

**CRITICAL CASE STUDY: SUPPORTING THE NEW GRADUATE  
NURSE ENTERING SPECIALIST PSYCHIATRIC  
MENTAL HEALTH NURSING PRACTICE**

**by**

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## ABSTRACT

This critical case study was undertaken for the purposes of illuminating information relating to new graduate nurses' experiences in their first clinical placement, in order to consider ways an established entry to practice programme (the programme) can better support and enhance the students' transition from student nurse to staff nurse within psychiatric mental health nursing practice.

Seven of the 1999 students of the programme participated in the research. The project provided the researcher with a variety of challenges related to her dual role as researcher and programme coordinator. Data was collected through the use of discussion groups, participants and researcher jointly identifying the themes that were explored. These themes related to preceptorship and support, socialisation of the new graduate and risk management.

The research has provided rich data that has and will continue to be used to inform future developments within both the educational and clinical components of the programme. The research has also provided opportunities for personal and professional growth through the sharing of experiences and working together to identify emancipatory action which has in turn led to transformation.

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## **CHAPTER 1: INTRODUCTION**

I have always been interested in working with other nurses to support and enhance nursing practice. During my years of clinical practice I worked in areas of Staff Training and Development, New Graduate Orientation programmes, Psychiatric Skills Training for Enrolled Nurses, and Casual Resource Nurse orientation to Mental Health. I have seen many changes in the scope of nursing practice and education that is now available to nurses at both the undergraduate and post graduate levels. One of the reasons why I have always wanted to work in education is because this is where I feel nurses can be best prepared to enter the practice setting and supported to gain the knowledge and skills required to sustain life long learning. Life long learning skills which utilise critical reflective skills are necessary for a nurse to continue to develop and grow once he/she has entered the practice setting. My intention has always been to make a difference, and it is this moral intentionality that is embedded within this project. It is the driving force behind my journey to date and will continue to be a driving force into the future.

This critical case study explores the experiences of seven new graduate nurses entering specialist psychiatric mental health nursing practice. The purpose is to illuminate the differences and/or consistencies between the students' needs and the educational processes and content of the existing curriculum. The information gained from this project has already empowered the participants and the researcher to take actions that have led to change themselves. The goal is to take actions that will transform

the curriculum processes and content in order to better support new graduate nurses entering mental health in the future.

### **Positioning the Self**

My nursing career commenced in September 1977 when I presented myself at Wellington Hospital to become a nurse. I had been accepted to undertake the then Community Nurse Training consisting of 18 months hospital based training. In December 1977 alterations were made to the Nurses Act, the title was replaced with Enrolled Nurse, and the training was reduced to twelve months. The title of Enrolled Nurse came into effect immediately, however the changes to the length of training did not take effect for another 12 months.

My Enrolled Nurse training provided me with enough knowledge and skill to work in most medical/surgical settings under the direct supervision of a Registered Nurse. I applied myself well and obtained good marks throughout, in fact within my class of forty I finished fourth. On completion I felt as though I had been given a small piece of a much larger puzzle, and I wanted the remaining pieces. I was frustrated by the restrictions placed on my practice due to my limited training, and wanted to become what I called a 'proper nurse'. So I applied to enter the General Obstetric training programme, however was unsuccessful. I was devastated, but looked around to see if there was a back door in, and that is how I entered the field of psychiatric mental health nursing practice.



In January 1981 I commenced working at Porirua Hospital as an Enrolled Nurse, and in March 1982 I started the three and a half year psychiatric nursing training programme run at Porirua Hospital. I registered as a Psychiatric Nurse in June 1985. After staffing for eighteen months I was successful in my application to undertake the bridging programme to Comprehensive registration through Wellington Polytechnic.

Finally ten years after starting in December 1987 I was a Registered Comprehensive Nurse, or as we used to say a 'proper nurse'. Since then, other than six months in a general surgical ward, I have worked in psychiatric mental health nursing practice. My specialist area is within Adult Acute Inpatient and Liaison Psychiatry Services. I have held a variety of positions from Staff Nurse through to Clinical Nurse Specialist, and have seen many changes within the health sector in New Zealand. I finally left clinical practice in August 1996, (or did I), and entered the field of nursing education. In 1997 I spent twelve months working in the undergraduate programme at Wellington Polytechnic, before commencing my current position at Whitireia Community Polytechnic.

### **How the Question arose**

This question came about a long time ago, without my consciously being aware of it at the time. It is the recurring echo of a phrase I once heard – “nursing is the only profession that eats it's young” (Unknown). This is a phrase that has been in the back of my mind for a long time. I do not even remember the first time I heard it. During my involvement as Programme Coordinator for the *Diploma of Entry to*

*Specialist Psychiatric Mental Health Practice* (the programme) provided through Whitireia Community Polytechnic, this phrase continued to recur in my mind, and in my discussions with colleagues. It was this phrase that encouraged me to focus my research into the area of supporting new graduates entering practice.

I commenced my current role of Programme Coordinator, in January 1998. The programme was to undergo a major review in July of that year. As part of the review process I was required to compile a detailed written report for the review panel. The review panel consisted of stake-holders associated with the programme. These stakeholders included the funding agency, clinical providers, educational representatives from within the Polytechnic and one outside Polytechnic that also offered the programme. The panel also included one previous student of the programme. However I am not sure how comfortable this previous student felt being part of a group of so called 'experts' from the various stake holder groups. In retrospect it may have been more advisable to have invited two previous students to sit on the panel. This would have allowed the two students to support each other, in what could potentially have been an uncomfortable situation. It could be said that those stakeholders involved in the review had their own vested interest in any recommendations made at the outcome of the review. During the review process these stake holders met and talked with other stakeholders, namely myself as programme coordinator, current students of the programme, and other clinical stakeholders who were not directly involved in the review panel itself. I found the whole process very interesting, and in hindsight I would say the review process that occurred was an intense learning curve for me, both as a new lecturer and employee of the Polytechnic. I came to have a greater understanding of the course as a whole

and started to gain some insight into what might be the wider issues for the students. These were mostly ideas and questions at that stage, all of which have helped to shape my thinking in relation to this project.

The main issues that surfaced during the review were related to the curriculum and the learning outcomes for the programme itself. These were not overtly specified within the documentation. The programme handbook outlined the curriculum as that of the Whitireia Community Polytechnic Bachelor of Nursing programme. As the students of the Diploma of Entry to Specialist Psychiatric Mental Health Nursing Practice had already completed an undergraduate programme this did not appear to meet their needs. What was needed was a curriculum that provided a clearer foundation for new graduate nurses entering psychiatric mental health nursing practice. The curriculum should be more specific to the needs of this group of nurses and the organisations in which they are entering, not generic to undergraduate nursing education. The existing curriculum clearly stated that the programme was based on the Australia New Zealand College of Mental Health Nurses Inc.(ANZCMHN's): Standards of Practice for Nurses in New Zealand, May 1995. These Standards were developed within New Zealand by New Zealand Mental Health nurses to represent best practice for psychiatric mental health nursing. As such these standards provide the ideal basis for a specialist entry to practice programme. However there did not appear to be any specific learning outcomes. Learning outcomes are required within the programme documentation to identify clearly what the programme consists of both within the theory and the clinical paper. Learning outcomes state what the student is expected to achieve on completion of the programme. These form the basis for the theory content of the

programme, and the standard by which the student will be measured when evaluations are carried out. This definition of learning outcomes sits very much within the positivist paradigm, which tends to separate the means from the ends. Within the positivist paradigm the end is the goal, the means becomes separated from the end(s). It tends to ignore the understandings gained along the way. This is different from a critical social science perspective which sees the means and the ends as inseparable. How you get there is just as important as where you end up. The differences between the positivist and critical social science paradigms are central to this thesis and are revisited throughout.

Returning to the review and its outcomes it was clear that the programme had initially been developed at a time when most of the graduates were entering the programme with a Diploma qualification. This has since changed with all nursing education now at Degree level. In line with the issues discussed I included a series of recommendations in the report compiled for the review panel. These included a need for learning outcomes to be made overt and measurable and increasing the academic level of the programme to better meet the needs of new graduates with Diploma qualifications. The review panel agreed with these and other recommendations, including them in their final report.

Following the review the programme documentation was developed to include specific learning outcomes based on the ANZCMHN's: Standards of Practice for Nurses in New Zealand, ( May 1995) (see Appendix 1). The issues relating to the development of these learning outcomes are outlined in Haggerty (1999). Moreover, in developing learning outcomes for the programme it was important to

identify a level at which students would be expected to achieve on commencing the programme. This level corresponded with the Mental Health Performance Criteria outlined within the 1997 Nursing Council of New Competencies for Entry to the Comprehensive Register. These are the criteria that all registered comprehensive nurse's in New Zealand are expected to have achieved on entry to the register. These competencies are looked at further within the thesis as Competency 5: Management of the Environment is used as a basis for the facilitating the discussion groups.

After undertaking a detailed evaluation of the existing programme, and implementing the recommendations of the review panel, what I felt was now required was additional information. This additional information I hoped would help gauge the extent to which the course, through processes and content, meets the needs of new graduate nurses entering the specialist area of psychiatric mental health nursing practice.

### **The Question**

The question that I have addressed in this thesis is - *How can the educational content and process best support the new graduate nurse entering specialist psychiatric mental health nursing practice?* A critical case study has been used to research this question. A series of group discussions were carried out, consisting of seven participants from the 1999 programme. These group discussions were used to collect data relating to the students experiences while undertaking the transition from student nurse to staff nurse in the complex environment of psychiatric mental health nursing practice. The questions used to stimulate the discussion have been

taken from the Nursing Council of New Zealand Competencies for Entry to the Register of Comprehensive Nurses, 1997, and focus on the mental health components of Competency No. 5 Environmental Safety. A detailed outline of the methodology and method can be found in Chapters 4 and 5.

### **Aims and Benefits of the Research Project**

This project has accessed information relating to the students' experiences in their first clinical placement in order to further understand their preparedness for the staff nurse role in the psychiatric mental health specialty. It has illuminated some of the differences and/or consistencies with what the students express as their needs in comparison to the educational content of the existing curriculum. As part of this process the participants considered how and in what ways both processes and content are implicated in their transition from student nurse to staff nurse. The information gained from this project will inform the curriculum and pedagogical processes to enhance future possibilities for the curriculum.

It is important to have a better understanding of ways the educational processes and content of the Diploma of Entry to Specialist Psychiatric Mental Health Nursing Practice can support the students' understanding and enactment of their changed role from student to staff nurse. As part of the ongoing curriculum development, the information illuminated by the participants will also inform the clinical environment and the ways in which new graduates may be better supported.

## **Project Outline**

I have introduced the research project in this first chapter, positioning myself in relation to the question and how it came about. In order to position the research project even further, in chapter two I have outlined the socio-political context in which this research is being carried out, in particular, psychiatric mental health nursing training versus education, and the history of the Diploma of Entry to Specialist Psychiatric Mental Health Nursing Programme. I have also discussed the programme in relation to the Australia and New Zealand College of Mental Health Nurses, the Nursing Council of New Zealand Competencies for Entry to the Comprehensive Register (1997) the Ministerial Taskforce on Nursing (1998) and the Mental Health Commission's Recovery Approach. In order to further position the research project, chapter three contains a discussion of the theoretical perspectives that underpin the research, the epistemological perspective of constructionism and how this links with the question and the project as a whole.

Due to the scope of the project nursing's theoretical heritage has not been explored. It is well recognised that much of this theory building has contributed substantively to debates on education in nursing. Moreover, issues concerning the environment have also been excluded for the same reasons.

Enculturation, the socialisation of the new graduate nurse into the culture of mental health nursing, and processes of hegemony, reification and subjectivity and the implications these have on, and for, the new graduate nurse entering practice are highlighted. I have also looked at nursing's patterns of knowing as first identified by Carper (1978), adapted by Jacobs-Krammer & Chinn (1988) and further added to by Munhall (1993) and White (1995). The relevance of the patterns of knowing,

to both psychiatric mental health nursing and this research project are identified and discussed.

Chapter four describes the methodological underpinnings of the project, namely the critical social science perspective and the writings of Paulo Friere, Jurgen Habermas and others. Emancipatory inquiry and participatory research methodologies are also discussed in relation to undertaking this critical case study. Chapter five outlines in detail the method/s used to complete this research and formed the basis of the approval submitted to the Victoria University of Wellington and Whitireia Community Polytechnic Ethic Committees. The issues relating to special hazards and/or inconvenience are of particular relevance with the researcher also being the participants' tutor. This prompted the need for specific mechanisms and processes to be put in place to protect any participant and/or student, from any prejudice and/or penalty whether or not he/she participated in the research. These mechanisms and processes are outlined in chapter five. The data collected is outlined in chapter 6, which introduces the reader to the main themes that were jointly identified by the participants and the researcher. Each theme is then discussed in depth in the following chapters. Chapter seven looks at preceptorship and support and the issues raised within the discussion groups. Enculturation is discussed in chapter eight, with chapter nine looking at risk management issues. These three chapters contain participants' extracts, all of which were obtained from the first discussion group (unless otherwise stated). During the second discussion group participants and researcher identified the themes they felt were important and discussed ways of better supporting new graduate nurses through some of these issues. This discussion is contained in chapter ten, which looks at recommendations for the future. An evaluation of the research project was



completed, and this is outlined in chapter eleven. Individual participant's thoughts and feelings in relation to being involved in the research process, the impact this has had on his/her practice and future intentions, have been explored. The researcher's evaluation of the process is also contained within this chapter along with an evaluation of the research from a critical social science perspective. Chapter twelve concludes the thesis with an overview of how we came to be at the end, and the understandings we have gained along the way.

## **CHAPTER 2: SOCIO-POLITICAL CONTEXT**

This chapter locates the socio-political context of psychiatric mental health nursing in relation to this research project. Exploring the historical foundations of how psychiatric mental health nursing has evolved helps to situate the development of the Diploma of Entry to Specialist Psychiatric Mental Health Nursing programme. The things that impact on psychiatric mental health nursing today are many and for the purposes of this research project I will be looking more specifically at the Australian & New Zealand College of Mental Health Nurses, the Nursing Council of New Zealand, the Ministerial Taskforce on Nursing (1998), and the Mental Health Commission specifically the working in partnership with consumers within the 'Recovery Approach'.

### **Psychiatric Mental Health Nursing Education in New Zealand**

Prior to 1854 the care of the mentally ill in New Zealand was administered through the prison system.

Those who were seen to be socially undesirable were sent to goals for safe keeping. These included deserters, convicts, delinquents, waifs and strays, prostitutes, debtors, drunkards and vagabonds as well as lunatics. Lunatics were sent to goal because they upset the peace. Mentally ill behavior was seen as a law and order problem and was dealt with accordingly (Williams, 1987, p. 3).

According to Williams (1987) the first separate accommodation for the 'insane' was built next to the then Wellington prison, however this separate accommodation remained part of the Wellington prison, and continued to be administered through the

prison. The first independent provincial lunatic asylum was built in Karori in 1854, then moved to the Town Belt and named the Mount View Lunatic Asylum. Finally relocated to its present position at Porirua in 1887, as with most asylums around that time, Porirua Hospital was situated outside a large city (Wellington) and away from the general population. However over time the city of Porirua has developed as a large dormitory city around the site on which Porirua Hospital stands. Along with being one of the major employers within the area (up until de-institutionalisation commenced), Porirua Hospital has become an accepted part of the community.

The first organised psychiatric nursing training commenced in New Zealand in 1905, with a Register of Mental Nurses being established in 1907. Psychiatric nurse training was administered through the then Department of Health, with medical staff providing most of the lectures to the trainee nurses. The training provided by these medical staff was neuro-biological in nature. The focus on the psyche (the mind and all things mental and how this affects the person within his/her environment) did not become a focus of psychiatric mental health nursing practice until nurses became responsible for the training / educating of nurses. The psychiatric nurse of earlier years worked mostly in an institutional setting under the direction of the medical staff. Now psychiatric nurses work in all areas of health, with a large number working in the community. This diversity of practice has led to psychiatric nursing today being known as psychiatric mental health nursing. Psychiatric nursing explores the concepts of illness, and mental health, looking more at wellness within a holistic framework. This distinction is to make overt the alterations in the scope of practice of nurses working in the field. Changes in describing the title of nurses working in this field is internal within the profession rather than being officially sanctioned by the national registration body the Nursing Council of New Zealand.

In 1972 the administration of psychiatric hospitals was transferred to the Hospital Boards and the training schools within these hospitals came under the control of the main training school in the area. At Porirua Hospital the training school was administered by the Wellington School of Nursing, which was based in Wellington and covered Wellington, Hutt Valley and Porirua hospitals. Following this transfer of administration the focus of training for psychiatric nurses underwent development. Medical staff continued to have involvement, however this diminished over time with more and more attention being placed on the role of the nurse in working with the patient within a bio-psycho-social context as opposed to a purely biomedical context.

In 1973 the first tertiary based nursing education commenced in New Zealand with graduates entering the workforce from 1976 onwards. This signaled the demise of the hospital based training programmes throughout the country. The last trainees from Porirua Hospital graduated in 1987. Subsequently all newly registered nurses entered practice through tertiary-based education programmes.

These tertiary-based programmes continued to develop nationally and all nurses now enter the workforce with a Bachelors Degree. The 1998 Ministerial Taskforce on Nursing discussed the gains achieved by the education of nurses in the tertiary sector. These included the increased use of evidence/research based practice resulting “in a clearer linking of nursing theory to practice, and aided the development of critical and reflective thinking in nursing graduates” (Ministry of Health, 1998, p. 50). However the Taskforce also recognised that there were some areas of concern with programme content, particularly in relation to specialty training such as psychiatric mental health nursing. Interestingly, this same concern was expressed during the transition of nursing education from hospital based programmes to tertiary educational settings

and is discussed in the following extract from an interview undertaken as part of the research for the centennial history of Porirua Hospital.

In 1972 the transfer of the administration of Porirua Hospital to the Wellington Hospital Board meant that the training programme for psychiatric nurses, which had previously been administered by Porirua Hospital, became instead a specialised programme within the Wellington School of Nursing, although it continued to be situated at Vailima. In 1970 a World Health expert visited New Zealand and advised that it was necessary to move nursing education away from hospital based programmes and into the technical institutes. These programmes, which started in New Zealand in 1973, have meant that nursing education has moved away from the hospitals and into the polytechnics. As a result, in 1987 the last group of nursing students will be sitting their State Examination for Psychiatric Nurses. In the future, psychiatric nurses will be trained within the comprehensive nursing programme which covers all facets of nursing and when they graduate they will select the area of nursing in which they wish to specialise. This has caused a problem, as it seems that psychiatric nursing and psychopaedic nursing is not the first choice for these graduates. Recently there has been a special committee set up by the Nursing Division of the Department of Health to see if there is a need to have some form of internship after training in psychiatric hospitals, because that's where the poverty of graduates lies. The closing of the Porirua Hospital Nursing School in May 1987 is the end of an era in nursing education, and that's sad (Williams 1987, p. 292).

It can be seen from these comments that some form of internship was discussed in 1986, however this did not progress any further than discussion until 1994. In 1994 the then Professional Nurse Advisor (Mental Health) at Capital Coast Health Limited (CCHL), Francis Hughes undertook an internal survey of team leaders and unit managers. The purpose of this survey was to better understand the issues relating to

why psychiatric mental health nursing did not appear to be a valued area of practice for new graduate nurses. The outcome of the survey found that “70 percent reported that new graduate nurses had insufficient skills in the areas of mental status examinations, interviewing, psycho-pharmacology, defended hearings, electro-convulsive therapy, and seclusion policy in relation to the Mental Health Act 1992” (Hughes, 1995, cited in Cook, 1998). The unit managers and team leaders at that time were comparing new graduate nurses with those nurses who had previously graduated from the hospital psychiatric training programme, up to and including 1989. As well as what was deemed to be the result of inadequate knowledge and inappropriate support, it was also noted that over a six month period 29.41 percent of the new graduate nurses had their practice restricted following reported incidents. These incidents mostly involved the administration of medication. By the second year of the Specialist Entry to Practice Programme (1996) the number of new graduate nurses requiring restrictions to their practice had reduced to 10 percent. (Cook, 1998). As well as the above outlined concerns, in 1994 interviews of nurses leaving the organisation who had commenced as new graduates identified further issues that needed to be addressed. These were some of the feelings described by these exiting nurses, “feeling ‘intimidated’; ‘out of my depth’; ‘lacking support’; and ‘being scared’”. Others felt they were more skilled to work in medical and surgical services than in specialised services like psychiatric mental health” (Cook, 1998, p. 27). All these concerns lead to the development of a programme at Capital Coast Health Limited to support new graduate nurses entering specialist psychiatric mental health nursing practice.

## **History of the Entry to Practice Programme**

In 1994 Francis Hughes, representing CCHL, Julia Hennessy - Lecturer at Whitireia Community Polytechnic and Professor Jill White of Victoria University of Wellington, Department of Nursing and Midwifery advanced the notion of an intern programme for new graduate nurses entering psychiatric mental health nursing practice. As a result a steering committee was formed to investigate the feasibility of such a programme and representation was invited from both the clinical and education sectors.

The steering committee identified the need for a specialist entry to practice programme for psychiatric mental health nursing, and formulated a proposal for such a programme. A proposal for a pilot programme to be delivered as a joint venture between Capital Coast Health Limited and Whitireia Community Polytechnic was forwarded to the Clinical Training Agency. The Clinical Training Agency (CTA) is a government agency responsible for the funding of post-registration education for all health professionals within New Zealand. The CTA was established in 1993 following what is referred to as the 'unbundling' of post-graduate education funding from vote health. Prior to 1993 all money for post registration training was included in the funding allocated to individual hospitals. The CTA was established to ensure that this money for training was used for the purpose that it was intended, and to set priorities for training in accordance with governmental policies and directions within the health sector.

The intention of the internship was to provide a forty week programme for new graduate nurses entering specialist psychiatric mental health nursing practice. The programme would provide theory, at least three clinical placements in a variety of

inpatient and community settings, clinical preceptorship plus clinical supervision for role development.

The CTA accepted the proposal and agreed to fund a programme commencing in 1995. This programme was to be a pilot programme and was evaluated for its effectiveness. Thirty new graduate nurses started the first programme commencing in 1995 at Capital Coast Health Limited. The programme was supported academically by Whitireia Community Polytechnic and was described as a *Certificate of Entry to Psychiatric Mental Health Nursing Practice*. This changed to *Diploma of Entry to Specialist Psychiatric Mental Health Nursing Practice* in November 1997. The programme equates to Degree level on the Nursing Council of New Zealand Education Framework (1997), and does not provide credit towards post-graduate and/or Masters programmes at a university level. However those students entering the programme with a Diploma in Nursing, gain extensive credits towards an undergraduate degree.

In 1997 Mid Central Health became an affiliate with employees participating in the programme. Over the last few years other agencies have also nominated participants and by 1998 the programme included seven hospitals in the Mid Central Region and one Non Governmental Mental Health provider. The basic theoretical framework of the programme has not altered since it commenced. The first major review of the programme was carried out in 1998. Following this review the programme has been further developed to ensure it continues to meet the changing needs of both the programme participants and their employing organisations. Earlier criticism identified that the following areas required attention.

- ◇ increasing the academic level of the programme within more participants entering with a Degree in Nursing;



- ◇ clearly outlining the learning outcomes of the programme, and their links to the Australian & New Zealand College of Mental Health Nurses;
- ◇ improving the clarity of assessment, both academic and clinical to better reflect these learning outcomes. (Haggerty,1999)

Originally the contract to administer the programme was held by Capital Coast Health Limited. The programme has since been purchased by Otago Polytechnic and Eastern Institute of Technology in Hawkes Bay. In 1998 Whitireia Community Polytechnic (WCP) also bought the rights to deliver the programme from Capital Coast Health Limited. The main reason for WCP purchasing the programme was the increasing involvement of other mental health providers in the region and the need to offer a more generic programme as opposed to one tailored specifically to the needs of one agency. Future contracting with the CTA requires the programme be accredited by the New Zealand Polytechnic Programme Association (NZPPC) who has designated authority from the New Zealand Qualifications Authority (NZQA) to approve and accredit programmes in the polytechnic sector. During 1999 WCP has sort and obtained accreditation for the programme from NZPPC for a period of three years. At the end of three years re-application for accreditation will be made.

The CTA has been tracking graduates of the programme for three years post completion. This is to provide data relating to the effectiveness of the programme and that the programme achieved what it set out to do with particular reference to the increased retention of graduates in the mental health setting. The final results of this data are not yet available. However, informal observations within Capital Coast Health Limited has shown that the retention rate of new graduate nurses on completion

of the programme has increased. Cook, 1998, stated these have risen from 71% in 1995 (with 55% remaining after three years) to 88.8% in 1997 (p, 29). Of the eight participants from Capital Coast Health who completed the programme in 1998, 100% continue to be employed at Capital Coast Health at the end of 1999.

### **Australia New Zealand College of Mental Health Nurses**

The programme has throughout its delivery utilised the Australia New Zealand College of Mental Health Nurses Inc.: Standards of Practice for Nurses in New Zealand, May 1995 as the basis for the theoretical and clinical components of the programme. The Australia New Zealand College of Mental Health Nurses Inc. (ANZCMHN's) was first established as The National Mental Health Nurses Congress in Melbourne Australia in 1975. New Zealand mental health nurses joined the Congress in 1987, with the first congress held in Dunedin the same year. The Congress officially became the Australia New Zealand College of Mental Health Nurses Incorporated in 1991. In May 1995 the New Zealand branch officially launched the Australia New Zealand College of Mental Health Nurses Inc.: Standards of Practice for Nurses in New Zealand. These standards "represent the standard of performance which can be expected from a registered nurse who has been working for a period of the equivalent of two years full-time in any mental health context" (ANZCMHN's, 1995, p. 2).

New graduate nurses entering the programme do not meet this criteria, however this is the standard of performance that these new graduate nurses would aspire to achieve. Therefore the ANZCMHN's Standards of Practice for Nurses in New Zealand are utilised extensively as the curriculum framework for the programme. The standards

have been rewritten to form the learning outcomes for the programme. The knowledge associated with each standard has become the theoretical content. The skills comprising each standard now form the clinical assessments associated with the learning outcomes. Students of the programme are not required to achieve the same level of performance as their counterparts with two years full-time experience in any mental health context. However, they are expected to achieve a level of performance at least mid way between the ANZCMHN's Standards and the Nursing Council of New Zealand Competencies for Entry to the Comprehensive Register, November 1997.

### **Nursing Council of New Zealand**

In 1995 the Nursing Council of New Zealand commissioned the development of competencies for entry to the register of comprehensive nurses. The final document incorporated eleven competencies with an expectation that all nurses put forward to undertake the State examination would have attained these competencies as part of their undergraduate tertiary education. In 1997 these competencies were expanded to include specific mental health performance criteria against the existing eleven competencies. They were further expanded in 1999 to include specialist and advanced competencies, particularly in light of the recent proposals, and changes in legislation to include nurse prescribing rights. These proposals and other issues relating to nursing in New Zealand were explored in a Ministerial Taskforce on Nursing (1998).

### **Ministerial Taskforce on Nursing**

In 1998 the then Minister of Health established a Taskforce to identify “the barriers that prevent nursing from improving the service to its patients and devising strategies

to remove those barriers” (Ministry of Health, 1998, p. 5). The final report “Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing” (Ministry of Health, 1998) was released in August 1998. This report covered a variety of areas relevant to nurse education and practice within the New Zealand context. The most relevant section to this research is the section on education, in particular the first year of clinical practice. Along with the issues relating to undergraduate training as previously mentioned, the report identifies two existing structural barriers that affect the transition of new graduate nurses into the workforce. These are -

- ◇ the lack of structures for entry into community practice for new graduates, and
- ◇ the employee expectation that new graduate nurses will enter acute settings and “immediately take up a high work-load and a high level of responsibility with little structured help or support (Ministry of Health, 1998, p. 55).

The report goes on to state:

There are no national formal requirements or frameworks for structuring a nursing graduate’s first year of practice. Consequently, considerable variation exists in what is available. Some services provide formal new-graduate programmes, and these offer an excellent start for those nursing graduates fortunate to secure a job. The most developed programme is probably that funded by the CTA for mental health nursing graduates. This offers both clinical experience and education components during the first year of practice (Ministry of Health, 1998, p. 56).

The report recommends the development of a national framework for graduates in their first year of clinical practice, and that the existing mental health programme “should be used as a template for nursing as a whole” (Ministry of Health, 1998, p. 60).

The existing mental health programme referred to in the Taskforce report is the Diploma of Entry to Specialist Psychiatric Mental Health Nursing Practice delivered at Whitireia Community Polytechnic, (and it's variations offered in other parts of the country). The programme offered at Whitireia Community Polytechnic endeavours to provide an entry level education to new graduate nurses which will provide the additional understandings for these nurses to develop their own practice within the mental health setting. This in turn is hoped to support wider practice development within the mental health sector. As well it is hoped that a greater appreciation of the issues facing mental health services currently will be fostered. The issues facing the mental health sector at the present time are many and varied. These include working within the boundaries of the current legislation and government policy that affects the way in which mental health services function. These include, but are not limited to, the Mental Health (Compulsory Assessment & Treatment) Act 1992 (and the revised Act due for implementation in April 2000), the Health and Disability Code 1996, the Privacy Act 1993 and the Mental Health Commission. It is not possible to look at all these within this paper, however the Mental Health Commission and in particular, the 'Recovery Approach' which is part of a wider strategy for mental health services in New Zealand will be explored.

### **Mental Health Commission**

The Mental Health Commission was established in 1996 as an independent governmental organisation to oversee mental health services within New Zealand. Its function is to monitor mental health services and provide pathways forward in the development of services on a national level. The Commission also provides policy

advice to the Minister of Health on mental health matters. One of the areas that has been targeted by the Mental Health Commission since its inception, has been to ensure the clients/consumers of mental health services are able to access services appropriate to their needs. This includes services that maintain the respect and dignity of the client/consumer, and sees the person with the mental illness as a person with the right to choose, remain autonomous and in control throughout the process of accessing care and treatment. In order to address this endeavour the Mental Health Commission is looking at a variety of approaches which include ways in which stigma and discrimination might be reduced against people with a mental illness. At the same time it has sought to foster the 'Recovery Approach' as a way of moving forward. Briefly the notion of the 'Recovery Approach' is a way of being within mental health, and was first introduced to New Zealand by L. Curtis in the 1980's. Recovery can best be captured in the following ideas outlined in the Mental Health Commission documentation:

- ◇ A journey as much as a destination;
- ◇ Different for everyone;
- ◇ Being able to live well in the presence or absence of an illness;
- ◇ A process, and approach, and attitude;
- ◇ Assisted by strong connections and positive support.

(Disley, 1999).

Recovery is characterised by instilling hope, maintaining self-responsibility of the client/consumer and the professional working with the client/consumer, providing the client/consumer with the know-how to take responsibility for self and make informed choices. This notion of self responsibility is empowering for both the client/consumer and the health professional. Implications for the practice of nurses, and other health care providers, center around

- ◇ the maintenance of hope within the therapeutic environment,
- ◇ entering into negotiation and collaboration with clients/consumers and their family/whanau,
- ◇ and rejecting the notion of the person as illness.

This is a simplistic explanation of the recovery approach, however it is important to outline the model in order to discuss the approach's relevance to psychiatric mental health nurses in the context of this project. There is an expectation that the 'recovery approach' in itself is a model/framework for practice that health professionals should integrate into their practice. However despite this national strategic direction that has been outlined by the Mental Health Commission and other governmental and professional organisations, this change in philosophy is slow to occur. Dr. Barbara Disley, the Mental Health Commissioner highlighted this in her speech to the Wellington Branch of the Australia New Zealand College of Mental Health Nurses in April 1999. The following is an extract from her speech, worthy of inclusion because of its relevance.

Inquiry after inquiry have diagnosed that the mental health sector is not well. For too long, the sector itself has been caught in the grip of too few resources and unclear leadership. It has resulted in feelings of Hopelessness, blame, isolation and inward thinking. Few have prescribed an effective treatment.

While it may seem that changing this culture is outside the control of nurses, the attitude of nurses is critical to promoting healing environments for those who use mental health services and for the sector itself. It is you that work at both the individual and personal level to help people achieve their own visions and it is you who collectively, as a group, can take up the vision of a mental health service as set out in the Blueprint [National Mental Health Strategy] and work to see it implemented.

You [psychiatric mental health nurses] have the ability to provide leadership, to challenge, to encourage, to model and enable recovery of the mental health sector as a whole. As a professional group you can keep the vision for a stronger mental health sector burning brightly ...

The sector as a whole is beginning its own journey of recovery, getting more services, getting better services; developing a stronger infrastructure for delivery; promoting within and across sector co-operation and collaboration; promoting innovation and good practice; and creating a culture where everyone asks constantly whether what we are doing is really making a difference to each individual and whether we are on the pathway towards the sectors recovery.

Only when everyone in the mental health sector feels that they do have control over the way services are delivered, that their role is valued by the rest of the health sector and by the community, where the needs of people with mental health problems are regarded as priorities by other sectors, and where those from within the sector see that their efforts have influenced this, will the mental health sector itself have recovered (Disley, 1999).

This is a very tall order for psychiatric mental health nurses to fill. However with education, support and ongoing commitment to change it is not an impossible one. Dr. Disley is correct, nurses can lead the changes in the mental health sector, and we are well positioned to do so. In order to meet this challenge we must understand, and become involved in the socio-political aspects of mental health in New Zealand. We must foster the growth and development of those new nurses entering the mental health sector, and those who are undergoing advanced education. These nurses are the future of our profession and it is these nurses who will collectively make a difference. This project seeks to look at how we can better support new graduate nurses entering



psychiatric mental health nursing practice, so as to allow for ongoing growth and development in a sector that is 'unwell', and oppressive in nature. The following chapter looks more at the theoretical underpinning of this project and provides some insights into the nature of knowledge development, oppression and hegemony within the education and clinical settings.

## CHAPTER 3: THEORY

*Sit down before fact like a little child, and  
be prepared to give up every preconceived notion,  
following humbly wherever and to whatever abyss nature leads,  
or you shall learn nothing.*

*Huxley (1992), (Cited in Munhall, 1993)*

This chapter introduces the epistemological and theoretical underpinnings of this thesis. These underpinnings will be discussed in relation to the thesis and the ground laid for further discussion during the chapters on data analysis. The main themes of this chapter look at knowledge and knowledge construction, using a constructionist epistemology. Other issues that will be addressed relate to who holds the knowledge, how is it enacted, and whose interests are being served. Enculturation and hegemonic processes are also explored in relation to the epistemology and the research project. Nursing's 'patterns of knowing, empirical, ethical, personal and aesthetic knowledge and their relationship to this research are highlighted within the context of psychiatric mental health nursing. Since the initial articulation of these 'patterns of knowing' (Carper, 1978; Jacobs-Kramer & Chinn, 1988) they have been further developed by Munhall (1993) and White (1995). These developments will also be explored, along with the concept of environment and nursing theorists' contribution to knowledge development in nursing.

### **Epistemology**

Epistemology is a way of understanding and explaining how we know what we know.

The epistemological perspective of this project is that of constructionism.

Constructionism describes the construction of knowledge from the individual's interaction with their world. It refers to the construction of meaningful reality. Meaning is not created, it is constructed from our interaction with the world around us. There are no objective or absolute truths, the individual constructs meaning and knowledge from his/her interaction with the world and meanings emerge from these interactions. This meaning may be an individual meaning, or shared meaning within a social context. Individuals may not construct the same meaning from the same situation. When knowledge is relevant and useful within a given social context, that knowledge then becomes part of the self. Street (1992) discusses Habermas' (1971) position that there is more than one kind of valid knowledge as "knowledge is shaped within the context of social, historical, and cultural conditions, and is determined by specific needs desires and interests" (Street, 1992, p. 90).

### **Enculturation**

Enculturation is the process of assimilation into an existing culture. Nursing, a culture in its own right, has "practices, beliefs, knowledge, language and resources that is particular to nursing" (Street, 1992, p. 1). However nursing is also part of the health in the wider context, of which the medical culture would appear to be dominant. Psychiatric nursing in particular has been closely associated with the dominant medical culture from its inception. Enculturation as a process is necessary for the new graduate nurse to become part of the professional group he/she has chosen to enter. New graduate nurses need to have a feeling of belonging to the culture of nursing, of being accepted. When the enculturation process occurs in such a way as to show respect for the individual, value differences and maintains relations that are equitable, just and fair, this will support the identity of the person. However this process can be

destructive to one's identity when the new graduate nurse is socialised into an environment that erodes subjectivity, but fosters reification and hegemonic processes.

'Home' comes to be associated with 'culture' as an environment, process, and hegemony that determine individuals through complicated mechanisms. Culture is productive of the necessary sense of belonging, of 'home'; it attempts to suture . . . collective and individual subjectivity. But culture is also divisive, producing boundaries that distinguish the collectivity and what lies outside it and that define hierarchic organisations within the collectivity (Abdul Jan Mohammed, cited in McLaren & Leonard, 1993, p. 179).

## **Hegemony**

Hegemony is the way in which one group exercises control or domination over another group within a given political, social and/or cultural setting. Hegemonic interests are being served when the dominant culture resists movement toward equity, it "harbours oppression, manipulation, modes of injustice and unfreedom" (Crotty, 1998, p. 60). When entering the culture of psychiatric mental health nursing practice the new graduate nurse encounters these hegemonic processes. They are perpetrated by the dominant culture and are self-serving. That is, they serve the interests of the dominant group. Within such an environment certain practices and relations are enacted that manipulate those entering the culture to conform to the existing cultural practices. Within this environment the identity of the individual is suppressed. He/she no longer sees the environment as a whole, only object reality. The individual enacts the practices of the dominant culture, distancing the self from the other while engaging in practice. Subjectivity becomes a part of the environment where the feelings associated with the actions are oppressed. The individual sees him/herself as

having no choice but to submit to the dominant culture. They may also choose to withdraw completely by leaving, or by separating the self from the working self.

Because one of the purposes of this research was to enter into a process of critical reflection that supported the new graduate nurse entering psychiatric mental health nursing practice, it became important to engage in consciousness raising in order to question these hegemonic processes. By making overt that which is suppressed within a reified environment, the individual maintains his/her identity. Using critical reflection the individual then has an opportunity to see that he/she does indeed have choices, and by choosing to make one small change in such an environment he/she can make a difference.

The ways in which practitioners lives become distorted are not only through cultural traditions in practice, but are co-located within organisational activities more generally. Through the ways in which curriculum is constructed there are also dimensions of knowing that remain hidden. This invisible knowledge contributes substantially to one's understandings of the world.

### **Hidden Curriculum**

The individual participant enters a facility in which he/she undertakes an educational process to become a nurse. During this time the individual is subjected to hegemony within that educational setting. He/she then enters the health sector and again becomes part of a hegemonic process. So what is this hegemony, and how does it happen, in relation to the educational and health sectors and our student/new graduate nurses. Firstly let us look at the educational sector. An individual enters an

educational setting for the purpose of becoming a registered nurse, he/she enters an environment that is established with its own socially constructed knowledge, along with its social norms, rules and regulations. The socially constructed knowledge is the knowledge that is understood within the educators and the institution itself. Within the School of Nursing there is an agreed (official) curriculum which will outline the philosophy of the undergraduate degree and the content of the particular papers offered within it. This philosophy will underpin the way in which the educators facilitate student learning and shape the individuals knowledge construction. However within the official curriculum is the hidden curriculum. The 'hidden' curriculum refers to the experience of the student nurses within the practice setting, perhaps captured in the notion of the conflict between the theoretical teaching of the education setting, and the actual practice engaged by nurses within the clinical setting. Mayson & Hayward (1997) undertook a study of ten third year students in New Zealand, looking at the contribution of the hidden curriculum within the clinical setting, and its role in the socialisation of nurses. Mayson, et.al. suggest that educators need to become more aware of the hidden curriculum and its value in student learning. By making that which is hidden overt, the educator increases the opportunity for critique of clinical experience, both good and bad. This critique seeks to increase the consciousness of students and this can only benefit the development of critical reflective practices in nursing.

Another issue that can and does impact on students is the knowledge carried by educators within the curriculum and how that knowledge was constructed. These knowledge constructions are the foundations from which the educator/s will teach. If the educator sits within the positivist paradigm, in which many of our educators of the recent past have, then he/she will teach from within that paradigm, despite the

curriculum. The curriculum may be situated within the critical social science paradigm, however, if the educator has not yet problematised their practice, how then can he/she educate others using a critical social perspective? And what happens when the educator positions him/herself within the critical social science paradigm, and the official curriculum remains linked to the positivist paradigm? This educator could not help but be critical of the existing curriculum. Within this latter scenario the educator would be mirroring critical reflection in action, but would this be of benefit to the students? I am not sure of the answer to that, I would like to say yes, however I think it may also have the potential to create problems for the student. This has, and continues to be an issue in nursing education. The student nurse learns what is outlined within the official curriculum, but under the influence of the hidden curriculum, the student also learns about the educator's situatedness, as well as other narratives. Therefore the way in which the student constructs his/her knowledge, has its foundations not only in his/her history, but also the tensions between the various types of knowledge conveyed during his/her education.

This is very relevant when considering the new graduate nurse entering an established practice setting. Although each new graduate will have had similar educational experiences, the way in which these experiences have been interpreted, and thus meaning developed, would be different for each person. This would be due to the individual's life experience, the culture he/she was born into, and the variations in his/her own world. The new graduate nurse leaves the educational and clinical settings in which his/her knowledge relating to nursing has been constructed, and enters the culture of a mental health service which has its own socially constructed knowledge. These different knowledges may or may not create tension, in some instances forming sites of resistance. What then happens to the new graduate nurse

when he/she enters this culture? The dominant culture will usually prevail because it serves particular interests. Hence things become taken for granted and reified. Understandings become entrenched, unchangeable and beyond question. Thus some knowledges remain dominant while others are less valued.

### **Nursing's patterns of knowing**

Carper (1978) described four patterns of knowing that she identified from an analysis of the *conceptual and syntactical structure* of nursing knowledge. These were further developed by Jacobs-Kramer and Chinn (1988). These four patterns as identified by Carper (1978), and adapted by Jacobs-Kramer & Chinn, (1988) are four parts of a whole and are interrelated. In fact Chinn & Kramer (1991) state,

“[w]hen knowledge within one pattern is not critically examined and integrated with the whole of knowing, distortion instead of understanding, is produced. Failure to integrate all of the patterns of knowing leads to uncritical acceptance, narrow integration, and partial utilisation” (p. 15).

The four patterns of knowing are discussed below with an emphasis on their relationship to psychiatric mental health nursing.

### **Empirical Knowing**

This is the science of nursing and has its roots in the empirico-analytical tradition. It is the knowledge associated with the systematic organisation of “general laws and theories for the purpose of describing, explaining and predicting phenomena of special concern to the discipline of nursing” (Carper, 1978, p. 14). Empirical knowledge is based on fact, is objective, and can be replicated and generalised. By its very nature it is reductionist, and embedded in the positivist paradigm. Positivism “is a form of



scientific methodology which believes that there is a single true world ‘out there’, independent of the observer, and that by detached observation, science can identify causes and laws regarding that world” (Wadsworth, 1997, p. 108). This then describes a world where science and empirico-analytic knowing are paramount, and that only scientific knowledge is valid. This is the paradigm from which the majority of our medical colleagues work, and it is the dominant paradigm operating within mental health (and health) as a whole. When we consider the impact the medical profession has had on the development of psychiatric nursing, it has almost exclusively directed our knowledge development prior to Peplau publishing her humanistic theory in 1952, is it any wonder that “the materialist medical epistemology was absorbed uncritically and became assumed psychiatric nursing knowledge” (Horsfall, 1997, p. 59). The consequence of this has been the minimising of “class, ethnicity, and gender constraints relevant to individual patients, and practices that are distancing, depersonalising, and ultimately disempowering” (Horsfall, 1997, p. 64). Horsfall goes on to state, “[i]t is essential that psychiatric nurses explore and critique hegemonic psychiatric beliefs and critically reflect on their own practice” (1997, p. 63). The positivist paradigm sees the world through objective truth derived from facts, whereas the critical social science perspective is that there are no objective or absolute truths, and that all knowledge is socially constituted. Engagement with others, namely clients, is the backbone of the practice of psychiatric mental health nursing, therefore it could be said that psychiatric mental health nurses should indeed be working from a critical social science paradigm. In fact Dawson (1997) states ‘[p]sychiatric nursing is a quintessentially social praxis. It deals with people, their life situations, and the responses of others to these situations” (p. 69). However is psychiatric mental health nursing aware of the paradigm it may be working from? Can it be critical social science when as a profession we have not yet

become critical enough to move ourselves, and our clients, from within the domination of the positivist paradigm that exists within our institutions?

### **Ethical Knowing**

Carper (1978) describes this as “the ethical component of nursing is focused on matters of obligation or what ought to be done” (Carper, 1978, p. 20). She states that ethical knowing in nursing is not simply the ethical codes of the discipline, but the action that is undertaken by the individual nurse in his/her practice and within the context of his/her practice. It is the process by which the nurse makes decisions on a day to day basis involving what is good, what is right, whose interests are being served, is the action responsible and what are the consequences? (Chinn & Kramer, 1991). Ethical knowing is both subjective and objective. The objective, empirical knowledge can inform the development of ethical principles. However the ethical decision is one that is made within the subjective reality of the individuals involved. It is argued by such authors as Gilligan (1982) and Noddings (1984) among others, that nursing ethics are distinct from biomedical ethics in that nursing ethic is more associated with the principles of relationships as opposed to the universal principles related to justice (Tong, 1993). Ethical knowing in nursing needs to take into account the differences within and between people. For Noddings, relationships are not about universals, but about particulars - “about what makes each man or woman, boy or girl uniquely different” (Noddings, 1984, in R. Tong, 1993, p. 110). Horsfall (1997) relates this to research approaches. In that

“research methods that ignore lived experience may demean both nurses and patients. These approaches to research assume that it is ethically acceptable for patients and other nurses to be subjects of somebody else’s research project – providing that no harm is done.

Immediately unequal power relationships are established with the research domain. By ignoring these circumstances, harm, whether of a social, emotional or political nature, may be done” (Horsfall, 1997, p. 5).

In critical social science research, and indeed in emancipatory inquiry, the researcher makes all information available to the participants and the participants become co-researchers. The data interpretation is a shared experience, within an environment of openness. It takes into account the individual uniqueness of the participant/s, and values the participant/s contribution to the research process. This in turn reduces the potential for unequal power relationships, taking-for-granted of the participant/s by the researcher, and the potential for harm. This concept can and should be enacted within the nurse-client relationship in psychiatric mental health nursing. The nurse sees the client as a unique individual with his/her own knowledge relating to his/her mental health status and walks beside him/her within an environment of openness, respect and power sharing. This is what is being espoused with the ‘recovery approach’ discussed in Chapter 2, and is not possible within the empirical-analytical / positivist paradigms. In order to step outside of these paradigms, the nurse needs to become critical, increasing his/her awareness of the personal, the aesthetic, socio-political and unknowing aspects his/her practice.

### **Personal Knowing**

Personal knowing is concerned with the knowing, encountering and actualising of the concrete, individual self. In order for the nurse to enter into a relationship with another, the patient, he/she needs to know self in order to see the other as a unique individual as opposed to an object or diagnosis. In knowing self the nurse comes to know the other, and enters an authentic relationship with the other. An authentic

relationship with another, to me is when I am open to the world of the other while acknowledging previous understandings. Allowing myself full awareness of the self, the moment and the context. It rejects notions of stereotyping and stigma. Personal knowing is essential for effective ‘therapeutic use of self’ within psychiatric mental health nursing practice, by being aware of individual experiences and the impact these experiences have on both our clients and ourselves. It is important that the nurse knows him/herself, in order to enter into the world of another. This entering into the world of another should be done in such a way as not to adversely influence the outcome of the relationship. In order to do this it is important that individual nurses achieve an understanding of self, the roles individuals develop and why, what roles are utilised in our interactions with others, and what impact these roles have on the outcome of relationships. Sally Gadow, states “personal knowing is so to speak, an idea whose time has come, a phenomenon we ignore at our - and our patients’ peril.” (Gadow 1990).

Burnard talks about the need to know one’s self before being able to know another human being and provide for a therapeutic, meaningful encounter.

To become more aware of ourselves is also to learn conscious, intentional use of ourselves. We become agents: we are able to act rather than feel acted upon. We learn to realise how we can use ourselves to the full benefit of ourselves and others. To have awareness of how we may act gives us a greater range of choices. If we are blind to many aspects of ourselves we are also blind to the possibilities open to us. Increased self-awareness brings increased personal choice (Burnard, 1985, p. 25).

Increased personal choice, subjectivity, and critical reflection, leads to transformative action and emancipation. It also highlights one of the moral dimensions of practice.

This is important for the psychiatric mental health nursing and the profession as a whole. Nursing is currently being acted upon within the health care system in New Zealand, and therefore, so are clients. In order to achieve the best possible outcome for ourselves, and in turn our clients, we as professionals must become more aware of our environment and the choices available to us. We must become critical in relation to whose interests are being served and move toward transformative action for ourselves and our clients.

### **Aesthetic Knowing**

This is the art of nursing. “ The art of nursing involves the active transformation of the patient’s behaviour into a perception of what is significant in it - that is what need is being expressed by the behaviour” (Carper, 1978 p. 19). Her interpretation of aesthetic knowing is abstract and subjective in nature, and allows for self expression and creativity. The language used draws attention to the position of the author. Carper’s (1978) expression of aesthetics could be understood as an articulation of binaries, for the purposes of this research her aesthetics reflects an appreciation of the artistry in psychiatric mental health nursing practice.

Aesthetic knowing is an important part of psychiatric mental health nursing practice, which is the practice of working with the person not the diagnosis. The behaviour exhibited by all of us, not just those of us experiencing mental illness, usually signifies a deeper meaning. In order to understand the significance of this meaning the psychiatric mental health nurse needs to first establish a relationship with the person exhibiting the behaviour, otherwise how can the nurse understand the significance of what is occurring. The nurse needs to have made a connection with the patient in

order for this understanding to occur. The art of nursing would not be useful on its own and needs to be enacted in conjunction with personal and ethical knowing in order to be beneficial. In many ways it would appear to resist the dominant paradigm in psychiatry, that of the empirical-analytical. These ways of knowing need to be understood as having a dialectical relationship with one another, as socio-political knowing, and unknowing as developed by Munhall, (1993).

### **Socio-political Knowing**

This is in line with the work carried out by White (1995) who further developed the work undertaken by Chinn, and Jacobs-Krammer. White discussed the notion of socio-political knowing, broadening the perspective of the nurse from not just the nurse patient relationship, but the broader context of health and health care. White (1995) identifies the creative dimension of socio-political knowing as that which exposes and explores alternative constructions of reality, with the expression of transformation and growth. She goes on to ask the questions in relation to who is advantaged and who is oppressed within a process of critique, on a journey toward emancipation. This socio-political knowing sits within the critical social science methodology underpinning this research project. Without this socio-political knowing nurses will continue to participate within the dominant positivist paradigm operating within health. They will be objects within someone else's construction of reality. Fay (1997) cited in Street (1990) states:

the development of the ability to examine competing paradigms critically and to make value-consistent choices enables individuals to move from the powerless objects of the world, and to become the subjects, or actors, in their own real life drama (Street, 1990, p. 10).

This is critical to the recommendations of this research project in order for new graduates, and other nurses, to become more critical, they must first understand what is meant by critical reflection in action. This is discussed further in the chapters relating to data collection and recommendations.

### **Unknowing**

Munhall (1993) describes 'unknowing', as another pattern of knowing that is required to be authentically present with another. "To engage in an authentic encounter, one must stand in one's own socially constructed world and unearth the others world by admitting "I don't know you. I do not know your subjective world"' (Munhall, 1993, p. 125). Munhall argues that this unknowing reflects openness, and that openness is required to come to know the others' world-view. It is interesting though that within the empirical-analytical paradigm that remains dominant in mental health today, there is a distancing of feelings from actions. This is known as subjectivity and is when understandings have become so reified, that as an individual you continue to have the feelings, but bury them. The individual does not engage with the subjective self and actions become distanced from feeling. How then can an individual caught in this cycle connect with another human being? Without openness, is it possible to authentically engage with another?

Personal knowing to me is essential to the profession of nursing. It is the critical ingredient in the therapeutic relationships we have with our clients. It allows nurses as human beings to enter into the world of another and assist him/her to achieve positive outcomes within his/her life. Without it, nursing for me would not hold the magic of the establishment and ongoing development of a connection between two people. The

personal growth and development that occurs within that relationship and the lasting effect it has on the individuals involved.

Because of nursing's heritage of the medical model, women's understandings have been largely excluded. Women's ways of knowing have contributed to additional epistemologies relevant to the understanding of psychiatric mental health nursing.

### **Women's Ways of Knowing**

Gilligan (1982) looked at the moral development of women, and the notions of responsibility and care. This contrasted with the dominant thinking of the time in relation to human development, which at best could be described as white, middle class and male. Whereas the dominant male interpretation of morality relied on

abstract laws and universal principles to adjudicate disputes and conflicts between conflicting claims impersonally, impartially, and fairly. Those operating within a morality of responsibility and care – primarily women – reject the strategy of blindness and impartiality. Instead, they argue for an understanding of the context of moral choice, claiming that the needs of an individual cannot always be deduced from general rules and principles and that moral choice must also be determined inductively from the particular experiences each participant brings to the situation (Belenky, Clinchy, Goldberger & Tarul, 1986, p. 8).

Is it possible to resolve conflict by standing outside and making a judgment based on general rules and principles? Does this suggest that there is only a right and a wrong perspective? Who says what is right and wrong, and what are their interests in doing so? Is this the dispassionate moral adjudicator? Are there other ways to think about moral agency? By standing inside and viewing the tensions from a position of



relatedness, it may be possible to consider the scenario from a different light, albeit with openness that values the unique knowledges and differences.

The work of Belenky, et.al. (1986) looked at knowledge development in relation to women which espouses the epistemological paradigm of constructionism. Belenky, et.al. discussed the emergence of subjectivism, moving from being silent and passive into action. “For many women, the move away from silence and an externally orientated perspective of knowledge and truth eventuates in a new concept of truth as personal, private, and subjectively known or intuited” (Belenky, et.al., 1986, p. 54). The acknowledgment of the subjective self, leads to discovering inner power. This path to discovery has been one of intuitive growth and development and has not usually been learned in a classroom. The positivist paradigm ascribed to by most early education settings, reinforces the stereo-typical notion of the male as the protector. Belenky, et.al., (1986, p. 57) identified in the women they interviewed the notion of “failed male authority”. This led to an absence of male authority in these women’s lives, and started them on their path of discovery. These constructions of knowledge in relation to women’s ways of knowing, are relevant to this research project and are also closely linked to the notions of oppression as outlined by Paulo Freire (1970). No longer maintaining the invisibility of subjectivity leading to emancipatory action and ultimately transformation.

## CHAPTER 4 : METHODOLOGY

*“Freedom is acquired by conquest, not by gift. It must be pursued constantly and responsibly. Freedom is not an ideal located outside the man[sic]; nor is it an idea which becomes myth. It is rather the indispensable condition for the quest for human completion”*  
(Freire, 1970, p. 24).

### Introduction

Methodology is defined as being “concerned with the ideas and principles on which procedures are based” (Holloway & Wheeler 1996, p. 28). This research project uses a methodological framework that utilises a case study approach to evaluate and illuminate students’ issues in their transition from student nurse to staff nurse in the specialist practice setting of psychiatric mental health nursing. The methodology is informed by critical social science in particular, emancipatory inquiry.

In this chapter I will discuss the methodology utilised for this research project. I will also outline the underpinning ideology of the project, namely emancipatory inquiry within a critical social science framework, and how this has influenced the research project.

### Case Study Research

Case study research can be used in both quantitative and qualitative research. “A case study is an entity which is studied as a single unit and has clear boundaries” (Holloway & Wheeler 1996, p. 156). Therefore a “case” can be understood to be an individual, a group, or a programme. For the purposes of this research project the

*case* is the Diploma of Entry to Specialist Psychiatric Mental Health Nursing Practice (the programme). The boundaries for the case are located around the questions being asked, how the data was collected and from whom. These boundaries are clearly outlined under the method section to follow.

The case study was undertaken utilising two small groups. This provided the opportunity to collect data from two separate groups. Themes that surfaced from the first meeting were shared between the two groups at the second meeting. A critical social perspective was brought to bear as the methodological underpinnings for group meetings and the research in general.

### **Critical Social Science**

Critical social science is very much associated with what has now become known as the Frankfurt School in Germany. Critical social theory has as its underpinning philosophy challenging oppression and conflict, and engaging in social action to bring about change. Fay (1987) describes critical social theory as a process of transformation of a social order through explanation. That is by understanding a social order it is possible to transform it. Carr and Kemmis (1983) discuss critical social theory as “an engagement in the process of critique that transforms conscious ways of thinking without necessarily changing practices in the world” (Street, 1992, p. 84). Habermas (1971) argues that critical social theory only becomes critical social science when combined with political action to overcome the inequalities and oppression within a social structure. Drawn from the work of Karl Marx (1818-83) critique of class, the Frankfurt School began to raise further questions about oppression. Scholars such as Habermas, Marcuse, Adorno, amongst others used this

method of ideological critique to problematise the social world and knowledge interests. Other critical social theorists followed, in particular Paulo Freire, whose philosophical theories inform this project.

### **Paulo Freire**

Freire was a Brazilian educator who lived in exile for much of his life. He is well known for his literacy education programmes within underdeveloped countries. With these programmes came the writing of his famous work *Pedagogy of the Oppressed* in 1970, and then, along with other works *A Pedagogy for Liberation* with Ira Shor in 1984. There has been criticism of the work of Paulo Freire, in particular from the feminist perspective. This criticism is related to the gender specific terminology used by Freire in his work, which is considered by the contemporary feminist movement to be sexist. This criticism should not overshadow the insights that can be gained through the reading of Paulo Freire's writings. When asked to comment on this bell hooks stated:

Freire's sexism is indicated by the language in his early works notwithstanding that there is much that remains liberatory. There is no need to apologise for the sexism. Freire's own model of critical pedagogy invites a critical interrogation of this flaw in the work. But critical interrogation is not the same as dismissal (Cited in McLaren & Leonard, 1993)

Freire (1970) discusses de-humanisation as a process that occurs when men/women are oppressed, and that the way for the oppressed to liberate themselves is through praxis, true reflection and action together. He goes on to state that it is not possible for the oppressed to be liberated by others, they must liberate themselves and in turn their oppressors.

Praxis as used by Freire (1970) refers to the dialectic of action and reflection, for separately they do not constitute liberation, only critique or revolution. But operating together they are a powerful force in the conscientization of men/women, which leads to transformation.

Conscientization according to Freire (1970) means learning to perceive social, political and economic contradictions, and take action against the oppressive elements of reality. Freire (1970) refers to this as *changing the consciousness of the oppressed*. Reality is both objective and subjective and cannot be separated. In order for the oppressed to achieve praxis he/she must critically confront reality, by first seeing it, analysing it, then reconstructing it. Left unproblematised does the practitioner perceive reality as object, but a constructed reality serving dominant interests? This reality becomes real to the oppressed as it is less threatening. The oppressed knows this reality and assimilates within it. The alternatives to assimilation involve becoming marginalised from ones colleagues. Maintenance of the relationships within this reality over-ride any desire to risk becoming alienated from one's peers. This is not to suggest that pockets of resistance don't exist, because they do. Thus Freire's notions of epistemology begins with critiquing how reality is perceived, especially with the banking concept of education.

Freire (1970) describes the education system as the *banking concept of education*, where knowledge is deposited in the students by the teachers and is regurgitated or used at a later date. This is simply another form of domination and is in turn oppressive. Freire (1970) describes a form of education that he refers to as liberating. This form of education consists of the teacher and the students entering into un-

coerced communication, which in turn is challenging through making things problematic in relation to human beings and their interactions with the world. Problem-posing education espouses communication as a process of consciousness raising. The teacher is no longer the one who transfers his/her knowledge to the student, but becomes the one who is taught through dialogue with his/her students and is also an educator of students, in the form of mutual engagement. The base of authority shifts with the teacher no longer responsible for the process, but all involved become jointly responsible. The educator (teacher) continues to have responsibility in relation to the educational process which includes self reflection within the process and its content. The students no longer become silent listeners but critical companions in the journey of learning. This problem-posing promotes a dialectic of thinking and action, which in itself is liberating. Freire states:

Only through communication can human life hold meaning. The teacher's thinking is authenticated only by the authentication of the students' thinking. The teacher cannot think for his students, nor can he impose his thought on them. Authentic thinking, thinking that is concerned about reality, does not take place in ivory-tower isolation, but only in communication.

(Freire, 1970, p. 50).

Habermas (1972, p. 313) contends "knowledge-constitutive interests take form in the medium of work, language and power". He discusses how the human species exists within systems. The individual's ego

adapts itself to its external conditions through learning processes, is initiated into the communication system of a social life-world by means of self-formative processes, and constructs an identity in the conflict between instinctual aims and social constraints (Habermas, 1972, p. 313).

If Habermas is correct, it would seem the development of identity although individual is influenced by the constraints of the society and/or system of which the individual is part, restricting the freedom to openly communicate disagreement as this may, and often does, bring critique from the society and/or system itself.

Knowledge is shaped within the competing interests of the society and/or system and constructs reality based on these interests. Habermas also talks about self reflection, autonomy and responsibility and humankind's evolution towards the reconstruction of that which has been suppressed. With the individual's growing ability to self reflect on the world around him/her, and knowledge interests that are being served, there is a questioning of the constructed reality. When the path to questioning and unconstrained communication is blocked, often through violence, it only serves to enhance the evolutionary process towards autonomy and responsibility. Habermas refers to this as the emancipatory cognitive interest, where "the power of self reflection, knowledge and interest are one" (Habermas, 1972, p. 314)

### **Emancipatory Inquiry**

Emancipatory inquiry is based in the critical social sciences with social change as it's goal. Henderson (1995) cites Fay (1987) in suggesting that "emancipatory inquires are ideologies that seek to understand oppression in society, and through this understanding, transform it" (Henderson 1995, p. 59). Emancipatory inquiry seeks to liberate both within the research process and society through communication and critical reflection, which leads to the development of knowledges. With its foundations in political resistance movements, emancipatory inquiry seeks to enlighten those within societies where individuals have unequal levels of power and

resources. The society that is referred to in the context of this research project is the community of psychiatric mental health nurses and mental health practice settings as a whole, but forms a microcosm of a larger world. The position in which the new graduate nurse finds him/herself, when he/she first enters the specialist practice area of psychiatric mental health nursing practice, may in fact be one of oppression. The purpose of using emancipatory inquiry to inform the research process is to provide each participant with an opportunity to reflect upon his/her world and to transform it through greater knowledge and understanding.

Emancipatory inquiry holds to the view that knowledge is “socially constituted, historically situated, and valuationally based. Thus, scientific research as a human endeavour to advance knowledge, is influenced by the socio-cultural and historical context in which it takes place and is considered neither value free, objective, nor neutral” (Henderson, 1995, p. 59). Therefore, rather than sidelining, or bracketing the values, biases and positioning of the researcher, emancipatory inquiry seeks to make these overt and positions them at the center of the research process.

### **Participatory Research**

Participatory research as a methodology, looks at how the research is conducted, rather than the specific techniques used. “Participatory research is an alternative approach that integrates scientific research with educational and political action” (Henderson, 1995, p. 61). Henderson (1995) goes on to outline the five ways of being that define participatory research as distinct from other forms of research. These are discussed below in relation to this project.



1. Participation by those being studied; that is the research is done with participants, as opposed to being done on them. Within this research project the participants and the researcher are jointly exploring the issues and ideas relating to the new graduate nurses experience as they live the specialist area of psychiatric mental health nursing practice. The researcher undertakes a dual role within the discussion groups of both participator and facilitator of the process. The facilitator role is required to ensure the process occurs within the time-frame allowed. The researcher undertakes this role herself rather than introducing another person into the group, which would have the potential to alter the dynamic of the group and hence the outcome.
2. Participatory research places value in experimental and popular knowledge and other non-scientific ways of knowing; therefore the situation, historical and personal knowledges of each participant and his/her experiences becomes legitimate. The research project provides the participants with the opportunity to discuss what they know and experience and this is legitimate in relation to the project and its outcome.
3. Participatory research focuses on empowerment and power relationships by problematising understandings.
4. Participatory research involves a mutually educative encounter where all participants generate both data and theory.

These are interesting in relation to this project as the researcher is also the participants' tutor within the education programme for which they are enrolled. In this situation the power distribution cannot be equal due to the nature of the relationship

between the researcher and the participants. However the researcher has endeavored to minimize the uneven distribution of power within the relationship, and has attempted to engage mutually with the participants, valuing the shared understandings relating to the issues explored.

5. The goal of participatory research is part of a larger agenda embodied in political or social action to change unequal power distribution in society. Within the research project one of the aims was for the participants to consider how and in what way both educational processes and content could better support the students' understanding and the enactment of their changed role from student to staff nurse. In order to achieve this, each participant reflected on his/her experiences on entering clinical practice, thus increasing his/her knowledge and understanding of the self, and the world in which they were now engaging. This led to an exploration of ways to transform his/her world in ways that are achievable and support the individuals development.

In relation to this project, participatory research was seen as the appropriate method to ensure the participants in the research process, including the researcher, were able to reflect on the reality of the milieu in question, engage in critical dialogue, and illuminate oppressive relations where action could/might be taken. This action can be two fold. For the researcher the illuminations and insights gained will impact on the curriculum and education process for both existing students and those in the future. This will occur formally through curriculum development, and the continued dialogue with students to allow students to inform their own educative process, and informally through researcher interactions with students in the future. For the participants the research process itself supported the raising of consciousness, and this in turn may

lead to change in the milieu in which he/she practices. As the individuals participating in the research process became more aware of their oppression they began to both question the status quo and understand how they have a tendency to take for granted the ways of acting consistent with the institution in which he/she is working. In addition it has assisted individuals to see how they are expected to come on board and not question, participating in the objective reality that has been created. Within this objective reality reification occurs where the individual exists without self-reflection. This self-reflection of the subjective reality is not considered as this would question the status quo. The individual carries out the requirements of his/her objective reality as if he/she has no choice. This can be seen within mental health and indeed the wider health sector, with those working within the institutions at a variety of levels implementing policy and directives as if they have no power to intervene.

Freire (1970) in discussing the characteristics of the oppressed suggests the duality of oppression where the oppressed themselves become the oppressor, whose image they have internalised. Fatalism is nearly always expressed when the oppressed becomes conscious of his/her oppressor, and therefore his/her own consciousness. Fatalism may appear as docility. Within this docile state the oppressed do not perceive the reality of whose interests are being served. While resisting the oppressor, the oppressed will often strike out at his/her colleagues. This is known as horizontal violence and is often referred to in the nursing literature. It reflects the duality mentioned previously; if the oppressor exists in the oppressed, by attacking his/her colleagues the oppressed is attacking the oppressor. In a form of hegemonic process within nursing, horizontal violence (Duffy, 1995) is a way of maintaining control over those who would choose to question the status quo and introduce new perspectives and/or understandings to the existing reality.

This project cannot be classified as fully participatory as true participatory research involves the participation of those being studied in planning the research project from its inception and also through its various phases to writing the report. This has not been possible in this project. However current and past students have contributed informally by expressing their individual interpretation of their existing reality and thinking in relation to potential areas for change.

## **CHAPTER 5: METHOD**

The method is the enactment of the process and the specifics of carrying out the research process, drawing on the methodological underpinnings previously mentioned. The approach is outlined sequentially in this section and covers most of the items identified during the process of obtaining ethical consent for the research.

### **Polytechnic Approval**

Prior to commencing the research project the researcher was required to undertake the approval procedure for research at the polytechnic where the research was carried out. I began by approaching the Head of School and requesting information relating to the polytechnic's procedures for research involving a lecturer and his/her students. A formal proposal was submitted to the Research Committee of the selected institution. This proposal followed the outline of an ethics proposal as would be submitted to most Ethics Committees. The Research Committee approved the project with two requirements specified.

The first requirement was the appointment of an independent person within the institution to ensure students were not subject to prejudice/penalty. This was required as the researcher is also the participants' tutor, and the Head of School was appointed to fulfill this responsibility. A further person was approached by the researcher and asked to act as an independent person for the students to approach should they have any complaints relating to the research process and/or the researcher. This person was external to the programme and the school and thus there was no direct power

relationship with either the researcher and/or the potential participants. This allowed for further objectivity should any issues and/or conflict arise during the research process. The second specification was that any and all requirements stipulated by the Victoria University Human Ethics Committee are forwarded to the Research Committee and that the research process adheres to any requirements outlined in the ethical approval.

Ethical approval was then sought and obtained from the Victoria University of Wellington Human Ethics Committee.

### **Characteristics of participants**

Participants of the project were new graduates of an Undergraduate Degree or equivalent in Nursing, with no more than 12 months full time experience within a mental health setting. The participants were also enrolled in the Entry to Specialist Practice programme at the selected institution which commenced in February 1999.

### **Recruitment of Participants**

During the second week of theory at the commencement of the programme, students were given a full verbal presentation by the researcher on the proposed research project. All nineteen graduates enrolled in the programme commencing in February 1999 were invited to participate. This presentation provided the potential participants with an overview of what was being proposed and how this would impact on them as potential participants and students of the programme. It was clearly explained to the students that the researcher was in the process of obtaining ethical approval, and that no approach would be made in relation to the recruitment of participants until ethical

approval had been obtained. However, since the potential participants were also students of the programme, and as the researcher was the tutor and programme coordinator it was important I thought, to advise the students of my intention right from the beginning of their programme. This was to ensure that the processes put in place were designed to reduce the risk of prejudice and/or penalty. The Head of School made herself available for the presentation of the proposed research to the students, and was there to discuss any issues that may have arisen in relation to the research and any impact it may have had on their role as students. I felt it was important to leave the room following the presentation so students could have an opportunity to engage in discussion and ask questions of the Head of School if they felt the need. I was not privy to what eventuated, wanting to ensure possible participants had an opportunity to raise questions with a sense of anonymity, thus supporting their interests. No further discussion was entered into with the students until the ethical approval had been obtained from the Human Ethics Committee, Victoria University of Wellington in early May 1999.

Once ethical approval had been obtained, all students were given a package containing a plain language statement, a consent form (Appendix ii) and a stamped, return addressed envelope. The package was given to students during their second theory block. As the students were located within different geographical areas, and their theory was delivered from two separate locations, the Wellington and Nelson Marlborough students received their packages on Friday 21 May 1999, and the Palmerston North and Wanganui students on Monday 24 May 1999. A covering letter was attached outlining the contents of the package. The appointment of the independent arbitrator along with his full contact details, and the proposed dates for the group meetings were enclosed. The students were also requested to return their

consent forms to the researcher by Friday 28 May 1999. (The covering letter, plain language statement and consent form are attached as Appendix ii). Seven students accepted the invitation to participate by returning the signed consent form.

### **How informed consent was obtained**

The plain language statement sent out to the potential participants set out clearly the information related to participation in the project. This statement conveyed the same information covered in the verbal presentation the researcher gave to all commencing students at the beginning of the programme. There was an opportunity to ask questions of both the researcher and the Head of School at that time, opportunities to ask questions about the research were provided at the commencement of the research and when necessary during the course of the project. The processes put in place to ensure confidentiality were fully explained to the participants, and are outlined further in the section on Confidentiality. The participants were informed that they had the right to withdraw from the research at any point without prejudice or penalty.

Consent to participation in the project covered several areas. The verbal explanation and plain language statement outlined the processes for group meetings, recording of data, collection of data, and release of the tapes to the dictaphone typist for transcription. These also included a commentary to the participants that they should feel free to contribute their opinions and information to a level with which they felt comfortable. The plain language statement also included the anonymous use of the data collected for the completion of a thesis in partial completion of a Masters (Applied) in Nursing, Victoria University of Wellington, and publication and conference presentations. The participants also agreed that the data collected could



also be made available to the researcher's supervisor and would be used for curriculum development purposes within the programme. It should be noted that no identifying data relating to personal, professional, employment or organisational information would be released.

### **Data collection**

The collection of data was through the use of discussion groups. Discussion groups seemed the most appropriate method of data collection as they provided the possibility of an equal relationship between the participants and the researcher. The researcher then became one of the participants undertaking the role of the facilitator within the group. This is more in line with the research methodology rather than the researcher interviewing the participants, which can set up an unequal power differential.

The discussion groups were to be held at the Royal New Zealand Police College in Porirua, where a conference room was booked by the researcher in advance. This venue was chosen to provide a neutral space for the participants outside of their normal employment and/or education setting. The location provided easy access for students residing within the Wellington region, and was easily accessible for students from Wanganui and Palmerston North. However this became an issue a few days prior to the first group meeting. One of the participants traveling from out of Wellington was unable to travel that day, also affecting another participant as both travelled together. These participants then asked if there was any way the group could be held in their geographical area, meaning the participants would not have to travel at all.

Discussions were held with my thesis supervisor, Penny Cash, and Dr. Paul F. Davis, the student advocate. It was agreed that the original group of seven participants be separated into two groups within each of the main geographical areas. This reduced the inconvenience to the participants, leaving the researcher traveling the longest distances. These groups have been identified as A and B to ensure confidentiality, and a second neutral venue was identified for group A. The issue then was how to make sure data collected from the two groups could then be pulled together, thus still maintaining the original intention of undertaking the data collection with one discussion group. A second consent form was created requesting consent to disclose information from each discussion group to the other. This information was related to the development of themes only and did not include consent to name the participants in the other group, or disclose the specific details of conversations held. All seven participants signed this consent form and the data collection proceeded. This consent form is attached in Appendix (ii).

The first discussion group, group A, was held six weeks into the students second clinical placement. The researcher had initially planned to hold the discussion group within two weeks of students completing their first placement, but this was not possible to arrange within the time-frame, taking into account ethical approval, and the need to rearrange the discussion groups following the identification of the issues around travel. Group B gathered for their discussion group two weeks later, eight weeks into their second clinical placement.

Prompt questions based on the Nursing Council of New Zealand (NCNZ) Competencies for Entry to the Register of Comprehensive Nurses (November 1997) Mental Health Competencies - No. 5 Management of the Environment were used as

starters to focus the group. This specific competency covers two main foci. The first is relating to the therapeutic environment in which psychiatric mental health nursing is practiced and the second to the identification, assessment and management of risk within the mental health setting. These were chosen by the researcher to promote discussion about the therapeutic nature of the environment, and risk management issues for new graduate nurses entering specialist psychiatric mental health nursing practice, perhaps for the first time. These questions provided the basis for a wider discussion.

The specific questions used were formulated by the researcher prior to the discussion groups and in this way served as part of the facilitatory role. The competency as stated by the Nursing Council of New Zealand covers a variety of points relating to managing the environment within a mental health setting. The first point covered is the understanding of the principles of community mental health. The researcher chose not to use this as part of the prompt questions as only two of the participants had been involved with community health services during their first placement. The second and third points however refer to maintaining a therapeutic environment and the impact of the milieu on the mental health of the patient/consumer. Both were combined to form the first question that related to understanding the participants' views of a therapeutic milieu, and what had assisted the participants to develop that view. The final three points related to the identification, assessment and management of risk (to self and/or others) within a variety of mental health settings. These points were combined into the second question that focused on the participants' experiences relating to the identification, assessment and management of risk.

The discussion groups were audio taped. The intention was to have the tapes transcribed by a professional dictaphone typist, a person not associated with the institution or the field of inquiry, and who had signed a confidentiality agreement. (See Appendix iii). However the typist experienced difficulty transcribing the tapes, perhaps due to the poor quality of the recordings and the specific nature of the content which was difficult for a lay person to follow. Due to these problems the researcher transcribed the tapes herself.

Copies of the transcripts were sent to the participants following the first discussion group. This was to ensure participation of all involved in the research process and provide the participants with the opportunity to identify themes independently of the researcher. Participants were invited to comment on the transcripts and discern what had been for the individual the major themes arising from the transcript. The themes that arose became the agenda for the discussion at the next group meeting. The second discussion group for A was held six weeks later, on the last day of their second clinical placement. For B it was held five weeks after the first, one week following the completion of their second clinical placement.

### **Special hazards and/or Inconvenience**

As the researcher is also the Programme Coordinator of the Diploma of Entry to Psychiatric Mental Health Nursing Practice - Whitireia Community Polytechnic as well as the participants' tutor, any risk of prejudice and/or penalty was reduced through the following processes being put in place.

The Head of the School of Nursing and Health Studies - Ms Jan Pearson, and Dr. Paul F. Davis were appointed by the Whitireia Community Polytechnic Research Committee and acted as student advocates and arbitrators throughout the project. Ms Pearson attended the initial verbal explanation of the project and was available immediately following to respond to any questions the students had. Ms Pearson and Dr. Davis continued to be available to students throughout the project if they had any concerns regarding consent, withdrawal of consent or prejudice.

In relation to the assessments undertaken by students who were or were not participants of the research project, the following was put in place. Students' clinical assessments were completed in the clinical setting by nursing staff who were not associated with the research. The results of these assessments were then forwarded to the Programme Coordinator (the researcher) to be placed on the student records. All academic assignments were forwarded to the Administration Staff of the School of Nursing and Health Studies to ensure all identifying data, other than the student identification number were removed before the assignments were forwarded to the tutor (the researcher) for marking. At no time did I hold a list of student's names and their corresponding identification numbers, and was therefore unable to identify which academic assignment belonged to which student. All Whitireia Community Polytechnic internal and external moderation processes were followed to ensure consistency and fairness in marking of all academic assignments.

## **Anonymity and Confidentiality**

The research was unable to be carried out in a truly anonymous way as the programme and the education institution can not help but be identified within the research. Students of the programme can be identified in part by those working in mental health in the central region of New Zealand. Also those employed in the education sector and the funding agency have access to class lists and therefore student details. However the confidentiality of the research participants, and the information they provided to the researcher was maintained surrounding the consent to participate in the project. Participants consent forms were forwarded to the researcher's home, and were only disclosed to the administrative secretary of the Whitireia Community Polytechnic for the purposes of administrative support. The Administrative Secretary signed a confidentiality agreement. (See Appendix iii). Other than the researcher and the administrative secretary, only those participating in the discussion groups knew which students were involved in the research project. Participant responsibility was negotiated and agreed upon at the commencement of each of the first discussion groups, A and B, between the researcher and the participants in relation to the confidential nature of the discussion group and the content and context of ideas surfaced. Neither the content nor details pertaining to information raised during the course of group discussions, nor the participants involved were discussed and/or identified outside the group. No identifying information relating to the participants personal information, geographical location or professional employment details has been included. Participants did not want the use of pseudonyms in the written text. Rather where consensus of opinion was reached the participant comments were sited in text, and would not be attributed to any one participant. As previously mentioned, the professional dictaphone typist transcribing the discussion group tapes signed a 'Non disclosure of Information' statement. More over, she was an independent person

not associated with the institutions and nursing generally. No other person (other than the researcher's thesis supervisor) was given access to tapes and/or written data. The data was stored in the researcher's private residence.

### **Storage of, access to and destruction of data**

All data (tapes and transcripts) have been stored in a locked cabinet at my home until the project reaches completion. Copies of the transcripts were sent to the participants following the first discussion group. Participants were invited to comment on the transcripts and discern what were for them the major themes arising from the transcript. These themes formed the basis of an agenda for discussion at the second group meeting. Participants brought the transcripts to the second meeting for the purposes of returning them to the researcher, and they will be shredded on completion of the research. All tapes have been electronically erased, and all paper data will be shredded on completion of the project.

### **Procedures for Feedback and Reporting of Results**

A verbal summary of the findings to date was presented to the full student group in mid November 1999. This was undertaken only once verbal consent was obtained from the seven students participating in the project. Once it has been completed and undergone academic marking process participants will be able to read the thesis. Publication of results will be in article format, in Nursing journals in New Zealand or Australia, as well as in conference papers. The information will inform curriculum development for the programme within the institution.

## CHAPTER 6: DISCERNING THE THEMES

This chapter will introduce the themes identified by the participants during the first and second discussion sessions. They are issues highlighted by each participant entering his/her first clinical placement, but for the purposes of the project have been pulled together. Following the first discussion group both the researcher and the participants individually and collectively identified the themes that were discussed at some length in the second and final session. These themes will be introduced in this chapter and discussed in more depth in the following three chapters. The second discussion group focused on looking at ways forward leading to the formulation of recommendations for future changes in the programme content and processes. These recommendations are discussed in Chapter Ten.

Each participant was asked to think about the therapeutic milieu in relation to the environment he/she had experienced in his/her first clinical placement. The participants were then asked to discuss the individual impressions and experiences within that environment.

Initially the participants discussed the therapeutic milieu in relation to the clients experiences rather than the individual participants' experiences. The issues identified were around the perceived lack of working together to achieve mutually agreed goals (client centredness) and the perceived lack of adherence to management plans. One participant discussed the "game of tennis that she was learning to play", relating it to his/her experiences within his/her first placement, which was described as:



*like playing tennis ... you get all these referrals of clients that are supposed to be seen, and you're sitting in this meeting and everybody looks for ways in which these clients can be flicked off to other areas so they don't have to deal with them. ... admittedly ... you are worried about budget constraints and the [admission] criteria for the service ... you battle six of them, ... and it is a successful meeting because you only have to deal with two clients. It just doesn't sit right with me. I'm finding it very difficult.*

The participants were then asked to think about the issues identified and to replace the client in the situations discussed with the new graduate nurse entering practice. Do the same issues apply? The participants all agreed that although situations may be different the issues remained the same.

I want to first look at the use of structured plans for the support of new graduate nurses entering practice. All participants experienced a lack of support to varying degrees during their first clinical placements. Each participant discussed the role of the preceptor within the clinical setting and how there were marked inconsistencies as to how this model was applied. All participants identified a lack of clarity around not only the role of the preceptor, but also the roles of programme coordinator, the site coordinator, the employing organisation, the polytechnic and themselves as registered nurses enrolled in the programme.

The lack of clarity around the roles and responsibilities of those involved in the programme impacted greatly on the support provided within respective employing organisations. Walker (1998), cites Wootton (1987) who identified factors that assist the transition to registered nurse as “the attitudes of staff, planned orientation

programmes, preceptorship, support networks, clearly identified expectations of the new staff nurse and feedback to new employees” (Walker, 1998, p. 37). This was reiterated in the research undertaken by Prebble and McDonald (1997) “successful transition for the graduates into the specialty area appeared to depend in part on the quality of the formal orientation programme provided” (Prebble & McDonald, 1997, p. 34).

Themes relating to the clarity of roles and responsibilities were central to several other areas discussed by the participants, in particular preceptorship - roles, responsibilities, training and ongoing support. This is discussed in the following chapter and again in chapter ten which identifies areas where the programme could provide greater support for new graduates entering specialist psychiatric mental health nursing practice.

A further theme identified by the participants was the process of socialisation (a term the participants used) into practice and individual experiences of potential/actual conflict within the clinical setting. This theme centered around the participants’ personal philosophy of practice and individual expectations on entering the clinical setting as a registered nurse. All participants disclosed examples of being placed in a position where there was the potential for, or actual conflict with, other nursing staff when the participant questioned existing practice and made suggestions for alternative ways of acting. All participants discussed this in relation to the reflective nature of their practice and how this reflective engagement had at times put him/her in conflict with others.

The final theme discussed was risk management. Participants were asked to consider the identification, assessment and management of risk, and how they as nurses having recently entered the Comprehensive Register of Nurses, dealt with an expectation that

this was an area in which they were competent. How did this statement sit in relation to the participants as new graduate nurses entering the specialist practice area of psychiatric mental health nursing practice? Each participant discussed his/her experience of the assessment and management of risk, and the impact these experiences had on his/her development. There appeared to be inconsistencies again in how risk was assessed and managed within the clinical setting and this caused some concern for the participants. The discussion developed to identify some of the underlying issues relating not only to the assessment and management of risk, but also to the socialisation of the new graduate into the psychiatric mental health setting. It seemed that underpinning risk management were issues relating to power and control. The participants were very clear that as an individual new graduate nurse entering practice the locus of power and control lay with the existing, and/or senior staff within the clinical setting. However this contradicted the new graduate's understanding in relation to working collaboratively and in partnership with consumers. This also created tensions and confusion for the participants and in some cases conflict.

It is interesting to note that a three year study by Ferguson and Hope (1999) looking at Project 2000 nurses entering the specialist area of mental health in the United Kingdom identified some similar issues as this research project. Ferguson & Hope discuss the contrast between student life and the real world of work, particularly in relation to the patient-centered approach to the nurses activities. Also noted is some "evidence of a negative socialising influence, which promotes the professional agenda at the expense of the patient" (Ferguson & Hope, 1994, p. 636). Another area noted in Ferguson & Hope's study was the absence of preceptorship and clinical supervision for the new graduate nurse and the positive impact both of these processes can have on

the new graduate nurse entering practice. Preceptorship and support is clearly identified in a wide variety of literature to be a critical component for supporting new graduate entry to practice and is discussed further in the following chapter.

## CHAPTER 7: PRECEPTORSHIP AND SUPPORT

There is a wide variety of international literature on preceptorship for both undergraduate students and new employees within a variety of health care settings.

Oermann and Moffitt-Wolf (1997) identified an important theme relating to the level of support from preceptors for new graduate nurses entering the workforce, that is the level of support from preceptors directly correlated to the development of clinical competencies. Where there was a perceived lack of support from preceptors the new graduates' learning was inhibited. Oermann and Moffitt-Wolf (1997) also stated, "an important theme was the need for consistent preceptors during orientation who supported and guided their [new graduates] learning in clinical practice" (p. 25).

However there is little New Zealand literature relating directly to the preceptorship of new graduate nurses entering the specialty practice area of mental health nursing. Prebble and MacDonald (1996) undertook a qualitative descriptive study in 1994, which looked at the lived experience of comprehensive nurses adaption to the mental health setting. Adaption would however suggest assimilation into the culture of the organisation, and I am not sure this is what is really wanted. Three main themes were identified in Prebble and MacDonald's research, *passage of transition into practice*, *conflict and contradiction*. The *passage of transition into practice* theme focused on the orientation and ongoing support provided within the new graduate nurses employing organisation. This relates to the enculturation of the new graduate nurse into the cultural practices within his/her work environment. Enculturation as discussed previously and in greater depth in the following chapter, is the process of integrating into the existing culture, that is the dominant culture and the subgroups within it, of which nursing is but one. Melia (1987) describes nursing as students saw it as "a

divided occupational group whose organisation presents considerable problems for those attempting to gain acceptance into its ranks” (p. 1). The processes enacted in relation to supporting the new graduate nurse on his/her transition from student nurse to staff nurse within psychiatric mental health nursing practice have been characterised by disorganisation and conflict. These are key themes identified throughout our discussion groups and will be the focus of this chapter. The participants comments are taken from data collected at the first group discussion, unless other wise stated.

Butterworth & Faugier (1992) define a preceptor as “a teacher or instructor” (p. 12).

Morton-Cooper & Palmer (1993) describe preceptorship as:

a form of educational relationship which is intended to provide newly qualified (or returning) professionals with three things:

1. Access to an experienced and competent role model.
2. A means by which to build a supportive one-to-one teaching and learning relationship.
3. A smooth transition form learner to accountable practitioner (p.99).

They go on to identify the uniqueness of the preceptor role due to its one-to-one nature and the negotiation of content and direction, which should enable preceptorship to allow for “individual personalities, situation and learning styles of both preceptor and ‘preceptee’ (Morton-Cooper & Palmer, 1993, p. 101). Wright (1992, in Butterworth & Faugier, 1992) however, refers to preceptorship as a “mock-apprenticeship system of attachment to ‘preceptors’, whose roles and qualities may not have been clearly defined and who have not necessarily moved beyond competent to expert practitioner” (p. 211). This observation by Wright (1992) is consistent with the finding of this research project. The participants identified lack of clarity and inconsistency around roles and responsibilities, along with *ad hoc* preceptor selection processes as not being conducive with

establishing an environment which encouraged growth and development of their practice.

Benner identifies the preceptor as someone who prepares the new nurse “for the kinds of additional clinical judgment skills they will eventually need to acquire” (Benner, P. 1984, p. 186). Benner then goes on to discuss the need to ensure adequate preparation, training and support for nurses who undertake the role of preceptor. The preceptor will work with the new graduate nurse on a shared caseload with the preceptor initially managing the caseload, and the new graduate working alongside him/her. Over the few weeks the new graduate will gradually take over the management of the caseload, with the preceptor taking an increasingly silent role, but continuing to oversee the new graduate’s practice and provide support and advice. This in itself is an issue of time. A time limit is set within most clinical organisations relating to how long a new graduate nurse will be supernumerary to the staff numbers and within what time frame, the new graduate nurse can be expected to carry his/her own case load. This is consistent with the rigidity and resource-driven nature of the existing mental health environment and reinforces the competitive nature of institutional life. What might happen if the new graduate nurse entering practice was treated as an individual who was allowed to advance at his/her own pace? Would the new graduate be brought into line with the organisational expectations through the pressures of work being placed upon the new graduate and his/her colleagues? It may not be a safe place for the new graduate nurse to stand outside these organisation norms.

Precepting is a specialised skill that requires training. The preceptor is usually an experienced practitioner who is able to articulate and reflect on his/her practice, and hold back to allow the new graduates to make their own decisions and undertake their own tasks. Benner states, the novice “should not be so protected that they are prevented from experiencing challenge and success sufficient to gain a sense of commitment and identity with the organisation” (Benner, 1984, p. 201-2). This statement shows enculturation at it’s best and is not consistent with the notion of preceptorship that is fostered by this programme. Yes, it is important to allow the new graduate to gain a sense of identity and indeed a sense of commitment however, whose identity and a commitment to what? By gaining a commitment to, and an identity with the organisation the new graduate nurse is in danger of losing his/her own identity and his/her commitment to the ongoing development of his/her practice of nursing, and dare I say it, commitment to the client/s. This definition is indeed serving the interests of the organisation/institution, not that of the new graduate nurse entering practice.

Another point of interest is the various levels of nursing that are found in the literature relating to preceptorship and other issues within nursing. Advanced, experienced, novice, senior, junior, these are all words that describe the level of skill and/or knowledge attached to a person. They denote a hierarchy of skills and/or knowledge within nursing as a profession and that some knowledges are deemed more important than others. The new graduate nurse is placed in the position of a junior nurse and as such within this hierarchy the value of the knowledge he/she holds is reduced. This denies the legitimate knowledge the new graduate nurse carries on entering practice, and is another way of placing the new graduate in the best possible position to become enculturated.



Preceptors are selected from within the employing organisation and training is provided through the polytechnic, by way of the programme coordinator. This training is offered prior to, and immediately following the programme commencing. The nature of the training is adjusted to meet the needs of those undertaking the preceptorship role. This will depend on the level of generic preceptor training already provided within the individual employing organisation, which varies enormously between organisations. The difficulty during the 1999 academic year was that not all designated preceptors took advantage of the training. This created an issue for both preceptors and students of the programme as there was a lack of clarity around roles and responsibilities in relation to the programme and the clinical assessments completed by the preceptor. Herein lies another conflict. Who is involved in preceptorship? Does the organisation choose who should be the preceptor, or does the individual unit invite existing staff to participate in preceptorship? When people are instructed/directed to participate in an activity there is often resistance. However when people are invited to participate and are given the choice, commitment to the process is often greater. One could well ask how many preceptors elected to undertake the role in 1999? Some clinical areas provided well organised models of preceptorship, whereas others were somewhat *ad hoc* and lacking commitment, leading to inconsistencies and frustration for the participants.

Each participant identified marked inconsistencies around his/her individual experiences of preceptorship within his/her first clinical placements and the impact these inconsistencies had on his/her learning in preparation for the second clinical placement. One participant discussed an experience within the first placement, when the preceptor was not adequately prepared for the role:

*In my first placement, I put very little effort into proving how I achieve things, and my preceptor had an extremely vague idea of what preceptorship was about ... I made the assumption of them [the preceptors] having knowledge of assessment process, of critique, of a lot of different things. And it was that assumption that became the problem, so I am assuring it doesn't happen this time [in my second placement].*

The participant goes on to discuss the individual responsibility of the student to ensure his/her preceptorship needs are met and how this was achieved within the second placement:

*we [students of the programme] have a responsibility to put forward what our role is, and I've really taken this as a mission in my second placement, to assume that my preceptor may not have the skills to start with, but has a good knowledge of my expectations of [him/her] and my expectations of myself, and we've got a clear line of communication between us.*

All participants were unanimous in agreeing that each had specific responsibility in ensuring his/her learning needs were identified and a process was put in place to provide support to meet these needs. However this responsibility was not the new graduate's alone, it was a shared responsibility between the new graduate and the employing organisation. This was the issue that most frustrated the participants who felt that often the individual new graduate carried the burden of this responsibility alone in an organisational sense. Participants felt their employing organisation had not placed enough emphasis on ensuring the preceptorship model was implemented appropriately, nor was it adequately monitored to ensure the model was meeting the needs of the new graduate nurse and/or the organisation as a whole. Within individual units/teams the issues related to pre-selection of appropriate preceptors, commitment

to ensuring preceptor training was attended and rostering of new graduates and preceptors was managed differently. This highlighted inconsistencies between and indeed within employing organisations. The commitment to the programme at an organisational level needs to be better clarified. The memorandum of understanding between the Polytechnic and the clinical providers from the year 2000 on will assist in this clarification. However there also needs to be some willingness and/or commitment within the clinical organisation to accommodate the individual differences and diversity. Each new graduate nurse needs to be have access to a preceptor who has an understanding of the programme and the wider principles of preceptorship. The preceptor needs to be able to work with the new graduate as an individual, respecting the uniqueness of the individual and his/her learning needs however, in order to do this the preceptor must have the support and commitment of the unit/team and the organisation as a whole.

Outlined below are some ideas from participants commenting on individual experiences in a variety of clinical settings:

*My preceptor has been good, supportive, getting through the competencies. [He/she] hasn't done a preceptorship programme or anything, she stated that at the beginning.*

*Well I didn't have that support [in first placement] ... we were on different shifts, so this time [in second placement] we [student and preceptor] make sure that we're rostered on the same shift, not necessarily the same area, but we could access each other.*

*My preceptor was only appointed after the second week, and was very honest with me by saying that [he/she] had never been a preceptor before. So we've sort of been working through the*

*process. [He/she] has been really good, supportive, in practice he/she knows what [he/she] needs to assess me on.*

*My preceptor is learning a lot from what we need to achieve, and how we need to achieve it. So my preceptor has a very clear picture of [his/her] role, and I give him/her a very clear picture of my role, and how those roles are ticking along.*

*I was just thrown in really. Wasn't given any sort of orientation. ... It was scary.*

These experiences again bring into question the clinical organisations commitment to the programme. The enactments of certain practices and relations identify a lack of commitment. When true commitment is present, the practices and relations associated with preceptorship within the organisation would be well organised in advance and monitored.

One participant's story in particular demonstrates some of the real issues faced by new graduate nurses entering a clinical setting for the first time and how that experience can adversely affect both the individual's physical and mental health:

*I was on a slightly different shift, so I started at 7am and the preceptor started at 8, so every morning I just came in, I wasn't allocated any patients and I just waited until 8, then I finished my shift at 3.30. Neither of our shifts were changed to be amenable. And I really needed a patient load, and when I look back that is my point about feeling useless and them [the other staff] probably thinking I was useless. I wasn't given a patient to look after I don't think in the first week. I can't remember what happened in the second week, it felt like there was a two week period of orientation. ... I didn't get any patients and people would look at me and say*

*'what are you doing?' and I would say 'I'm waiting until 8am when my preceptor starts'. They would do the allocation, and I wouldn't be given anybody, the preceptor would come in, disappear, and I would read notes and things, and the nurses would say 'we're so busy, we're so stressed, there's nobody on afternoon shift'. And I would think I am registered, I am being paid, I am not furniture. So when I did get allocated patients, I got four really demanding patients, and I ran like shit, like someone with a gastroenteritis problem. For two weeks, and I was trying to make their beds, and all that stuff, cause these were people who did not attend activities or anything, they were really sort of long stay, chronic people ... And I developed a migraine, I got such an awful, awful headache after this, and one of the nurses said to me 'you don't really look very well, you know is there something wrong?'. I was sort of well yeah, I got told nothing in my first two weeks, I felt really useless, and now I run around so busy that I can't even ask questions, trying to nurse, rather than me knowing what is going on, I'm reacting ... It was extremely difficult and looking back, if you were going to ask what would be different, I think that you need to have matched your shifts with your preceptor, cause sitting around is the most pointless orientation. I don't know why it is acted that it is a great surprise that someone is coming. They are doing you a favour letting you sit around, because you offer 'can I help with that, I am here to learn', and for them to say 'no, no you sit down and have a break, it gets pretty hectic around here, but don't worry you take it easy'. That is not what you are here for, you want to learn and participate, you don't want to feel like you are sort of a dead weight. You need to feel useful ... the patients knew that I was the weak link, they knew that I was useless to them when I didn't have a key ... eventually it did all work out, but I would say that that was more to my perseverance and my previous work experience. If you went in as a young new graduate, I think you would have just handed in your resignation to see if anyone noticed. But I really noticed the physical stress, I came down with this huge migraine because the*

*internal tension was just unbearable, and of not being able to really feel useful as a staff member, and having just registered I really wanted to work as a nurse.*

What a position to place a new graduate nurse in. Here is someone who has entered nursing with the intention of being able to make a contribution which is what nursing is all about. This new graduate nurse has completed his/her training and is finally able to start making that contribution, and it is not valued. What does that say about the new graduate as a person? What does that say about the system the new graduate has entered? In order to gain acceptance you have to be able to do the job, but on the other hand you have to be able to do the job to gain acceptance. What a catch twenty two.

Another participant went on to add:

*When you are new you don't know what you don't know.*

This is something critical to understanding some of the difficulties faced by new graduate nurses entering clinical practice, and is something preceptors need to be aware of in relation to supporting new graduate nurses. The focus is often on ensuring the new graduate develops skills and knowledge related to the specialist practice area. However it may be initially more important for the new graduate to learn the basic housekeeping knowledge and skills that are required to make him/her feel comfortable enough within the clinical setting to go on and develop more clinically specific knowledge and skills. Boyle (1994) also identified this as a barrier to learning in her thesis looking at clinical preceptorship with undergraduate nursing students.

The following extract from the participant's discussions demonstrates this well:

*It's really frustrating not having a key in the environment, not being able to transfer the phones, not being able to find little things that you are asked to find. How frustrating it is to get on to the ward and its the little things that make you feel useless, but you can identify so-and-so is hearing voices, with a knife, get that psych registrar down here, and its all action stations, so you know your big shit, and it's the little shit that makes your flustered, which is a really awful feeling to have when you want to feel competent and enjoy relating with people.*

This was a real issue for most of the participants who felt their individual development was adversely affected by a lack of housekeeping knowledge and by a lack of access to specific tools of the trade. Neither of these issues were addressed during the early stages of clinical placements.

Another issue identified by the participants was the experience level and ongoing education status of the preceptor. All participants agreed the preceptor needed to be more experienced than themselves, however when the preceptor was too far removed from the realities of the workplace and/or the memories of what it was like to start in a new clinical area, this in itself created some problems. This along with the difference in attitude perceived by the participants between those people who were involved in ongoing education and those who were not exacerbated the difficulties the participants experienced. There is a real issue here related to why some people are interested and involved in ongoing education and some not. What does this say about engaging in some kind of commitment to what nursing is about?

There are a variety of reasons why individual nurses participate in ongoing education while others choose not to do so. Two reasons for non-participation come to mind

immediately. Firstly, the institution has oppressed these nurses so much that they begin to perceive themselves as hopeless and helpless and think that they would not succeed anyway. This may be an example of gross institutionalisation over time. Secondly, there seems to be a relationship between nurses' non-participation and the fact that they cannot afford the financial costs of ongoing education unless it is funded by the organisation. To be seen to be in competition with colleagues for organisational funds is not the done thing and is often seen as letting the side down. Even if they were to take the risk and step outside they would seriously question their ability to succeed. This is indeed a sad indictment on our profession. However on a brighter note there do appear to be more and more nurses entering postgraduate education programmes. This is particularly evident within the field of mental health with the increasing governmental commitment to funding such programmes. The real benefit of this is that despite the individual nurse's reasons for originally entering into a programme, often by the time the programme is completed he/she has become more critical. This will only benefit the profession in the long term.

In some of the clinical settings involved in the programme, the appointed preceptors are also the senior nursing clinicians within the unit or area, these may be Clinical Nurse Specialists (CNS's), Unit Managers (UM's) and Clinical Leaders (CL's). Nurses in these positions have specific responsibilities relating to the day-to-day functioning of the unit or area, education and supervision of staff, clinical consultation, as well as in most cases, the management of the resources within the unit. It would seem somewhat unrealistic to add to these already substantial responsibilities. There does appear to be continuing rigidity of the senior nurse clinicians undertaking the preceptor role, despite the potential for this to create problems for both the preceptor and new graduate nurse, particularly in relation to time allocation for undertaking the



requirements of the preceptor role. Participants quickly noted this as an issue and found support elsewhere whenever possible. One participant identified that she had not spent much time with her preceptor and had met her clinical support needs elsewhere however she was still required to have the allocated preceptor complete her practicum assessment.

*Its not a personal thing, [he/she] is really lovely, however I haven't really seen [him/her] and there's somebody else that I actually go to more, rather than [him/her], because I don't feel that I get out of [him/her] what I need. I know what my needs are basically and I am finding that elsewhere ... Makes it difficult though cause that person has to do my assessment, but that's okay cause we get along.*

This is a real issue for new graduates who need to be assessed by their preceptor, even when they have not spent much time with him/her. This is often, however not always, the case when the preceptor is also a CNS, UM or CL. Another participant discussed his/her concerns around asking to have an assessment completed by the senior nurse clinician when he/she had not worked with her.

*Often when you are working with registered nurses who may have completed the programme last year or the year before, they know you better cause you are working alongside them. At the end of the time you go to the senior nurse and ask them to write out an assessment for you ... and they do not know you from a bar of soap, whereas the registered nurse you have worked with over the last month or so knows you really well. I found that sort of embarrassing when you have only talked to say hello and goodbye, and then say can you do my assessment? Although they say they talk to the person that you work with, but you are not to know that.*

Another participant discussed the guilt he/she felt during the assessment of the clinical competencies he/she completed in his/her first placement.

*I had to do these competencies with the [senior nurse clinician] who know [he/she] has not spent the time with me, has cancelled meetings that we had set up, so [he/she] feels guilty. So instead of having a chit chat about it, [he/she] is happy to sign it off so that I don't make waves. I sort of got the feeling that [he/she] felt guilty about not doing enough, so the way to meet that guilt was to give the new graduate the competency and be told that they are really good, ... cause if [he/she] criticised me I could say well I haven't got the support that I needed, remember the workbook says you will meet fortnightly for at least half an hour, well I have seen you twice in ten weeks. So the [senior nurse clinician] withholds some criticism, in case that criticism is turned back.*

One participant discussed the concerns he/she felt around being preceptored by a senior nurse clinician, and missing out on other opportunities for development that would have better supported him/her in the first clinical placement.

*I guess one of the things is that you are meant to be taught, preceptored by a senior nurse, and the other people think that they don't need to teach you because we have got a nurse specialist on the ward. But the people I could have really learnt from would have been the registered nurses who completed the programme last year. They would have known what it was like. Rather than the [senior nurse clinician], cause I thought that their part in the programme was more for status of the [senior nurse clinician] and not necessarily what was best for the new graduate nurse.*

Another participant discussed her discomfort around being preceptored by the senior nurse clinician, and how this affected him/her during the first placement.

*Working with another registered nurse who had completed the programme the previous year, could also take a lot of pressure off you as the new person, when the [senior nurse clinician] is really scary. You think am I being assessed then, but if you could buddy*

*along with a new person [who had completed the programme the previous year] and make a few stuff ups, or ask really dumb questions, you would not feel so out of place.*

These extracts illustrate the problems that can arise when the preceptor is also a senior nurse clinician within the unit or area and how this can impact on the support available for the new graduate nurse. They also highlight the participants desire to have those nurses who completed the programme the previous year undertake some role with the new graduate nurses. This is an issue that surfaced on several occasions during the group discussions and will be discussed further in the recommendations chapter.

In relation to the preceptor's involvement and/or interest in ongoing education, the participants agreed that those registered nurses who were neither involved, nor interested in becoming involved in ongoing education, were not suitable for the role of preceptor. The participants felt this for several reasons but mainly because these individuals lack commitment to the development of both clinical practice and the profession as a whole. This again asks the question about gross institutionalisation over time and the impact this has on some nurses. However it would appear that not all nurses have become institutionalised to the same extent. Participants agreed that this was a generalisation, however their experiences in the clinical setting had identified for them which staff to approach and which not to. And those they felt comfortable approaching and working with were on the whole, those involved in ongoing educational opportunities.

One participant stated the following -

*There do seem to be two groups of nurses. There's the ones who are prepared to critique what they do, and change their practice. And*

*the ones who aren't prepared to critique what they do, because they are not interested in changing their practice.*

Another added -

*There are two groups I see within mental health, those who do continue with their education, its an ongoing thing they want to be learning all the time. Then there are the ones who come to work everyday and are quite happy to do the overtime, and it is very clear that it is just money orientated. They are the ones who are not prepared to change, and don't feel they have to justify why they are there.*

Several participants identified a commitment to clients, self, team members and employing organisation as an attribute that would be beneficial for all preceptors to have. Several participants discussed the difficulties experienced when working with preceptors who lacked this commitment and the negative impact this had in relation to skill development and socialisation of the new graduate nurse. Participants all felt strongly they did not want to be socialised into the existing environment and needed positive role models and good supports to assist them in working to make sure this did not happen. This is covered further in the following chapter looking at the socialisation of the new graduate nurse into the specialist practice setting of psychiatric mental health nursing.

## **CHAPTER 8: SOCIALISATION**

*“One of the abiding problems of occupational socialisation has to do with the differences between the idealised version of work as it is presented to new recruits and the work as it is practiced daily by members of the occupation” (Melia, 1987, p. 1).*

As introduced in the previous chapter another theme identified by the participants during our discussions was socialisation into the specialist area of psychiatric mental health nursing practice. All of the participants comments contained within this chapter were collected during the first group meeting, unless otherwise stated. Berger and Luckmann (1966) identify two levels of socialisation. The first being primary socialisation which is the socialisation an individual undergoes in childhood, socialisation within the society he/she is born into. "Secondary socialisation is any subsequent process that inducts an already socialised individual into new sectors of the objective world" (Berger & Luckmann, 1966, p. 158). It is secondary socialisation that is being discussed within this chapter. Secondary socialisation is the internalisation of the institutional 'sub-worlds' we are exposed to. It is the acquisition of role specific knowledges and vocabularies, "often accompanied by ritual or material symbols" (Berger & Luckmann, 1966, p. 158). This is interesting in relation to this project as the secondary socialisation takes place after the primary socialisation. Therefore the new graduate nurse has already internalised a variety of institutional 'sub-worlds' prior to even entering the practice setting. To some extent they have already become enculturated into institutional life taking the practices, languages and social relationships for granted. The secondary socialisation during the educational system/s the new graduate has been involved in, maybe not to mention that a large number of students have either worked prior to commencing their undergraduate degree. Further enculturation occurs through the curriculum, the hidden curriculum and the ways in which the knowledges are used. This in itself can create some conflict and confusion for the new graduate nurse on entering the practice. The new graduate nurse wants to 'fit in', become part of the professional culture within the organisation and is entering into a process of enculturation. This enculturation into the reified environment in which he/she has entered creates conflict and confusion. Perry (1986)

discusses this as a political process, where “the actions of individuals may be seen to be socially constrained” (p. 12), that is, the individual enters an environment that seeks to constrain his/her choices for action. This constraining of choice suppresses feelings and leads to the notion that ‘I cannot make a difference, so I won’t even try’. The new graduate nurse then proceeds to find a way to ‘fit in’ to the reality of the practice setting while suppressing the idealism of his/her educational background. On the surface it may appear that the new graduate has become ‘socialised’ into the environment but a question remains about his/her inner experience and how congruent this experience is with the prevailing culture. Are they really enculturated into institutional ways of being? Does the struggle continue? I would venture to say it does.

Prebble and MacDonald (1996) discussed socialisation in their study particularly in relation to psychiatric mental health nursing being separate from other areas of nursing and as such potentially having “it’s own culture and identity, into which new graduates become socialised” (p. 31). Two themes discussed by Prebble and MacDonald, *conflict* and *contradiction*, are also supported by the participants in this research project. Jasper (1996) among others (Gray and Smith, 1999; Kelly, 1996; Melia, 1987) have written about nurses entry into practice within the United Kingdom. Common themes identified have been around ‘living in the real world’, and ‘us and them’, ‘pressure to conform’, ‘reality versus idealism’ all of which have been supported in this research.

All participants expressed concerns relating to the environments in which they practiced and how their desire to question existing practices created conflicts within those environments. As new graduate nurses educated within the tertiary sector, all

the participants identified frustration relating to the gap between his/her expectations of practice with the realities of the clinical setting. During their undergraduate education the participants had developed skills relating to critical reflection on both their own and their colleagues practice. This skill was transferred into the clinical setting on commencement of the programme. The participants all agreed that this ability, and indeed desire to critically reflect on practice had, and continued to create conflict for the them as new practitioners within the specialist practice setting of psychiatric mental health nursing. This 'conflict' again brings up the issue of accepting difference within the clinical setting, and reinforces the notion that new graduates are expected to be enculturated into the positivist paradigm of the institution in which they are employed. The other issue that surfaced in the data analysis was the participants' understanding of critical reflection. This then raises the question - what form of reflection is being taught in our undergraduate programmes? Is it reflection that looks back on and analyses, rather than the type of critical reflection that engages one in problematising practice. Maybe this is something as educators we should be addressing within our respective curricula. Another question that needs to be asked is when the new graduate engages in 'reflection' as opposed to 'critical reflective activities', does the new graduate negate his/her own power by feeling that he/she cannot make a difference. In reality one simple change can have a huge effect on a wider group and/or organisation, it can be as simple as one word interchanged for another.

One participant discussed his/her frustration in relation to the inability to achieve things for his/her clients in the current environment.

*Frustration, it's so frustrating. For me at the moment I just feel like I am battling uphill constantly, banging my head against a brick wall trying to get things done for my clients. ... They [the clients] are*

*not achieving their goals so consequently they sit and sit and don't move on.*

Jasper (1996) discussed the differences between the world of the student and the world of the qualified nurse, and the disappointment of the new graduates on entering practice. One expert from her study states, “this disappointment was translated into the emotions of disappointment and demoralisation at not being able to deliver care to their [new graduates] standards” (p. 784).

Another participant identified how this frustration with the system impacted on the staff around him/her and consequently set up an environment that could potentially effect the way in which he/she continued to develop his/her practice.

*I think that creates a lot of bitterness in staff ... I find for me to get socialised into that bitterness of, 'this is the way it is, it is terrible, we don't like it, we don't want to work in this environment'.*

Another participant identified a way of moving forward within the current environment.

*I think the first thing for me is to acknowledge the fact that we're being socialised into an environment. ... and then to see what I need to do to move myself forward, and you've almost got to trust that other people are going to do something to move themselves forward. ... don't you think us as the bottom level are the ones that are going to be doing the move forward for the whole system.*

Another participant went on to add -

*When there's enough of us there will [be a move forward], but at the moment we're just one in a group. You either become socialised or you stand out as a rebel and you get on the wrong side of everybody.*



*I'm finding it really difficult ... It doesn't go too well with the ideals and theories we're supposed to be putting into place.*

What is being discussed here is the notion of 'critical consciousness' which Freire (1970) espouses as the goal of the 'problem-posing' system of education. The consciousness of the participants has been aroused, however it has not yet become critical. The participants see themselves as being conscious in isolation. How many other individuals within the organisation also have this feeling of being conscious in isolation? I would venture to say quite a few, however the environment is such that in order to maintain his/her position within the environment, it would not be good practice to be seen to verbalise these thoughts/feelings, let alone act upon them. Shor (1993) on discussing Freirean education, and the qualities for developing critical consciousness, identifies the quality of 'de-socialisation'. "Recognising and challenging the myths, values, behaviours, and language learned in mass culture; critically examining the regressive values operating in society, which are internalised into consciousness" (McLaren & Leonard, 1993, p. 32). Each participant in this research project is recognising, and beginning to challenge in his/her own way. At this stage most of the challenging is undertaken quietly and privately. However all participants felt the need to continue working toward change despite the difficulties being experienced. And most participants had prior knowledge of some of the difficulties they would be facing on entering mental health yet, this understanding had not deterred them.

*The thing is we knew before we entered the mental health area that's what it was going to be like ... so if you are planning on going in there and sitting on your hands, you either want to change things or you don't.*

*When I entered I knew what it was like ... but one person can make a difference.*

The participants went on to discuss the need for a critical mass of like minded individuals who can work together to initiate changes. But all felt this is not the role of the new graduate nurse entering practice. However, the individual new graduate does have responsibilities to maintain his/her own practice standards until this critical mass is able to support change within the environment.

*But is it a matter of going in and changing everybody else? You're not going to do that and I would not even try. But the thing is if you do stand out, I'm not saying that we're anything spectacular, but the thing is if you know something doesn't seem right, then you should question it.*

In this way without realising it participants were becoming aware that people do have choices, although these choices are not always supported within the institution. This again reinforces the notion of reification, as does the following commentary where participants went on to discuss the conflicts associated with the ideals and beliefs held within an environment that, more often than not, were closed to critique and change.

*You get split off and you can alienate yourself from the rest of the staff when you're bringing in new concepts, advocating for your client based on what you have learnt in your training.*

Melia (1987) noted this in her work with nursing students in England. The students in her study recognised the difference between the 'proper' way of nursing taught in the college and the realities of the ward situation. The students in Melia's study also commented on the need to conform with these realities, as did the participants in this research project.

*If you don't go with the flow, if you don't conform, if you question things, if you question people's practices, if you question what's happening, you know you are not supposed to do that. You are supposed to just plod on (get socialised). You don't question anything. We [existing staff] have always done it this way.*

*I feel like a tadpole in the ocean trying to tell the sharks they're swimming the wrong way. ... and they are very good at eating tadpoles.*

Melia's study highlighted "fitting into the mould" (p. 12), where student nurses were not regarded as individuals, but workforce. She notes that "some students find life easier if they fit unquestioningly" (Melia, 1987, p. 12). One of the differences between the students in Melia's study and the participants of this research project, is tenure. Melia's students were transitory, they moved from ward to ward as part of their education process. The participants in this research project are employed within the organisation. Melia's students could fit in for the short period of time allocated to that specific ward, and then move on. Each participant in this research project was thinking about the compromises he/she may be expected to make in order to 'fit in' in the long term, and whether or not these compromises were an option. This need to re-evaluate your values and beliefs and decide whether or not to compromise in order to become part of the existing culture is also reinforced by Jasper (1996), Kelly (1996), Walker (1998), and Gray & Smith (1999). Participants in this research project were still considering their options at the time of the second interview.

Participants also talked about the boundaries that are used to both protect the individual and support the environment.

*For me it is a really fragile environment, but the fact that we are almost acknowledging that it is fragile, we are actually putting boundaries on ourselves as new practitioners as to what we do and don't do. I have found in the places that I have worked that there is an expectation that we do have knowledge and we are applying it. ...but at the same time we are a threat. ...its like 'let this person [the new graduate] go forth and be knowledgeable', but at the same time 'don't let this person into our [existing staff] environment to make changes'.*

*I think there are boundaries on both sides. The environment is not the ideal we know it is not, we're trying to work with an ideal that doesn't fit the environment, at the same time we are doing our very best to work within that environment to make a difference within it. An environment that doesn't want to be different.*

However it seemed important to ask what the boundaries for and are they designed to keep people the same? Is this another example of the positivist paradigm at work within the institution where sameness is fostered? Will the notion the participants express in keeping boundaries around themselves work for them within such as environment? How can we as educators and clinicians better support the new graduate as they encounter these realities?

Participants then discussed their future role as change agents within the environment and what steps were needed now to prepare for that role.

*I think we are moving toward being an agent of change. I'm thinking about what the environment is, its not a great environment, and I think we need to work out why and what needs to change.*

*I need to gain the knowledge and skills first ... and yes you do make some enemies along the way.*

Participants identified the cultural understandings they had on entering the practice setting and the importance of maintaining that culture as a way forward.

*I think we as new graduates bring a culture of our own of saying why do we do what we do. And we are coming into a culture of, that's what we do ... because we have always done it, so we clash and something has got to give and it does give and that's when we become the enemy as much as they [existing staff] become the enemy.*

*I think there is a big difference between our culture and the culture we are entering into. New graduates with that sort of idealism of 'yes we do need to further our education' and 'we do need to be constantly identifying how we can do our job better'. While we're entering a culture of 'this is what we do, this is the way we do it', and 'no I don't want to do more study, I've done my study', that's the culture we are entering into. With our culture that causes a big clash.*

*I don't think it is possible for us to do that [make changes] at our level, but I think the important thing is to maintain the culture that we have as we move through nursing to make that difference eventually.*

The group then discussed some of the coping strategies used within this environment of conflict and frustration. One strategy discussed was 'voting with the feet', meaning it was preferable to leave the system rather than committing the time and effort to work within the system to facilitate change. This option, along with the option of just becoming part of the system to protect yourself, are the choices most frequently followed by new people entering the system. You either conform or you leave. This

was also identified in the research undertaken by Jasper (1996) with seven of the eight Project 2000 graduates deciding to join the system and stop fighting it “for the sake of their own survival” (Jasper, 1996, p.784). Freire (1970) describes this as the *duality* the oppressed suffer;

they are at one and the same time themselves and the oppressor whose consciousness they have internalised. The conflict lies in the choice between being wholly themselves or being divided; between ejecting the oppressor within or not rejecting them; between human solidarity or alienation; between following prescriptions or having choices; between being spectators or actors; between acting or having the illusion of acting through the action of the oppressors; between speaking out or being silent, castrated in their power to create or re-create, in their power to transform the world (Freire, 1970, p. 30).

However it did not appear to be the case for the participants. The following are some comments from the group as to why this was not an option for them.

*But where does that get the system? It happens all the time, people vote with their feet so the system goes down to it's base culture again.*

*People stay quiet until they take their knowledge somewhere else and the same thing occurs so it's a vicious circle.*

There appeared to be a strong desire to maintain / sustain themselves within what Freire would describe as an oppressed environment, in order to fight another day. The main supportive strategies the participants discussed were the use of clinical supervision and critical reflection to support the development of his/her own practice and maintain professionalism. Critical reflection was important to all participants. As a polytechnic tutor it was refreshing for me to hear this from the participants, as I have

often wondered how serious undergraduate students have been in relation to reflecting on their practice. So to hear a group of new graduate nurses talking about critical reflection as if it was one of the main tools they carried and used on a regular basis to gain insights into their experiences, was indeed a pleasant surprise.

Reflection is defined by Palmer, Burns & Bulman (1994) as “the process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self, and which results in a changed conceptual perspective” (p.13). Palmer et.al. go on to discuss Schön’s (1991) work in which he suggests “two types of reflection: reflection-in-action and reflection-on-action” (1994, p. 13). Reflection-in-action influences the immediate practice situation whereas reflection-on-action occurs after the event. Andrew, Gidman & Humphreys (1998) discuss reflection and it’s role in enhancing professional practice.

If the reflecting nurse sees knowledge attainment as an end in itself, then practice is unlikely to change. However, if he/she see it as part of a development cycle whereby new knowledge is integrated with previous knowledge and practice, then changes in practice are likely to occur (Andrews, et.al., 1998, p. 413).

These positions would suggest a neo-positivist approach which sees practice and theory as separate. This contrasts with a critical social science perspective which sees theory embedded in practice. Practice is theory and theory is practice – they cannot be separated for they exist in a dialectical relationship. This position is not always advocated by the institution which sees theory as separate from practice, which needless to say contributes to the contradictions. Freire (1970) would argue that critique, or reflection, must be followed by action, as reflection on it’s own does not constitute liberation, only critique or revolution.

The action that seemed most noticeable with the participants in this research project was that of questioning existing practices and using theory to inform his/her practice. This served to increase the consciousness of others which is an action in itself. However, as previously noted the participants' understanding of the different types of reflection remains questionable and will be discussed further in the recommendations chapter.

Jasper's 1996 study of Project 2000 graduates in England highlighted that these graduates actively used research to support their practice. However, a study undertaken in the New Zealand context by Walker & Bailey (1999), unexpectedly suggested this was not the case for new graduates entering clinical settings in this country. In contrast to Walker's & Bailey's (1999) findings, the participants in this research project expressed a commitment to using research in practice and to critically question existing beliefs and practices. Participants talked about asking questions in clinical settings and how by asking questions, they were asking other staff to explain the 'how's', 'why's' and 'what-might-be's' in practice. This in it's self created some conflict for the participants. Some comments from participants:

*we are in a learning role, we can ask questions. I think you have to be careful about how you ask them maybe. I mean you are not going to go in there and confront them, are you?*

*we are aware that we have to be accountable for our practice, and maybe the others [existing staff] have slipped in cruise mode, and with us asking them questions they are going to have to stop and think what they are accountable for, what they are saying, what their beliefs are, what their rationale is, and the other biases, or prejudices, or whatever it is that they are operating from, is going to*



*be out there. They are going to have to justify why they are acting in a certain way, and that may be putting them on the spot, cause it is challenging their values.*

One thing that each participant did discuss was the unique position he/she held in being able to move around three or more areas within the one employing organisation and this gave him/her the opportunity to observe how those areas connected with each other. Being able to see the environment from such a perspective served to highlight other concerns. Participants expressed these as follows -

*When you are in one particular area you can see how things should be functioning there ... Then you work in another area and you see how people in the area you've just come out of are not doing their part, and you go 'what the hell's wrong with you people, this is what you should be doing, get on and do it'. And you know they try and job off work to other areas all the time, shirk their responsibilities and I find that really annoying.*

*We're in a unique position to see where the communication between areas actually falls down, and you can see both sides of the fence. And a lot of the issues are very simplistic communication ones.*

*It is really good for us on the course to be exposed to different areas, cause you see what your roles are in that area, and what would be helpful for people in other areas. Whereas people working in one area for years, they just learn to bat, and they couldn't be bothered really where the ball ends. They leave it to that area to bat again, and I mean nothing gets done.*

One criticism from the participants was that they did not feel that the initial theoretical component of the programme prepared them adequately for the socio-political aspects of their clinical location. More information relating to the politics and historical

heritages surrounding psychiatric mental health nursing practice in general would have given them a greater insight into what had brought clinical practice to where it is today. Knowledge of these areas may have illuminated details surrounding what the participants described as 'burn-out' of staff in the clinical setting. In addition perhaps participants might have had a greater appreciation of the defensive practices they observed in the clinical setting and given some thought to possible alternative courses of action. This is further discussed in the following chapter which looks at the issues around risk management and the participants as a risk factor within the clinical environment.

## CHAPTER 9: RISK MANAGEMENT

The third theme that developed was risk management within the clinical setting. The question that was initially put to the group was related to the Nursing Council of New Zealand Competencies for entry to the Register (1999) which talks about the identification, assessment and management of risk within the environment. The participants were asked to discuss this in relation to what risk management meant to the participants as new graduate nurses working in a psychiatric mental health setting.

The first thing participants identified was the benefit of Calming and Restraint training that was provided to each participant as part of his/her employment. Of the seven participants, two had not as yet undergone this training at the time of the second group discussion. Those who had received this training expressed how useful this was for them as individuals in their development and confidence to work in clinical settings, in particular Psychiatric Intensive Care and Forensic Psychiatry. Calming and restraint training was incredibly useful for individual confidence building and de-escalation techniques. Those participants who had not undergone the training felt disadvantaged and expressed concern that they and their colleagues were potentially being placed at risk due to the absence of this training.

The discussion centered around each participants' understanding of risk management in the clinical setting and how he/she manages this. In particular the need to discuss with other staff before making plans and/or carrying out certain interventions. Each participant was aware of his/her need to develop specific expertise and knowledge and that there could be things that as a new graduate he/she may not have considered.

However, each participant expressed concern relating to the variety of responses he/she might have received when approaching other staff. Two extremes were identified, that of managing risk to the extent that the therapeutic-ness of the environment was diminished, or to the other extreme, managing risk in a *ad hoc* manner that potentially made the environment one that placed all within it at risk.

One participant summed up the over management of risk:

*The easiest way to manage risk is to totally eliminate it, but are you solving the problem by totally eliminating risk? Are you solving the problem by putting up boundaries that are so rock solid, that you are actually removing all power and control [from the patient], giving it all to yourself [the nurse], and you are ending up with the risk that you are managing not even being there, but it's only not there while you have all the power and control. But what are you solving by doing that? And a lot of that is really scary when we [new graduates] come along, and we move the power a little bit and manage the risk by tilting the balance a little bit more. And it's hard to justify, it's very hard to justify.*

Managing risk through maintaining the control over what the risk is was critical to health professionals in reducing the risk to him/herself and others in the organisation. However, the participants felt this contradicted the notion of self determination for consumers of mental health services. Self determination empowers the consumer and his/her family/whanua through education and support giving them the right to make choices relating to his/her own care. This can sometimes be undermined by the dominant paradigm within mental health which looks at managing the risk for the organisation as opposed to the client/patient and his/her family/whanau. It is dominant because knowledge is grounded in science, and associated with rules and principles, and it is this heritage that has so heavily influenced nursing practice in psychiatric settings. Thus nursing knowledge while carrying the heritage of the

positivist tradition, does not sit exclusively within this paradigm. Nursing includes other knowledges, of which empirical knowledge is but one, and personal understandings are another. Personal knowing in nursing is often described as intuitive. It is knowledge that comes from practical knowledge and experience. This personal knowing resides within, and is unique to the individual who knows. This type of knowing is often hidden and not clearly articulated by nurses, nor is it valued by the dominant positivist tradition. Alongside this intuitive knowledge is ritual knowledge, which is also part of personal knowing but could also incorporate empirical understandings, but not exclusively empirical. Empirical understandings contribute to other ways of knowing and should not be regarded as the way as the positivists might suggest. Ritual knowing is often hard to justify, and is not usually questioned, it just is. It is this ritualistic learned knowledge that creates some of the tension for the new graduate nurse entering practice. He/she is not clear as to why something is done in a certain way and is often unable to get any clarity when the practice is questioned.

Another participant added:

*What about the people who go to one extreme and there are others that are ad hoc again, so you need to find someone, that is I don't know competent.*

I asked what 'competent' meant to the participant, to which the response was:

*Someone with sound rationale for their actions, and able to say, well this is why I am doing it. Lots of people would just go well we wouldn't do this because the clients might do this, that or the other thing, not giving the client any responsibility for themselves and sort of looking at it from the view of if their is an inquiry that won't be my fault. As well as defensive practice stuff, and that doesn't do anybody any good.*

A further participant discussed his/her experience within the clinical setting where he/she wanted to learn how to complete risk management assessments and plans, however he/she found he/she was being taught two different ways of doing within the one clinical unit.

*New admission coming in and having to do risk management plans. I would ask another nurse, and get some nurses who really down play it - 'okay you know you just look at the last one, and you just slap this on it, sweet as, just got to have something written down'. Then get other nurses who were quite thorough and say, 'okay lets go round to the front desk and get the patients file, bring it back here and have a look, what brought them in? what were the stresses in this persons life?' It is all a matter of integrity of practice and whether you want to take the easy way cause you have not got enough time, or whether you just want to fulfill bureaucratic policy, or whether you have a vested interest in what the real risks are for this person and others.*

This raises some interesting questions in relation to both risk management itself and differences in practice which reinforce the contradictions new graduate nurses encounter within the practice setting. Risk management is a complex issue and most writers will agree there is no precise way to predict risk (Ministry of Health, 1998). However there are several factors to consider when undertaking an assessment of risk. These are looking at the patient/client in the here and now and assessing any factors which may point to risk. It is also important to look at the history of the patient/client and identify any risk factors in the past that may impact on the patient/client today. Most clinical settings have very clear policies and procedures on the assessment and management of risk which are directly linked to the current Ministry of Health Guidelines (1998). From the above

commentary it would appear that these are not always followed. This can be confusing for the new staff member who wants to learn sound practice as opposed to institutional ritual. How then does this impact on the development of the new graduate nurse? Does he/she need to learn one way of doing something before developing his/her own way? Or, does learning only one way of doing something reinforce rigidity and assist in the process of enculturation? Alternatively, will this exposure to a variety of ways of acting assist the new graduate to become more critical in relation to what is happening in his/her environment?

Another participant discussed a worrying experience he/she had during his/her second clinical placement within a community mental health team. He/she was looking after a client who the participant felt could potentially be a risk to self and more particularly others. However the participant was unable to access a medical assessment for three days, and when the client was assessed he was immediately admitted to hospital. The participant discussed his/her concerns in relation to having to carry this risk for three days despite his/her limited knowledge and training telling him/her the client needed to be assessed.

*If you are unsuccessful in bringing your concerns to the attention of others, you end up carrying the burden inside of yourself, which is really horrible, cause if something goes wrong, in some ways you were proved right and wrong at the same time. Right that there was a risk, and wrong in that you didn't do the right thing [by making people take notice of your concerns].*

This 'carrying the burden' shows the conflicting value systems that are operating. On the one hand the participant wants to become involved with the patient and on the other hand, the institution espouses no involvement and directs the participant to stand

back. These conflicting values reinforce the notion that a positivist paradigm continues to exist within mental health settings, at the expense of those working within it and ultimately at the expense of the clients/patients wellbeing. The participant went on to add:

*When you are new, and a new graduate, and you don't know how to make the system work. If you are told by someone more powerful like a consultant not to worry. You wonder, 'do I have the power to kick up a stink about this?' It does begin to impact on the power relationships you know.*

Another participant said that all power and control in relation to risk management had been taken away from him/her. This reduced the risk that he/she as a new graduate nurse posed within the clinical environment. However it did not support him/her in developing the knowledge and skills required to assess and manage risk within the clinical environment. The participants related this situation to the way in which risk is often managed with clients, in that the risk is removed totally rather than managed in conjunction with the client whenever possible. This approach only reinforces the oppressive and institutional nature of the environment participants have entered where power over, and/or control of clients and other staff continues to support the status quo. Will each participant hold on to his/her power within the institution or become part of the institution's culture of docility? What has happened to those experienced staff who are undertaking the preceptor role? Have those working within the system been so traumatised by the events that have occurred over the years, that they no longer have a voice or are unable to see the choices they have, let alone make them? Has the system become so controlled by politics, and risk managers that clinicians can no longer make choices related to clinically based risk assessments? What is the therapeutic value in this for the client? Where is the satisfaction in having supported



a client through a potentially risky situation? The question I would ask is whose interests are being served by the current risk management processes employed within most mental health services?

Another participant mentioned his/her experience working in the community in relation to having the knowledge and experience to undertake risk assessments.

*One of the things that I was always fearful of when people started getting unwell and they hadn't reached that point where they become a risk to others. I was always frightened of saying that they were all right, in case they weren't all right and they would go out and do something strange and hurt someone else. So I always thought it was better to say that they are a potential risk than say that they are all right and they go and do something. At least people are aware.*

Participants then went on to discuss the stress placed on the new graduate nurse when he/she is placed in a community setting with minimal support early in the programme, in particular the first clinical placement. Those participants who felt supported within the community setting were least apprehensive in relation to the assessment and management of risk. However those participants who had minimal support in the community setting and in some instances expected to carry a caseload of clients almost immediately on arrival, felt apprehensive and carried a lot of stress in relation to the assessment and management of risk. All participants felt it was more beneficial both to the individual, and the employing organisation for the new graduate nurse to undertake his/her first clinical placement within a hospital based setting where a lot of support was available and accessible. Or alternatively should the new graduate nurse be working with a community agency, the orientation and support provided to him/her should be of such a nature that the new graduate nurse is able to develop the knowledges required without feeling isolated and stressed. It is interesting that most

mental health services place a very high emphasis on managing risk for the organisation. However new graduate nurses can be sent into the community with minimal support in some cases and be expected to manage the risk. This would seem somewhat contradictory.

## CHAPTER 10: RECOMMENDATIONS

*“It is only the oppressed who, by freeing themselves, can free their oppressors. The latter as an oppressive class, can free neither others nor themselves. It is therefore essential that the oppressed wage the struggle to resolve the contradiction in which they are caught; and the contradiction will be resolved by the appearance of the new man[women]: neither oppressor nor oppressed, but man[women] in the process of liberation” (Friere, 1970, p.38).*

Throughout the last four chapters I have discussed the themes identified from the group discussions held with the research participants. These themes were jointly identified by myself and the participants and reflect the individual experiences of the participants' first clinical placement as new graduate nurses entering the specialist area of psychiatric mental health nursing practice. Following the first discussion groups, the tapes were transcribed and the transcripts sent to the participants. During the second group discussions the participants and I jointly identified what we felt were the themes that had surfaced. These themes were preceptorship and support, socialisation, and risk management. This chapter will focus on looking forward, and identifying ways in which the programme can best support the new graduate in the future. These recommendations have come from the participants in the research, who will, I have no doubt, also be watching future programmes with interest to monitor the implementation of their recommendations. The participants' comments included in this chapter have come from the second discussion groups, unless otherwise stated.

Firstly, I would like to look at preceptorship and support. The participants identified the lack of clarity around the various roles of those involved with the programme. These included the preceptor, the programme coordinator, the site coordinator, the employing organisation, the polytechnic and even themselves as registered nurses, and students of the programme. There was an inconsistent approach to how the preceptor model was implemented both between and within employing organisations. This lack of clarity was complicated by preceptor workshop non attendance. In some way the needs of the preceptors were not met by the workshops, for reasons unknown. Another issue discussed by the participants was the selection of preceptors within employing organisations. The inappropriate and/or *ad hoc* selection affected the participants' ability to feel supported during the development of his/her entry to psychiatric mental health nursing practice. Also of concern to the participants was the frequent lack of orientation to the housekeeping responsibilities within the clinical setting. The participants felt there was insufficient orientation to the basics, such as knowing where things are kept or using the phone system seemed to increase the participants' stress during the initial period of the first clinical placement. How then does the programme ensure the preceptor model is implemented effectively within the clinical setting and the new graduate is better supported during his/her clinical placement/s?

The first issue to look at is that of clarity of roles and responsibilities, and as with most things if the head is not clear, how is the body expected to know what is going on. The polytechnic, and in particular the programme coordinator has a responsibility to clarify the roles and responsibilities of all involved with the programme. This is something that has been worked on during the 1999 academic year, in particular with a Memorandum of Understanding being developed that does provide clarity around

what is expected of the Polytechnic, the Programme Coordinator, the employing organisation and the Site Co-ordinator. This memorandum was developed by me as the programme coordinator to clarify the roles and responsibilities of those involved with the programme. The memorandum brings together the requirements of the Clinical Training Agency contracting specifications relating to entry to practice programmes. These specifications clearly state the requirements that are to be met within both the clinical and education settings involved in the programme. The memorandum of understanding once drafted was then approved by the Polytechnic, and tabled at the Mental Health Advisory Meeting in July 1999. The Mental Health Advisory Meeting is a group of representatives from the clinical sectors who meet with Polytechnic staff to discuss any issues relating to the mental health programmes offered at the Polytechnic. These advisory meetings are held three times a year. The meeting approved the memorandum of understanding for use in the 2000 academic year. This is the first part of a strategy to improve accountability in relation to aspects of the programme and should provide greater clarity within employing organisations as to what is expected.

The second part of the strategy for improving clarity relating to roles and responsibilities is to improve the communication and liaison between the programme and the clinical providers. This liaison is something that occurs on a regular basis, however as with the preceptorship model there are inconsistencies between employing organisations. It is the programme co-ordinator's responsibility to ensure that communication occurs on a regular basis with all site co-ordinators and that any issues are identified and corrected as soon as possible. As programme co-ordinator I have discussed how this can be best achieved in the year 2000 and beyond with the existing site co-ordinators. It will include more frequent visits by myself to the clinical

providers on a regular basis, not only to visit the site co-ordinator and students, but also to provide support to preceptors in their workplace.

That brings me to preceptorship which is one of the factors that has the potential to impact greatly on new graduate nurses depending on how the model is implemented within the clinical setting. All participants clearly articulated the need for appropriate selection, education, and support to be provided for preceptors prior to the new graduates entering the clinical setting, and throughout the programme. Despite the fact that preceptor training was offered to, and provided in, all clinical settings in the 1999 academic year, it did not appear to meet the needs of the preceptors and ultimately the new graduates nurses. Discussions have been underway during the year to ensure that adequate preceptor training is provided within each clinical setting in the year 2000 and dates have already been booked for most areas. Alongside this the programme coordinator will hold preceptor support meetings in all clinical settings at least once during each clinical placement making a minimum of three support meetings a year. These meetings will be to identify any issues and/or problems that may be arising for the preceptors; to allow the preceptors an opportunity to discuss how the role is developing, and identify any further/different support he/she may require. The effectiveness of the training and the ongoing support of preceptors will need to be evaluated throughout the programme. This evaluation will be undertaken using a Likert based questionnaire. The purpose of the evaluation is to measure the effectiveness of the preceptor model from both the new graduate and the preceptor perspective. It will provide a snapshot of how things are at any given time and can be used to provide feedback and develop systems and processes to better meet the needs of both students and preceptors. This questionnaire is currently being developed and will be utilised in the 2000 academic year and beyond.

Preceptor selection is undertaken within the employing organisation and more specifically within each clinical unit/team. This selection occurs by a mix of self selection and appointment by direction. Two issues that were identified by the participants were the allocation of senior nurse clinicians as preceptors and the allocation of nurses who were not interested and/or actively participating in ongoing education. Participants clearly felt uncomfortable and/or disadvantaged when the senior nurse clinician was allocated as the preceptor. This was due to the high work demands placed on senior nurse clinicians and the limited availability of time to spend with the new graduate, as well as that likelihood the new graduate and the senior nurse clinician would be on different shifts. In some clinical settings it is the senior nurse clinician within the clinical unit/team that is responsible for overseeing the preceptorship and support of the new graduate. One of the issues that I have already discussed with the site co-ordinators is ensuring the senior nurse clinician can delegate the specific role of preceptor to another experienced nurse in the unit, a person who is able to have his/her shifts matched with the new graduate. By delegating the day to day role of preceptor the senior nurse clinician would continue to have some input. He/she would monitor the overall education and development of the new graduate without having to be ultimately responsible for undertaking every component him/herself.

In relation to the allocation of nurses who were not interested and/or actively participating in ongoing education, participants were also clear that this was not something that on the whole they desired and/or found helpful in relation to their own learning. Discussions are currently underway with the site co-ordinators in relation to establishing an ideal person specification for those who are put forward to undertake

the preceptor training and the role of preceptor within the clinical setting.

Participants suggested that a job description could be constructed for the preceptor role as this might help to clarify the role and provide some consistency within and between clinical settings and employing organisations. These suggestions require further discussion with clinical settings and will be followed up in the year 2000 programme.

Several of the participants felt it would have been helpful if the new graduate nurses who had undertaken the programme the previous year had played a support role for the new graduates undertaking the programme this year. Most participants believed it was not a good idea for those nurses one year out to be responsible for the preceptor role nor the assessment of competencies and/or clinical practice. However they were clear that some sort of mentorship from last years students would have been beneficial. I have discussed this with the site co-ordinators who are looking at some sort of support role within their individual organisations. One site coordinator was very clear that he/she would be setting up a support group for the new graduates entering the programme in the year 2000, which would also include those who had completed in 1999. What he/she hoped would occur was some sort of buddy system where each of the 2000 students would buddy with one of the 1999 graduates. Support would center around time management, completing competencies and assignments, and generally being there as someone who was not expected to evaluate the new graduate's performance. It was hoped the new graduate would feel free to discuss issues that may not be appropriate to discuss with the site coordinator or at clinical supervision. Participants also identified that this would support them the first year out of the programme with continued involvement in an education based programme after they completed. They felt it should also assist them in resisting



becoming enculturated into the dominant culture of the organisation. This was something that all participants expressed as a concern. What would happen to the participant when he/she was no longer part of the programme? Would he/she become just another worker? The setting up of some form of mentorship as discussed above, may lessen some of the participants' concerns.

This brings me to the second theme that was discussed – socialisation. Becoming socialised into the role of a nurse. This is discussed in the wider context of enculturation. Enculturation is the process of entering into an existing culture, in this case the culture of nursing, within the wider dominant culture of health. The recommendations outlined in relation to preceptorship and support would also assist in relation to the socialisation of the new graduate into the clinical setting and the issues relating to risk management that were identified by the participants. By providing appropriate and timely support to the new graduate nurse entering psychiatric mental health nursing practice, it would reduce the likelihood of him/her experiencing some of the difficulties outlined by the participants.

Several participants commented on the different culture he/she entered and how this felt.

*The theory we are bringing in and the practice we were in, in the environment. Entering a culture that does not want to be challenged.*

*Difficulty in maintaining a positive learning approach in an environment where further learning is not seen as part of the job, as a wanted part of the job.*

*Is it that we [new graduates] are in the role of being accountable. We are aware that we have to be accountable for our practice. And maybe the others [existing staff] have slipped into that cruise mode of doing things, and by us asking questions they are going to have to stop and think what they are accountable for. What they are saying, what their beliefs are, what their rationale is, and the other biases, or prejudices, or what ever it is that they are operating from is going to be out there. They are going to have to justify why they are acting in a certain way, and that may be putting them on the spot, cause it is challenging their values.*

The challenging of values is not something that is encouraged within a reified environment that does not value difference. The new graduate is there to be taught how to be a good psychiatric nurse, not to question the values and practices of those of us who know better. However the new graduate needs to question, to understand and make some sense of what is being enacted. This is done through challenging and critiquing of self and others. This self and other critique is necessary to identify actions that lead to transformation. That action may be to say I will never treat someone the way \*\*\* just did. As previously stated this emancipatory action may be as simple as not using a commonly accepted phrase that may be oppressive. By not using the oppressive terminology the individual makes a slight alteration in the environment. This alteration can lead to others becoming aware of the impact language can and does have on others. Small changes can and do lead to transformation.

Participants identified one strategy that could enhance their understanding of the environment he/she is entering. The socio-political context of mental health nursing in New Zealand could be incorporated into the theoretical component of the

programme. Participants felt this would give them a better understanding of what they were entering, and help them to formulate strategies to cope in the clinical environment. One participant described it as a 'brick wall', and discussed how increasing the new graduate's knowledge may assist him/her in practice.

*The brick wall won't go away, the programme won't take the brick wall away. I guess identifying what it's made up of, the parts of the brick wall, the history of the brick wall, and what put the brick wall there; will help us identify how we will deal with it when we get to it.*

Although the programme does include the 'history of psychiatric mental health nursing', this needs to be further expanded to look critically at the knowledges held within the mental health setting and how these knowledges legitimate the existing society/culture (Giroux, 1983). Through the use of this critical lens, actions are identified, leading to the emergence of existing and/or new opportunities for transformation. Giroux (1983) describes this critical theory of education as:

knowledge that would instruct the oppressed about their situation as a group situated within specific relations of domination and subordination. It would be knowledge that would illuminate how the oppressed could develop a discourse free from the distortions of their own partly mangled cultural inheritance. On the other hand, it would be a form of knowledge that instructed the oppressed as to how to appropriate the most progressive dimension of their own cultural histories as well as how to restructure and appropriate the most radical aspects of bourgeois culture. Finally, such knowledge would have to provide a motivational connection to action itself; it would have to link a radical decoding of history to a vision of the future that not only exploded the reification of the existing society, but also reached into those pockets of desires and needs that harboured a longing for a new society and new forms of social relations (Giroux, 1983, p. 29).

Before this could be undertaken the students' understandings of reflection would need to be clarified and further developed to a position of reflexivity. As discussed in Chapter Eight the type of reflection utilised in the new graduate nurses undergraduate programme would appear to be different from the critical paradigm that is being discussed here. Freire's (1970) definition of critical reflection, which is followed by emancipatory action, leading to transformation, may not be something the students of the programme are familiar with and would therefore need to be incorporated into the curriculum. However, building understandings of critical reflection into the theory component alone would not be enough. Critical reflexivity also needs to be incorporated into the preceptor training and support sessions. This can only be achieved through the education environment mirroring a critical process. As programme coordinator I need to enter into a process of critical self-reflection as well. By gaining greater understanding of the self, and becoming aware of the possibilities and potential within the self, I am then promoting my own well being. hooks (1994) identifies this as self-actualisation. She goes on to talk about 'engaged pedagogy', which is progressive, holistic education that transgresses the boundaries of the existing positivist paradigm.

Progressive, holistic education, 'engaged pedagogy' is more demanding than conventional critical or feminist pedagogy. For unlike these two teaching practices, it emphasizes well-being. That means that teachers must be actively committed to a process of self-actualisation that promotes their own well-being if they are to teach in a manner that empowers students (hooks, 1994, p. 15).

This is an interesting concept, however it does make sense that unless you are comfortable with yourself and work to your full potential, you cannot empower others to be the best that they can be. It is as equally valid for the clinical setting as it is as for education. In addition, it fits with the notion of personal knowing, the knowing of

the self in order to enter into an authentic relationship with another. Perhaps this willingness to let go of what you know to enter into another's world, and accept him/her for the unique individual he/she is, can go a long way towards participating in a therapeutic relationship. Engaged pedagogy identified by hooks (1994), is a point to work for, one sought through the exploration of the self moving in multiple directions towards new possibilities in self-actualisation. This will be work in progress, a journey that has had its beginnings in this research project and will continue its movement to transforming the curriculum of the programme into the future, through understanding the history and reflecting and acting in the present. It is a bit like planting a seed that when nurtured will grow into a strong, healthy plant. If the seed is planted within this programme now, how far will the branches extend in the future?

Several participants discussed the following notion in relation to changing the culture of existing units/wards.

*They [existing staff] have their own culture in there [ward/unit] and it is really hard to change. Although the staff keep coming in and always new, it's the same culture and it never changes. I would like to work with a whole bunch of new graduate nurses doing this programme. We would be fresh, we have all these philosophies that we are told, and we have our own idea of what nursing should be about. It would be neat to work with a lot of new graduates doing the programme. We could bring a fresh new culture I think.*

Other participants agreed with this notion, adding the following:

*Let the new graduates choose who they want there as senior nurses, wouldn't that be wonderful.*

*Image the client care and the respect and the integrity that would be in the unit/ward. And very, very quickly the organisation would see the value of it.*

In saying this, the participants were articulating their vision for one single mental health setting and are really looking for the opportunities to show that they are capable of making a difference. While also identifying that as individual new graduates, he/she could not do it on his/her own, but with the support of those senior nurses the new graduates had identified as like-minded colleagues. If such a venture were to be tried, what impact would this have on the wider organisation? As the participants stated, the organisation would quickly see the value of it, or would they? Would such a venture be allowed to progress within the current climate in mental health? What, if any, processes would be enacted to bring these rebels back into line with the existing culture?

This then brings me to the issue of risk management. The recommendations already outlined in this chapter will, when implemented, address some of the areas of concern expressed by the participants. In particular those areas relating to who holds the power and whose interests are being served within current relationships. These relationships include those between existing staff, new graduate and client of the service. In addition to those recommendations already discussed, the curriculum content and processes in relation to risk management issues need to be addressed in the future. Participants discussed the benefit of more time spent during the first theory weeks looking at assessment and management of risk in a mental health setting. This is part of the current curriculum, however the way in which the risk component is delivered may require some review, as it would appear that it has not met the needs of the participants. However, what are the needs of the students? I would venture to say

that students would say their need in relation to understanding risk management is for somebody to tell them how to do it. This approach would indeed support the 'banking system of education' as discussed by Freire (1970) and hooks (1994) where students are taught to recite back rote fashion whatever it is they are required to learn. But in order to educate students on the principles and possibilities surrounding risk management, it is important to engage the student as a participant in the learning process rather than a passive consumer. The principles that follow the national best practice standards in relation to risk management need to be clearly explored with the students early in the programme and revisited at various intervals. These national best practice standards are those covered by the Ministry of Health Guidelines, 1998. Along with these guidelines, the student should also have some understanding of the development of risk management within mental health in New Zealand as part of the socio-political context of his/her practice. By engaging with the student/s in locating how existing knowledges, principles and practices have been positioned historically, the student might be empowered to develop deeper understandings of the issues and the context. This deeper understanding would also enable the student to reflect on current practices and critique self and others with a well grounded framework of knowledge. This knowledge, along with the other recommendations, should support the new graduate nurse in developing his/her confidence in asking the questions relating to risk management (and other issues) within the clinical setting. In turn perhaps these strategies could reduce the stress placed on new graduate nurses who may at times be carrying the burden of risk within the clinical setting.

And finally, the allocation of a new graduate nurse in the community for his/her first placement was the last issue the group discussed. All participants felt this should be avoided wherever possible. If it is necessary to allocate new graduates to the

community for the first placement, it should be enacted in such a way as to avoid the new graduate being isolated and left to carry the burden of managing a case load with minimal support. This has been discussed with site co-ordinators within the clinical providers and every attempt will be made to ensure that new graduates are not exposed to this stress in the future.

This chapter has discussed the recommendations developed from the identification of the following themes:

- ◇ preceptorship and support,
- ◇ socialisation, and
- ◇ risk management.

These three themes are indeed closely linked and cannot be examined in isolation. As this chapter outlines, any interventions in one theme, impacts on one, or both of the other two. The recommendations include:

- ◇ clarifying understanding related to the roles and responsibilities of those involved in the programme;
- ◇ improving preceptor selection, training, support and evaluation;
- ◇ the introduction of a mentorship relationship between current students, and those from the previous year's programme;
- ◇ increasing the socio-political context, and critical reflection content of the programme;
- ◇ positive mirroring of the critical paradigm when interacting with students and clinical providers;
- ◇ the inclusion of the historical development of risk management in mental health into the programme content;



- ◇ further developing the national best practice standards of risk assessment and management within the programme content;
- ◇ avoiding the placement of new graduate nurse in the community for his/her first placement; and
- ◇ if this cannot be avoided ensuring appropriate support is provided.

This is the first step in a longer journey of discovery and enlightenment. This research project has provided valuable insights into the issues facing new graduate nurses entering psychiatric mental health nursing. By listening to their stories, and involving the participants in a process of critical reflection relating to these issues, emancipatory actions have emerged. These emancipatory actions have already lead to transformation for both myself as the researcher and the participants. The small steps that have already been taken with more to follow and have opened a pathway to new possibilities. This pathway can no longer be closed.

## **CHAPTER 11: EVALUATION**

At the end of the second discussion group I talked with the participants about evaluating the research process. Critical social science research, the methodology being employed, utilises a participatory process and although as researcher I facilitated the group, I was also one of the participants, and as such felt it was crucial that we jointly participated in the discussion. Therefore it was important to evaluate the research process, particularly how we felt the process developed and any major insights that we gained. Each participant was given the opportunity to evaluate the process of the research. This session was taped and transcribed by the researcher following the meeting. There were four main areas where the participants considered the research had been valuable. These were the commonality of the participants and their feelings of no longer being alone; the flow on effects of participating in the research when the participants returned to the clinical setting; the improved understanding of research itself and the removal of some barriers to using research now and in the future; and finally, how to maintain this support when the research group was disbanded so the participants could continue to benefit from the process.

### **Participant Evaluation**

The participants all expressed the feeling of no longer being alone. It had been a very powerful and empowering experience to discuss the issues. It was actually quite powerful knowing that other people had the same concerns, powerful how it brought with it the strength to work through issues when the participants returned to the clinical setting, and powerful because now the participants had other people who had

shared, discussed and identified similar concerns. This empowered situation enabled the participants to go back and look at these and other issues slightly differently.

*Its been really good having the opportunity to talk about those issues, and also to find that other people all have the same thoughts and can either provide clarity to it, or can make it even more complex. You're not alone, you know in what your thinking and feeling and the difficulties that your experiencing, that for me has been really quite comforting in a way, but also to look at the way, where we're coming from to see whether we're actually being too idealistic in some ways, in being faced with what the realities actually are out there. And trying to find a middle ground, to look at where your coming from and match it to what's happening, without burning out and becoming socialised into the whole scenario.*

*I think the biggest thing for me is it's been really good having these discussions, to see that your concerns aren't your own concerns, everybody's got those same issues cropping up, and so you know that you're not alone, its quite good, it's been a quite good way of reflecting on them I suppose and seeing that perhaps they are not such a big issue after all, you know you can work through it.*

*The main thing that I had after having that session was the I wasn't alone in having had the problems that I faced in my first placement. I thought I had it really bad until I heard that you guys had it worse. So it was good to hear that I wasn't the only one that felt a little bit incompetent or alone in, that we all sort of had problems along the way. Believe it or not that was quite comforting. Comforting to know that you suffered too.*

Participants went on to identify how being part of the research process had flowed on to the clinical setting following the discussion groups.

*About the commonality stuff, during the interview [group discussion] and when I looked over the transcript again what it was like to be in ICU for the first time, and also giving more thought to risk management stuff as well.*

*Its of use to my practice, because the sorts of things that we talked about that are actually needed, we're almost fulfilling here, we're defining our role a lot more, we are defining what we expect from other roles a lot more, and because of that I think that the potential to have those roles defined for other people and around us is a lot easier.*

*Because of that my learning will be more advanced in my next placement, as it has been since our last discussion. We've got more clear definitions of what our roles are and its made advancements. So that role definition, the discussion on that makes a big difference to my practice even at this point.*

*I put a lot of effort into the students that were in my placement, I guess cause I experienced the difficulties. Oh and the second thing is I then volunteered to be the co-ordinator for some research, having seen that it just gets done, not magic. So I did have two particular flow on's ... I identified problems in my first placement, and I was much happier in my second placement, and the issues I identified has resolved.*

The discussion then when on to look at why it was that nurses stay in mental health when they appear to not like it. The group felt that for a nurse to remain in an area when he/she no longer enjoyed working in psychiatric mental health served as a destructive influence upon the nurse and the system as a whole. The group felt that this was not unique to mental health. However, the need to use 'self' as the key therapeutic tool within mental health had a tendency to make it more obvious. The

environmental impact appears to be greater when individuals within the environment are feeling less than contented and it is something recognised by those with fresh eyes. Nurses who remain within the environment often, but not always, tend to become so enculturated into the dominant paradigm that this ability to see things is often lost. It is frequently not until one leaves the environment, that the vision begins to clear. It is the standing back that enables a new vision. The focus on client centredness dissipates the interests of the organisation and the medical model in a resource driven culture. The participants in this research project identified a desire to maintain the client centered nature of practice and in doing so became critical in relation to how this was enacted in the clinical setting. Participants, in claiming those staff whose intentions were more closely aligned with the client centered approach, were consciously selecting those staff they prefer to have working alongside them.

Another benefit of being involved in the research process was the insights the participants gained in relation to research itself and how that insight has affected individual's understanding of research reports and thinking in relation to research in the future.

*Yeah, I have found it good, because I have seen the process of you having to get consent and standing up in a class asking people to participate. Less people participated than what I expected which was a bit sort of disappointing so I know I am naive, but when I read a research article and I see N=8 and I think I bet the researcher asked 20 people to participate. Yeah just seeing the personal knock backs, the things of consent, it was nicely done, the food and the environment.*

*It has given me an insight for when I read the research, and I think its interesting from all our verbals you get the themes, I think it is really clever.*

*I volunteered for a role in some other research, so it has given me a bit of a germ of what is quite contagious. I was thinking if I met my old Undergraduate Research Lecturer – I would want to say I got the point, I know it is a year later but I didn't get the point until, and now I have done this research I have got the point. You know you learn by doing, I was involved in it, and it was better than reading about it.*

Participants also discussed how great it had been to be part of a research project that would make things better for others who followed in their footsteps and just how rewarding this had been.

*Yeah it was an honour to be part of it really. It is great to know that I was there in '99 . Yeah it was great and it will be really good to see the changes next year and the year after just to see the impact that this has made. And just bringing home the reason why we do research.*

*I just brings it [research] home, do something that you are interested in, it is the only way. And you are making it real and you are making a change, which is something I am really interested in doing.*

*I really think that I could help and undergraduate nursing student now that I have done this qualitative research, its really put the theory of qualitative research now into the practice of it now. And I really struggled.*

*For me this is the first time that I have been involved in any kind of research that I know of. But it has been really interesting for my own learning about making changes and applied theory and making*

*rationale for the things that you do. So it has been interesting, it has never been like a passion anyway to do research, even to read it, I find it really tedious. But it has been really interesting finding out about this, probably because I have been involved.*

*...and I think finding people within the organisation that you can discuss them with too, you know you sort of get together a little group if you like of different people that you're able to discuss these issues with as well, which helps.*

I asked the group what would happen at the end of the year when they all went their separate ways and supervision was no longer provided by the organisation and the danger period in which they would find themselves.

*You've prepared us all very well to be, I think I said in the last session, that I didn't mind being the odd one out, but having said that I also want to fit in, I don't want to be just standing out there on my own. And you really need to have people that you can discuss those issues with, and it's a matter of looking ahead to when we aren't doing this course anymore and knowing that there are those people that you can go to for support. I keep going back to that support thing, and its something that I will still need, even when I'm not a new grad.*

The participants discussed how important this was for each of them.

*I think everybody does [need support] and if you have that little group of people and yeah its been something that's come out of this for me I think is knowing who you can go to. But it's nice to see that you've all got the same issues.*

*Maybe we will all be each others support, because we know the issues we face.*

*Well you would hope. And you can sort of look at how you can support the next group that come through.*

*It does make you stop and think, yeah.*

*Yeah I mean gradually you sort of build up enough people supporting each other, hopefully so that you can eventually change things, it may have been happening over the past, what is it three years that the course has been going, it may take five years, or ten years.*

I inquired at the end of the evaluation whether the group felt both reflection and action had come out of the process? All of the participants agreed that this was indeed what had happened.

### **Researcher Evaluation**

For myself as the researcher the process had been both enlightening and empowering. Being involved with the participants as unique individuals and seeing the development that occurred in the participants has been very rewarding. The group initially saw me (the researcher) as part of the establishment and as such, an oppressor. This perception appeared to change over the course of the research to the point where I became integrated into the group and was seen as a participant with different knowledge. For me the process has been empowering in that I now feel as though I have some sort of mandate to continue to develop the programme for future students. Personally I have learnt so much from the participants and the research process itself. Although I had some expectations of what would come out of the research, those



expectations were through the eyes of an experienced practitioner within the mental health setting, not the fresh eyes of new graduates entering practice. There were no real surprises in relation to the themes developed. What came across for me was the depth of the individuals' insights, the genuine commitment to changing things and making things better, and the participant's astounding level of awareness of the things that are going on around them. I found this quite empowering, and enjoyed the discussions of which I was privileged to be a part.

The experiences described by the participants were privileged information and these discussions have been treated with due regard. The discussions were transcribed exactly as stated by the participants and the transcripts from the first discussion groups were returned to the participants for authentication. Along with authenticating the transcripts the participants entered into a process of analysing the data, along with the researcher. The themes emerging from this analysis were jointly agreed upon by both the researcher and the participants. During the writing of the research report, the researcher had ensured that the experiences expressed by the participants were reproduced exactly as they were recalled. Any alterations made have been to provide the reader with clarity as to who or what the participants were talking about in specific extracts or circumstances. The researcher has endeavoured to select individual experiences that accurately reflect the group as a whole.

The themes identified in this research project have also been discussed by a wide variety of authors looking at the new graduate nurses entry to clinical practice in all areas of health (Oermann & Moffitt-Wolf, 1997; Prebble & MacDonald, 1996; Jasper, 1996; Gray & Smith, 1999; Kelly, 1996; Melia, 1987). The themes and discussions have in the most part been consistent, however, where an inconsistency was identified

this was clarified and research possibilities for the future discussed as part of the recommendations chapter.

In relation to myself as the researcher and my role within the research process, which was initially the role of a facilitator. It required negotiating with the participants to arrange the discussion groups and considering alternatives when it became clear that the original intention of one large group did not appear possible. When it became obvious that it was necessary to separate the one large group into two smaller groups while remaining true to the original intention of the project, it became necessary to provide an avenue for sharing the data between the two groups.

As the researcher I provided the initial boundaries for the research project by selecting the experiences to be explored, those within the participants' first clinical placement. I also selected the framework from which the questions for starting the discussion would be based thus facilitating the process. As the discussion groups progressed my role shifted from that of facilitator to that of co-participant in the process. Once the process was initiated the group made choices as to which direction the discussion would take. The group chose the important themes to be explored in the second discussion group during which I saw myself as a group member rather than a facilitator.

The research process was consistent with the notion of critical social theory as a process of conscientisation leading to emancipatory action, and ultimately transformation. The participants clearly identified this during their evaluation of the process. This conscientisation began during the first discussion group when each participant began to describe the issues he/she was facing. Some action was identified

during the first discussion group however, by the second meeting each participant had identified and/or carried out an action which he/she found made a difference. If no other action comes out of this research the insights the participants have already gained would justify the project itself. However, the privileged information shared by the participants needs to be further honoured by the implementation of the recommendations contained in Chapter 10.

## CHAPTER 12: CONCLUSION

This critical case study involved seven new graduate nurses who were students in the Diploma of Entry to Specialist Psychiatric Mental Health Nursing Practice at Whitireia Community Polytechnic (the programme). A critical social science perspective utilising the writings of Paulo Freire, (1970); Jurgen Habermas, (1972) and others underpinned the ideological position of this project. Emancipatory inquiry and participatory research methodologies were used to conduct this critical case study. The purpose of the research was to access information relating to the participants' experiences in his/her first clinical placement. It was designed to consider ways in which the programme can better support and enhance the transition from student nurse to staff nurse. Of the seven participants, two identified as Maori, five as European. Six of the participants were female, with one male participant. The participants were employed within a range of mental health services from Wanganui to Nelson.

Ascribing to the notion that all knowledge is socially constructed, and that all social engagement leads to the development of new knowledge, it is understandable that new knowledge is underpinned by historical and contemporary everyday worlds. Prior to entering the clinical area as a staff nurse, the new graduate has been enculturated into an (education) environment that valued caring processes which stood in contrast to what the new graduate encountered in clinical practice as a staff nurse. This created tension and confusion for the new graduate nurse when he/she entered an environment that continued to be closely aligned with the positivist paradigm and of which the dominant culture remained the medical model. Such an environment did not tend to

value caring, nor did it encourage or value difference. The relations and practices enacted in this environment did not appear to support the new graduate nurse in an equitable fair or just manner, and hence it was oppressive by nature. The new graduate nurse became enculturated into this environment through the enactment of hegemonic processes that suppressed the identity of the individual. The individual felt as though he/she had only two choices, to conform or leave losing the ability to see that other choices may have been available. They learned to see the environment, not as a whole but rather as an object reality. The new graduate entered into a position where his/her understandings were reified. He/she had become so enculturated that oppression resulted. The new graduate continued to have the feelings associated with what is going on around him/her, and proceeded to bury those feelings, distancing the self from the action. By utilising the Freirian (1970) sense of praxis, reflection and action leading to transformation, this research project has supported the participants to become more critical. Through this process each participant has examined his/her world from a critical perspective, identified actions that could be taken immediately to make a difference, and actions for the future. By being part of this research project, each participant was able to reflect upon small steps that he/she could take to make a change in his/her world.

Alongside the small changes, participants also identified curriculum processes and content that could be altered. During the first discussion group the participants disclosed several areas in which his/her entry to mental health practice could have been better supported. From this discussion the following themes were identified jointly by the participants and the researcher, preceptorship and support, socialisation, and risk management. During the second discussion group the participants and myself

identified certain actions that may assist new graduates in the future. These actions were designed to provide the new graduate with knowledge and skills before entering clinical practice, those understandings that would better support the new graduates' appreciation of the socio-political aspects of the profession and service area in which he/she is entering. Grappling with the socio-political dimensions of practice students will be supported with opportunities to discuss the notion of reflection in practice, and be encouraged to start developing skills in critical reflection as espoused by Paulo Freire (1970). By increasing the socio-political knowledge and critical reflective skills of the new graduate nurse he/she will be better prepared to enter a clinical setting and view the relations and practices enacted through a more critical lens.

As well as better preparing the new graduate nurse for practice, the programme would also benefit from improved communication with clinical providers, and improved selection, preparation and follow-up of preceptors. The first action is to better clarify the roles and responsibilities of those involved with the programme. The existing lack of clarity for the participants was very confusing and only served to add to the frustration on entering the clinical setting. By further clarifying the roles and responsibilities along with improving the liaison between the education and clinical providers it is hoped this confusion and frustration will be reduced. Coinciding with attempts to clarify the role, education and ongoing support provided to preceptors will be evaluated and improved. More intensive preceptor training is to be offered as well as follow up meetings with the preceptors to explore issues relating to the role and how it is enacted.

In relation to the curriculum content, the participants requested the socio-political perspective on psychiatric mental health nursing to be covered during the early theory

weeks. The rationale behind this request is so that the new graduate nurse can better understand the environment he/she is entering, and reduce the risk of becoming overwhelmed. I would agree with this proposal, however an alteration in content needs to be accompanied by a corresponding commitment to a curriculum that embraces the ideology(ies) of critical social science. By living the critical curriculum, the programme by 'walking the talk', would then mirror to the students and the clinical providers, the relations and practices that value difference and encourage individuality and critique.

The intention of the researcher was to make a difference. An ongoing concern for new nurses entering the profession as a whole was the initial starting point for this project. The researcher wanted to take some action that would in the longer term prevent 'our young' from continuing to be 'eaten'. This project is but a small step in the right direction. This is a journey that has only just begun.

## **POSTSCRIPT**

It is recognised that this piece of research, while political, honours the contributions made by the participants who have after all engaged in grappling with practice in an evolving world.

**APPENDIX i**

**Australian & New Zealand College of Mental Health Nurses Inc.:**

**Standards of Practice for Mental Health Nursing in New Zealand**

**May 1995**



**STANDARDS FOR MENTAL HEALTH NURSING PRACTICE****The Mental Health Nurse:**

- I ensures her/his practice is culturally safe
- II establishes partnerships as the basis for a therapeutic relationship with consumers
- III provides nursing care that reflects contemporary nursing practice and is consistent with the therapeutic plan
- IV promotes health and wellness in the context of her/his practice
- V is committed to ongoing education and contributes to the continuing development of the theory and practice of Mental Health Nursing.
- VI is a health professional who demonstrates the qualities of identity, independence, authority and partnership

(ANZCMHN's, 1995, p.4)

**APPENDIX ii**

**Information Sheet**

**and**

**Consent Forms**

**How can Entry to Practice Programmes best support the  
New Graduate Nurse entering the specialist area of  
Psychiatric Mental Health Nursing?**

**Information Sheet**

Thank you for showing interest in this research project. My name is Carmel Haggerty and I work as Programme Coordinator for the Diploma of Entry to Specialist Psychiatric Mental Health Nursing Practice.

I am conducting a study as part of the requirements for a Masters (Applied) in Nursing through Victoria University of Wellington, Department of Nursing and Midwifery.

I hope to:

- access information relating to the student's experiences in their first clinical placement to further understand their preparedness for the staff nurse role in the psychiatric mental health specialty.
- illuminate the differences and/or consistencies between what the students express as their needs in comparison to the educational content of the existing curriculum.
- consider how and in what way the educational process and content can better support the students understanding and enactment of their changed role from student to staff nurse.
- offer suggestions for improving the curriculum and pedagogical process that might better support and enhance the students transition from student nurse to staff nurse.

I am interested in learning how best to structure and deliver the programme in order to support the new graduate nurse in their transition from student nurse to staff nurse in the specialist area of psychiatric mental health nursing practice.

In order to do this I would like to invite you to be participate in this research project.

Your involvement will consist of attending two discussion groups that will consist of the researcher and up to eight participants, all currently enrolled in the Diploma of Entry to Specialist Psychiatric Mental Health Nursing Practice. The discussion will be based around

- issues relating to entering specialist psychiatric mental health nursing practice as a new graduate nurses, and
- improving the way in which the program can best support your transition from student nurse to staff nurse in this specialist area of nursing practice.

The first discussion group would be held in May 1999 and would be of approximately one and half hours in duration. Nursing Council Competencies for Entry to the Register of Comprehensive Nurses (November 1997) Mental Health Competency No 5 - 'Management of the Environment' will be used as a basis for discussion.

The discussion group will be audio taped, and following the session these tapes will be transcribed. The transcripts will then be sent out to participants to invite each participant to -

- comment upon your contribution to the initial group discussion, and
- identify themes that have emerged in preparation for the second focus group meeting. These themes will then form the agenda for the second discussion group.

The second discussion group will occur approximately 8 weeks after the first. Participants will need to bring their transcript of the first discussion group with them, in order to return it to the researcher for shredding on completion of the research.

The focus of the second discussion group will be to establish, confirm and explore the themes that developed from the first meeting.

All information shared in the focus group will remain strictly confidential. Your name would not be used and there will be no information that could identify you in any written or verbal research reports. The focus group interviews will be tape recorded and then transcribed by a professional dictaphone typist. The typist will sign a confidentiality agreement.

You may request to have the tape stopped at any time during the group discussion.

There are no risks and no direct benefits to you in taking part in the study. However the results will assist in the future development of the programme and in turn those new graduate nurses entering the programme in the future.

In the event that information shared causes deep distress the researcher will be able to provide you with at least three contacts for ongoing counseling and/or support.

Tapes and transcripts will be stored in a secure, locked cabinet, and will be destroyed at the completion of the research project.

From the information that you give a thesis will be prepared. Later the material could be used in conference presentations and in journal articles.

Participation is voluntary. You have the right to withdraw at any time without penalty.

Any questions or concerns raised by you will be discussed as they occur.

My supervisor for the thesis research is -

Penny Cash - Research Associate  
Victoria University of Wellington  
Department of Nursing and Midwifery  
81 Fairlie Terrace  
Kelburn  
Wellington.  
Phone:

Penny Cash can be contacted at Deakin University, Geelong, Melbourne, Australia.

She can be contacted directly on (0061) 3 52 271009 during office hours.

Jan Pearson Head of School Nursing and Health Studies has agreed to be available to participants for any questions or concerns regarding the consent process and/or research. This is to ensure an independent person is available on campus for participants who are also students in the Diploma of Entry to Specialist Psychiatric Mental Health Nursing Practice, of which the researcher is the Programme Coordinator.

A verbal summary of the findings to date will be presented to you in mid November 1999.

Please take care to consider if you would like to take part in this study and feel free to discuss this request with anyone you wish.

If you are willing to accept the invitation to participate in the research please complete the consent form attached and return to the researcher in the enclosed stamped addressed envelope by .....

Carmel Haggerty

**How can Entry to Practice Programmes best support the  
New Graduate Nurse entering the specialist area of  
Psychiatric Mental Health Nursing**

**Consent Form**

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

I agree to participate, I am aware I have the right to withdraw from the study at any time, share only the information that I feel comfortable to share and I can decline to answer any particular questions without prejudice.

I agree to provide information to the researcher on the understanding that my name and any other identifying information will not be used in any written documentation relating to the research. And that the information will be used only for this research, publications arising from the research project and for the purpose of curriculum development.

I understand that the two group discussions will be being audio-taped. I understand that I may have the audio-tape turned off at any time during the course of the group discussions.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed: .....

Name: .....

Date: .....



**APPENDIX iii**

**Confidentiality Agreements**



I, Linda McElwee, Administrative Secretary – School of Nursing and Health Studies Whitireia Community Polytechnic, agree to maintain confidentiality in relation to those students of the Diploma of Entry to Specialist Psychiatric Mental Health Nursing Practice, participating in the research project being undertaken by the Programme Co-ordinator, Carmel Haggerty.

This confidentiality agreement is in relation to any and all correspondence, and other administrative duties completed by me on behalf of the Programme Co-ordinator Carmel Haggerty that relate to the research project she is undertaking, during the 1999 academic year.

In particular

- ◇ the names of the students participating in the research groups will remain confidential;
- ◇ no correspondence will be saved to my computer;
- ◇ all hard copies will be returned to Carmel Haggerty for safe keeping, and destruction by shredding on completion of the research project.

.....  
Signature

.....  
Date

I, Valerie Anderson, agree to maintain strict confidentiality in relation to the information supplied to me for the purposes of transcribing audio tapes of the discussion groups undertaken by Carmel Haggerty, the researcher.

This confidentiality agreement is in relation to any and all audio tapes, computer files, floppy disks and printed material. In particular

- ◇ the names of any participants contained on the audio tapes will remain confidential;
- ◇ no files and/or information will be saved to my computer;
- ◇ all floppy disks used to save the transcribed material will be returned to Carmel Haggerty for safe keeping and electronic erasing on completion of the research project;
- ◇ all hard copies will be returned to Carmel Haggerty for safe keeping, and destruction by shredding on completion of the research project;
- ◇ all audio tapes will be returned to Carmel Haggerty for safe keeping and electronic erasing on completion of the project.

.....  
Signature

.....  
Date

**APPENDIX iv**

**Victoria University of Wellington**

**Ethics Proposal**

**and**

**Approval Letter**

**HUMAN ETHICS COMMITTEE**  
**Application for Approval of Research Projects\***

**Nature of Proposed research**

- (a) Staff Research      Y/N
- (b) Student Research    Y/N

**Project Title:**      *How can entry to practice programmes best support the new graduate nurse entering specialist psychiatric mental health nursing practice?*

**Investigators:**

- (a) Principal Investigator:

Name:      *Carmel Haggerty*

Dept:      *Nursing and Midwifery*

Any Professional Code of Ethics to be followed

(Name)      *New Zealand Nurses Organisation Code of Ethics*

- (b) Other Researchers:

*Not Applicable*

- (c) Supervisor (in the case of student research projects)

*Penny Cash - Associate Lecturer Department of Nursing and Midwifery*

**Proposed Start Date:**      *Thesis 1/3/99      Groups 16/5/99*

**Proposed Date of Completion:**      *29/2/2000*

**Proposed Source of Funding:**      *Whitireia Community Polytechnic*

**Abstract:**

In 1995 Capital Coast Health Limited and Whitireia Community Polytechnic initiated a pilot programme for new graduate nurses entering specialist psychiatric mental health nursing practice. On completion the students were presented with a certificate.

The programme has since developed to a diploma, and is provided through Whitireia Community Polytechnic to hospital and community based providers of mental health services within the central region.

The proposed research project is an illuminative evaluation as advocated by Parlett and Hamilton (1977) (cited in House, E., 1980, p41), and will utilise a case study approach (Stake, R. 1995). The purpose is to illuminate issues within the educational programme supporting the new graduate nurse in his/her entry to specialist psychiatric mental health nursing practice.

The project will be informed by critical social theory and the work of Paulo Freire (1970, 1993) and Jurgen Habermas (1971, 1979 as cited in Fulton, Y., 1997, p 526). With the aim of “consciousness raising” (Dorothy Henderson, 1995, ) of those participating to issues facing new graduate nurses entering this specialist area of practice, and how the educational process and curriculum can best support and enhance this transition.

The project findings will be reported to Whitireia Community Polytechnic management with the aim of informing ongoing curriculum development.

**Briefly Outline:**(a) The objectives of the project:

This study invites a small group of Diploma of Entry to Specialist Psychiatric Mental Health Nursing (Whitireia Community Polytechnic) students to participate in evaluating a section of their educational experience. The Nursing Council of New Zealand Competencies for Entry to the Comprehensive Register (1997), Mental Health Competency Number 5 – Management of the Environment will be used as a starting point for discussion.

The purpose of this is to -

- *access information relating to the students' experiences in their first clinical placement to further understand their preparedness for the staff nurse role in the psychiatric mental health specialty.*
- *illuminate the differences and/or consistencies with what the students express as their needs in comparison to the educational content of the existing curriculum.*
- *consider how and in what way both processes and content can better support the students' understanding and enactment of their changed role from student to staff nurse.*
- *offer suggestions for improving the curriculum and pedagogical processes that might better support and enhance the students transition from student nurse to staff nurse.*

(b) Method of data collection:

- *This study utilises a case study approach (Stake, 1995). New students commencing the Diploma of Entry to Specialist Psychiatric Mental Health Nursing, (Whitireia Community Polytechnic) in February 1999 will be invited to participate in the research. The research will require that eight*

*participants are able to attend two discussion groups, which will be conducted at a pre-arranged neutral venue.*

- *The researcher is also the Programme Coordinator of the Diploma of Entry to Psychiatric Mental Health Nursing Practice - Whitireia Community Polytechnic and is therefore also the participants' tutor.*
- *Prior to completing their first clinical placement all students of the programme will be approached during their theory block at Whitireia Community Polytechnic and invited to participate in this study. This approach will be made by the researcher and an independent person/s as outlined under section (h.) thus reducing the risk of prejudice to the students.*
- *Students will be provided with an opportunity to ask questions of both the researcher and the independent person/s at the time of the approach. The researcher will leave the room, leaving the students free to ask questions of the intermediary.*
- *A plain language statement, consent form and return addressed envelope will be given to each student.*
- *Those agreeing to participate will return their signed consent form, ( in the return addressed envelope provided) to the researcher by a specified date.*
- *Eight participants will be selected from those accepting the invitation. This will be carried out through the use of random selection carried out by a person independent to the researcher and the students, and will not be the independent person/s as outlined in section (h).*
- *Arrangements will then be put in place to meet at a time and place that is suitable to the students, and outside of their normal education and employment environment.*

- *The first discussion group will be held within two weeks of the students completing their first clinical placement in the specialty area of psychiatric mental health nursing, and will be for 1 ½ hours.*
- *Prompt questions based on the Nursing Council of New Zealand Competencies for Entry to the Register of Comprehensive Nurses (November 1997) Mental Health Competencies - No. 5 Management of the Environment will be used to stimulate debate. This specific competency has a focus on risk assessment and management within the mental health environment and will promote discussion around risk management issues for new graduate nurses entering specialist psychiatric mental health nursing practice. This will provide the basis for a wider discussion, which may include issues other than risk assessment and management.*
- *The discussion groups will be audio taped, and the tapes transcribed by a professional dictaphone typist, not associated with the institution or the field of inquiry, and who has signed a confidentiality agreement.*
- *Using the transcripts and individual recollections participants will be invited to identify themes independently of the researcher.*
- *Copies of the transcribed tapes will be sent to the participants following the first discussion group. Participants will be invited to comment on the transcripts and discern what has been for the individual the major themes arising from the transcript. These themes will act as an agenda for the discussion at the next group meeting.*



(c) The benefits and scientific value of the project:

- *It is hoped the project may inform curriculum development and pedagogical processes that might support and enhance the students transition from student nurse to staff nurse in the field of psychiatric mental health nursing.*
- *To consider how and in what ways the educational processes and content of the Diploma of Entry to Specialist Psychiatric Mental Health Nursing Practice can support the students understanding and enactment of their changed role from student to staff nurse.*
- *To use the information illuminated by the participants to inform on-going curriculum development.*
- *The information illuminated by the participants will also inform psychiatric mental health nursing practice in relation to areas that may need to be addressed in the clinical setting to further support and enhance the students transition to staff nurse.*
- *This will hopefully benefit specialist psychiatric mental health nursing practice into the future, with on-going curriculum development ensuring the provision of a programme that meets the needs of students, industry and ultimately consumers of the services..*
- *To report the outcome of the project both nationally and internationally, thus adding to the body of knowledge relating to entry to specialist practice for new graduate nurses.*

(d) Characteristics of the participants:

- *New graduates of an Undergraduate Degree or equivalent in Nursing*
- *Registered Nurses*

- *Students enrolled in the Diploma of Entry to Specialist Psychiatric Mental Health Nursing Practice at Whitireia Community Polytechnic commencing on 15 February 1999.*

(e) Method of recruitment:

- *All nineteen graduates enrolled in the programme commencing on 15 February 1999 will be invited to participate.*
- *At a time in the education programme when the students are together, students will be given a full verbal presentation by the researcher and the independent person/s as outlined under section (h). This presentation will relate to the project and the involvement required from them as participants.*
- *At the time of the presentation all students will be given a plain language statement, a consent form and a stamped, return addressed envelope. See appendices (i) and (ii).*
- *Students will have an opportunity to ask questions throughout the presentation. At the end of the presentation the researcher will leave the room and students will have the opportunity to clarify any issues with the independent person/s as outlined under section (h).*
- *Those students accepting the invitation to participate will then return the signed consent form in the stamp addressed envelope provided, within 14 days of receipt of the plain language statement and the consent form.*
- *Should more students than required choose to be involved in the project. The researcher will arrange for an independent person who is not associated with the research to randomly select 8 participants. This random selection will be carried out by pulling the names out of a hat.*

- *If insufficient participants respond a further invitation for students to participate in the research will be issued through the quarterly programme newsletter to students.*
- *Discussion group meetings will be held at a place that is neutral, i.e.. outside of the students normal educational and/or employment environment. The venue will most likely be on campus at Victoria University, however this is yet to be negotiated. The date and time for the discussion group will be agreed by participants and researcher.*

(f) Payments that are to be made/expenses to be reimbursed to participants:

- *Not applicable.*

(g) Other assistance (e.g. meals, transport) that is to be given to the participants:

- *Participants will be provided with light refreshments during discussion group sessions, researcher initially covers the cost and will be reimbursed through the Whitireia Community Polytechnic Research fund..*
- *Travel expenses incurred by the participants will be reimbursed through the Whitireia Community Polytechnic Research fund, or alternatively through the programmes' development budget.*

- (h) Special hazards and/or inconvenience (including deception) that participants will encounter:

*The researcher is also the Programme Coordinator of the Diploma of Entry to Psychiatric Mental Health Nursing Practice - Whitireia Community Polytechnic and is therefore also the participants tutor.*

*Any risk of prejudice will be reduced by -*

- *the Head of the School of Nursing and Health Studies - Ms Jan Pearson, and an independent person appointed by the Whitireia Community Polytechnic Research Committee will act as student advocates throughout the project.*
- *Ms Pearson and the independent appointee will attend the initial verbal explanation of the project and will be available immediately following to respond to any questions the students may have.*
- *Ms Pearson and the independent appointee will continue to be available to students throughout the project should they have any concerns regarding consent, withdrawal of consent or prejudice.*

*To reduce the risk of prejudice and/or penalty in relation to the assessments undertaken by students of the programme who may or may not be participants of the research project, the following will occur-*

- *Students' clinical assessments will be completed in the clinical setting with nursing staff who are not associated with the research, undertaking the role of assessor.*
- *all academic assignments will be forwarded to an independent employee of the School of Nursing and Health Studies to ensure all identifying data, other than student number is removed before the assignments are forwarded to the tutor to be assessed.*

*To ensure that participants are able to feel free to discuss, and share any issues relevant to the research.*

- *Anonymity will be maintained for the participants as outlined under (k) in this document.*
- *Confidentiality will be a feature of the research, with participants responsibility relating to confidentiality of group membership and information discussed being negotiated and agreed upon at the commencement of the first discussion group.*

(i) How informed consent is to be obtained:

- *Potential participants will be provided with a verbal explanation of the research, its purpose, benefits and perceived risks. This verbal explanation will be carried out in a group, and at a time in the educational process when the students are attending a theory block at Whitireia Community Polytechnic.*
- *This approach will be made by the researcher and an independent person/s as outlined under section (h) thus reducing the risk of prejudice to the students.*
- *Students will be provided with an opportunity to ask questions of both the researcher and the independent person/s at the time of the approach. The researcher will leave the room, leaving the students free to ask questions of the intermediary.*
- *Potential participants will be fully informed at the time of the verbal presentation. In addition to the presentation a plain language statement will set out clearly information related to participation.*

- *Opportunities to ask questions about the research will be provided prior to the commencement of the research and when necessary during the course of the project.*
- *The processes put in place to ensure confidentiality and anonymity will be fully explained to the participants, (see plain language statement - Appendix i).*
- *The participants will be informed that they have the right to withdraw from the research at any point without prejudice or penalty.*
- *The researcher will be available to answer any questions during and following the initial information session, and throughout the course of the research.*
- *Written consent, containing all the information outlined above, will then be required prior to commencing the research.*

(j) State whether the consent is for the collection of data, attribution of opinions or information, release of data to others, or use for particular purposes:

*Consent is for the participation in the project which includes -*

- *collection of data;*
- *anonymous attribution of opinions or information;*
- *release of data to others, namely the dictaphone typist to transcribe the tapes and the researcher's thesis supervisor;*
- *use of the data for the completion of a thesis in partial completion of a Masters (Applied) in Nursing, Victoria University of Wellington;*
- *use of the data for publication and conference purposes;*
- *to use the information to support curriculum development within the institution.*

*It should be noted that no identifying data will be released, which*

*included data relating to personal, professional, employment or organisational.*

- (k) Whether the research will be conducted on an anonymous basis. If not how issues of confidentiality are to be ensured if this is intended.

*It is intended that the research will be conducted on an anonymous basis.*

*Anonymity will be supported by-*

- *Maintaining confidentiality surrounding the consent to participate in the project. Participants will contact the researcher confidentially using the return addressed envelope to enclose their consent form.*
- *Participant responsibility will be negotiated and agreed at the commencement of the project between the researcher and the participants in relation to the confidential nature of the discussion group. Neither the content nor details pertaining to information raised during the course of group discussions (this includes the participants involved) will be discussed and/or identified outside the group.*
- *No identifying information relating to the participants personal, geographical location or professional employment details will be included in the written document.*
- *Pseudonyms will be used in written text only when this cannot be avoided, and with the agreement of the participants. The key to the pseudonyms will be held by the researcher separate from the data.*
- *The professional dictaphone typist transcribing the discussion group tapes will be required to sign a 'Non disclosure of Information' statement, and will be an independent person not associated with the institution and nursing generally.*

- *No other person (other than the researcher's thesis supervisor) will be given access to tapes and/or written data.*
- *The data will be stored in the researcher's private residence.*

(l) Procedure for the storage of, access to and destruction of data, both during and at the conclusion of the research:

- *All data (tapes and transcripts) will be stored in a locked cabinet at the researcher's home until the completion of the project.*
- *Copies of the transcribed tapes will be sent to the participants following the first discussion group. Participants will be invited to comment on the transcripts and discern what has been for the individual the major themes arising from the transcript. These themes will act as an agenda for the discussion at the next group meeting.*
- *Participants will be asked to bring the transcripts to the second meeting for the purposes of returning them to the researcher, and will be shredded on completion of the research.*
- *These copies will be collected from the participants at the second meeting and will be shredded at the completion of the research.*
- *All tapes will be electronically erased at the completion of the project.*
- *All paper data will be shredded on completion of the project.*



(m) Feedback procedures:

- *A verbal summary of the findings to date will be presented to the full students group in mid November 1999. This will only be undertaken once consent has been obtained from the eight students who participated in the project.*
- *Participants will be able to read the completed thesis once it has been completed and been through the academic marking process.*

(n) Reporting and publication of results:

- *Results will be reported in NURS 593 - two paper thesis, in partial completion of Masters (Applied) in Nursing through Victoria University of Wellington.*
- *Publication of results will be in article format, in Nursing journals in New Zealand and Australia, as well as conference papers.*
- *The research findings will be reported to Whitireia Community Polytechnic with the aim of informing curriculum development.*



**APPENDIX v**

**NURSING COUNCIL OF NEW ZEALAND**

**COMPETENCIES**

**FOR ENTRY TO THE COMPREHENSIVE REGISTER**

**MENTAL HEALTH COMPETENCY NO 5**

**MANAGEMENT OF THE ENVIRONMENT**

## 5.0 Management of the Environment

The applicant promotes an environment which maximises client safety, independence, quality of life and health.

### *Mental Health Performance Criteria*

The applicant:

- ◇ Understands the principles of community mental health.
- ◇ Maintains a therapeutic environment.
- ◇ Considers the impact of the milieu on the mental health of the patient/consumer,
- ◇ Identifies potential risk factors within the mental health setting and community environments.
- ◇ Assesses risk factors and identifies strategies that maintain own, patient/consumer and others' safety.
- ◇ Implements nursing responses, procedures and protocols for managing threats to safety within the clinical environment.
- ◇ Identifies clinical protocols, for example, for seclusion, restraint, observation, specialising, treatment against the patient/consumer will, AWOL, self-harm, aggression.
- ◇ Describes basic de-escalation, calming techniques, and conflict resolution.

(Nursing Council of New Zealand, 1997, p. 15)

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