowing is not just a case of updating their knowledge through formal learning, it also about learning through their role by constantly reflecting on their practice. This process enables the mental health nurse to tacitly work through an ethical challenge in 'quick time' which involves the nurse having an inner dialogue where they imagine different solutions to the problem (Fesmire 2003). Where a problem is recognised quickly through pattern recognition a solution can also be applied quickly. This approach has to involve the use of emotional intelligence due to mental health nursing being a human endeavour. On reflection it appears to be a rational process and yet under the surface it is a process that is structured through the nurse using good habits which assist the nurse in making sense of the irrationality of mental health practice.

7.2. Methodological considerations and critical reflections

Research can be used to defend or justify a particular viewpoint, it can also be used within a practice context to 'inform future actions' (Greenop and Smith 2016, p.151). This approach is common when using an empirical research approach within a practice context such as 'evidence-based practice' (Greenop and Smith 2016).

Naturalistic methods which include IPA focus on increasing;

"... (empathic) understanding rather than merely explaining behaviours in terms of causes and correlates. In-depth interviewing, focus groups, participant observation and other naturalistic methods are therefore used to explore human experience, meaning and potential."

(Greenop and Smith 2016, p.153)

Taking this position into consideration the findings of this study create an empathic connection between the participants and the reader. The researcher's role is to facilitate this understanding, however the researcher cannot mitigate against the assumptions the reader will bring when making sense of this study (Husserl 1931/2012). These assumptions include; being concerned the sample size it to small, the participants' experiences are not representative of a larger and generalised sample, and naturalistic research does not control bias (Greenop and Smith 2016). There is also the concern from the researcher's perspective they have not fully represented the participants' voice. IPA tries to manage this concern through providing a robust analytical approach (Smith *et al.* 2009). In addition, Smith *et al.* (2009) signposts the researcher to putting in place an extra safeguard; the use of an independent and experienced researcher to provide input during the analysis of the data, which was a safeguard present in this study.

IPA is a new research approach even though its theoretical underpinnings have a long and well-respected history (Smith *et al.* 2009, Shinebourne 2011, Smith 2011). An evaluative study by Smith (2011) identifies IPA as being primarily used to makes sense of the 'illness experience', however it is also increasingly being used to make sense of the 'carer experience' and the 'health professionals experience'. Furthermore, a study's findings should be transparent, paying careful attention to highlight through the reflexive process the researcher's underlying assumptions (Smith 2011, Greenop and Smith 2016). This methodological advice has been embedded within both the research itself and the writing-up of this study, to ensure it has not been followed like a 'recipe' periods of activity have been followed by periods of calm reflection (Pan 2003).

7.3. Original contribution to addressing a significant knowledge gap

Applying coercion even when re-framed as persuasion is an ethical concern, one that the mental health nurse reasons through on a daily basis. To the nurse ethical reasoning within a practice context looks indistinguishable from making 'good' clinical decisions (Cohen 2004). In part, this is due to the professional nature of practice and in part due to the nurse seeing ethics as an abstract pursuit (Roberts 2004). When clinical situations are complex, with the outcome uncertain, and a quick response is required, distinguishing is less of a priority.

In these circumstances, the mental health nurse is appearing to act in a fast and fluid way, using different forms of knowing; this knowing appears tacit and intuitive and tends to be externally accessible after the event (Carper 1978, Benner 1982, Welsh and Lyons 2001). In addition, the mental health nurse, who has the power to coerce, has to be motivated to be ethical and do good (Roberts 2004, Roberts 2005). Taking the 'indistinguishable' into consideration there is a need within pre-registration mental health nursing programmes to ensure there is a close alignment between making clinical decisions and ethical reasoning. There is a professional requirement in place influencing these programmes, which includes decision making and ethics;

"… must practise with confidence according to the code: Standards of conduct, performance and ethics for nurses and midwives (NMC 2008), and within other recognised ethical and legal frameworks. They must be able to recognise and address ethical challenges relating to people's choices and decision-making about their care, and act within the law to help them and their families and carers find acceptable solutions."

(Nursing & Midwifery Council 2010, p.22)

There is currently a new code of conduct which came into effect in 2015, however the above requirement has not changed, it could be argued that through revalidation this requirement has been strengthened (Nursing & Midwifery Council 2015a, Nursing & Midwifery Council 2015b). In addition, to this requirement the standards for pre-registration nursing link ethical behaviour with the protection of the public they also signpost programme providers to deliver teaching and learning which includes focusing on professional codes, ethics, and the law (Nursing & Midwifery Council 2010). These mandatory requirements imply at a minimum level that following ethical rules and frameworks will engendered ethical behaviour (Cohen 2004, Robertson et al. 2007a). Of course the rules and frameworks are important, so is the ethical development of the individual before they entered the profession as well the context of their intended practice (Kohlberg 1984, Dierckx de Casterle et al. 2008, Fulford 2009). This context for mental health nurses is the unique nature of mental health nursing practice where coercive power is an everyday reality for mental health service users (Foucault 1961, Roberts 2005). The findings of this study indicate, firstly, that to bring the ethical into the everyday clinical decision-making of mental health nurses working with service users in acute mental distress there is a need to converge linear ethical reasoning frameworks with linear clinical decision-making models (Comrie 2012). This approach should be used to engendered good ethical habits – continually rehearsing good responses to various common practice issues (Fesmire 2003, Dewey 2015). Secondly, there also has to be a recognition, similar to clinical decision-making, this good habit approach should be a foundation for a more multi-dimensional approach and one that recognises the ethical imagination of the mental health nurse – feeling for a solution and taking an educated guess (Fesmire 2003, Dewey 2015).

7.4. <u>Implications</u>

Refining multidimensional ethical reasoning is a lifelong pursuit, it takes practice, you have to be motivated and willing to learn from others (Fesmire 2003, Smith 2016). Mental health nurses as; "*…, ethical professionals do not make decisions without deliberating about sufficiently. They think through the relevant considerations carefully, gathering information as needed, and use their ethical reasoning skills to resolve ethical dilemmas effectively*" (Ford 2006, p.289). Working constantly in this way promotes good habits as does constantly engaging in reflective practice (Fesmire 2003, Nursing & Midwifery Council 2015b). This notion of having good habits stems from the work of Dewey, Fesmire (2003) describes this notion of forming good habits in the following way;

"*Without the inheritance of established habits … death is inevitable. Yet without intelligent reformation of these habits, successors may be little better off. Thus, Dewey's central message to the classic moral tradition: moral conduct is not an issuing in of moral laws from the cocoon of autonomous transcendental reason. Individuals must be replanted in their social soil.*"

(Fesmire 2003, p.26)

Developing good habits is synonymous with good practice, however these good habits will cease to be good habits if they do not adapt to the ever changing social environment (Fesmire 2003, Dewey 2015). It is suggested through the work of Dierckx de Casterle et al. (2008) nurses are open to adapting there ethical reasoning to circumstance through being able to ethically reason at a pre-conventional level. This adaptive process involves testing and trying out different ethical solutions and then responding accordingly (Dierckx de Casterle et al. 1997, Dierckx de Casterle et al. 1998, Dierckx de Casterle et al. 2008). Deliberating and then imagining these different solutions which are then tested out in 'reality' or within the nurse's imagination requires an ethical imagination (Fesmire 2003). There are similarities between ethical imagination used in this way and the use of reflection-in-action though whether they are part of the same process is not clear (Fesmire 2003, Matthew and Sternberg 2009, Gardner 2014). Within a pragmatic position (Dewey), all reasoning is imaginative;

"*As experimental, pragmatist ethics must continually be revised in the light of empirical discoveries. Recent research in cognitive science, particularly in the field of cognitive semantics, bolsters and expands Dewey's claims that ethical deliberation – indeed all reasoning – is fundamentally imaginative and that imagination is not internal and subjective.*"

(Fesmire 2003, p.82)

Indeed this may be the case; however, Collier (2006) argues the skilled use of ethical imagination is an artistic activity, which requires; artistic discernment, empathy-based perception, and an ability to express one-self through a process of reflection.

Collier highlights;

"Moral imagination is 'artistic' in the sense that it uses skills that are characteristic of artistic activity. It needs firstly the skills of discernment and the ability to discriminate between what is relevant in the situation and what is not. It needs perception, a feeling for what is going on in the minds of others and a sense of how the issue might best be resolved."

(Collier 2006, p.315)

These features relate to the field of architecture and yet on the surface they appear compatible to how mental health nurses ethically reason – an area for future research. The similarity to mental health nursing relates to the role of empathy as a core part of ethical imagination, empathy is also the foundation of a mental health nurses ethical reasoning endeavours when applying coercive strategies.

Taking the study findings into consideration, the need to engender good ethical habits while actively encouraging an ethical imagination, it is recommended;

1. Prequalifying mental health nursing students should be introduced to ethical theory, which is sensitive to the context of mental health nursing practice including exploring pragmatic ethical approaches.
2. Post-qualifying education for mental health nurses which has a decision-making focus should not exclude the ethical nature of making decisions within a practice context. Indeed it needs to tease out both the good habits of practice and how the nurse may feel for a solution through the use of an ethical imagination
3. Mental health nurses need to understand their baseline reasoning skills and not just, how they make sense of the rules such as the code of conduct. Furthermore, they have a duty through structure reflection to develop good ethical reasoning which should underpin their good habits.
4. The mental health nursing profession needs to recognise through ongoing dialogue and research the value of a more holistic approach to ethical reasoning and one that encompasses the artistic nature of mental health nursing practice – ethical imagination
5. Coercion in mental health has a unique connotation and on this basis, there needs to be more research within this area, which does not just focus on the 'rules'. This would include further research related to the skilled use of ethical imagination within a mental health nursing context.

7.5 <u>Final insights</u>

IPA is a reflective process, which is iterative and typically non-linear. These reflections are constantly interacting with each other, however, for the purpose of writing this study these reflections are separated out and identified. This does not mean at this juncture this reflective process stops, even now as I am writing this section reflective insights are springing into my consciousness. Yet, I am mindful there is a need to capture these reflections as learning, which will hopefully improve the way mental health nurses practise. Wanting to improve mental health nursing practice is shaped by my continuing experiences as a registered mental health nurse. This wanting or drive is grounded by the pragmatic reality of this study – the findings.

In the recommendations of this study there is an emphasis on the steps that can be taken to improve the practise of both prequalifying and post-qualifying mental health nurses. These steps emphasise the importance of developing 'good ethical habits' combined with the use of an 'ethical imagination'. Good ethical habits and an ethical imagination are not added extras. All of the participants demonstrated the use of good ethical habits, which were accrued through years of mental health nursing practise. The informal and formal learning the participants undertook, including participating in reflective activities, shaped these good ethical habits. It is important to recognise the development of these good ethical habits are part of a mental health nurse's lifelong learning journey – 'cradle to grave'. Whereas the use of an ethical imagination is contextualised and directly developed through the mental health nurse's practise experiences. In addition, ethical imagination is potentially an undiscovered part of the mental health nurse as an artist. It also has synergies with the notion of practical wisdom or phronesis.

The original aim of this study was to 'explore how mental health nurses who within their practice have used sanctioned coercion make 'ethical' sense of their experiences'. In effect, the intention was to address a knowledge gap related to the ethical reasoning experiences of mental health nurses using coercive strategies. Due to this study, what do we now know that we did not know prior to this study? Of course, methodologically we have to be cautious, as this learning may not be generalisable. However, we now know that coercion is disliked irrespective of its justification, this includes changing the term 'coercion' to something less sinister like 'persuasion'. The use of coercion is grounded within the values and empathetic intention of the mental health nurse - 'I would not like this being done to me'. Knowing when to apply coercion is not just about pattern recognition it is about personal knowing. This type of knowing is embedded within the therapeutic relationship; it also constantly interacts with other types of knowing. Being ethical within a coercive context is underpinned by rules, theories, etc. The most important ingredient is 'common sense', having good ethical habits and a good ethical imagination (expert nurse).

Appendices

<u>Appendix 1 - ethical clearance</u>

With reference to your application for Ethical approval:

12/HEA/042 - Overriding the choices of mental health service users'; a study examining the acute mental health nurses perspective

Liverpool John Moores University Research Ethics Committee (REC) has reviewed the above application by Chairs action and I am happy to inform you that the Committee are content to give a favourable ethical opinion and recruitment to the study can now commence. Approval is given on the understanding that:

· any adverse reactions/events which take place during the course of the project will be reported to the Committee immediately;

· any unforeseen ethical issues arising during the course of the project will be reported to the Committee immediately;

· any substantive amendments to the protocol will be reported to the Committee immediately.

· the LJMU logo is used for all documentation relating to participant recruitment and participation eg poster, information sheets, consent forms, questionnaires. The JMU logo can be accessed at http://www.ljmu.ac.uk/corporatecommunications/60486.htm. For details on how to report adverse events or amendments please refer to the information provided at http://www.ljmu.ac.uk/RGSO/RGSO_Docs/EC8Adverse.pdf. Please note that ethical approval is given for a period of five years from the date granted and therefore the expiry date for this project will be August 2017. An application for extension of approval must be submitted if the project continues after this date.

Yours sincerely

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Invitation to participate in the research

Dear reader

Call for participants:

I would like to invite you to participate in my research focusing on the experiences of acute mental health nurse who have used coercive strategies to control mental health users such as the use of restraint, special observations, the law, psychological interventions and risk management approaches. If you are a registered mental health who is currently practicing and has recent experience within acute mental health services, you can participate. Participation will entail 3 separate 45-60 minute face to face interviews, which will be recorded and transcribed for analysis. All interviews will remain confidential, and the research material will only be shared with my supervisors at Liverpool John Moores University. All research material will be anonymised to protect the identity of participants. Participants can choose to withdraw at any time, at which point their material will be destroyed. This research study has been granted ethical approval through Liverpool John Moores University as part of my Doctorate studies, and will be supervised by Rose Khatri (R.J.Khatri@ljmu.ac.uk) and Dr Susan Giles (S.P.Giles@ljmu.ac.uk) at the University.

If you would like to discuss this research and perhaps would consider participating, please send me a reply by email.

Kind regards,

Grahame Smith

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LIVERPOOL JOHN MOORES UNIVERSITY
PARTICIPANT INFORMATION SHEET

Project Title: 'Overriding the choices of mental health service users'; a study examining the acute mental health nurses perspective

Researcher: Grahame Smith – Faculty of Health & Applied Social Sciences

You are being invited to take part in this research study. Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

1. What is the purpose of the study?

The issue of coercion has been thoroughly explored within mental health nursing practice though there is little work on the moral decision-making process of acute mental health nurses using coercive strategies. On this basis the aim of the proposed study is to bridge this gap by exploring the acute mental health nurse's experiences of overriding the choices of a mental health service user.

2. Do I have to take part?

Participation in this study is voluntary. It is completely up to you whether or not you participate. Participants can choose to withdraw at any time, at which point their material will be destroyed.

3. What will happen to me if I take part?

Participation will entail 3 separate 45-60 minute face to face interviews at the Faculty of Health & Applied Social Sciences, Liverpool John Moores University; these interviews will be recorded and transcribed for analysis. The focus of the interviews will be to explore your experiences as an acute mental health nurse who may have used coercive strategies to control mental health users such as the use of restraint, special observations, the law, psychological interventions and risk management approaches. All interviews will remain confidential, and the research material will only be shared with my supervisors at Liverpool John Moores University.

4. Are there any risks / benefits involved?

It is not anticipated that you will have any cause for concern during the interview; however, if at any point in the interview you become uncomfortable we will stop the interview immediately.

Talking about coercive situations may be upsetting and if this is the case you may wish to consider utilising the services of a confidential debriefing service, such as the Incident Support Service (ISS); Liverpool service: 0151 – 330 8103/ 8099, Southport service: 01704 383 007. Having completed the research I hope that I will be able to share my findings through publication with the wider mental health nursing community with the aim of developing and improving practice.

5. Will my taking part in the study be kept confidential?

Your responses will not be linked to your name or any personal details. In any publication, information will be provided in such a way that you cannot be identified. If any quotes are used you will not be named and you will be unidentifiable.

Contact Details of Researcher

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Thank you for taking the time to consider this study. If you wish to take part in it, please sign the attached consent form. This information sheet is for you to keep with a copy of the consent form.

**LIVERPOOL JOHN MOORES UNIVERSITY
CONSENT FORM**

Project Title: 'Overriding the choices of mental health service users'; a study examining the acute mental health nurses perspective
Researcher: Grahame Smith – Faculty of Health & Applied Social Sciences

1. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights.

3. I understand that any personal information collected during the study will be anonymised and remain confidential

4. I agree to take part in the above study

5. I understand that the interview will be audio recorded and I am happy to proceed

6. I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised.

Name of Participant   Date   Signature

Name of Researcher   Date   Signature

Name of Person taking consent   Date   Signature
(if different from researcher)

Note: When completed 1 copy for participant and 1 copy for researcher

Potential Interview Prompts

- What is your understanding of the term coercion?

    o Explore the participants experiences of using coercion within a mental health context

- How did you make sense of these experiences?

    o Explore thinking processes

    o Consider feelings

    o Explore the ethical dimension

    o Consider ethical reasoning

    o Look at values

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189

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