How is nursing practice with suicidal consumers in acute mental health inpatient units constructed?

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This thesis is dedicated, with all my love, to my children Amelia and Isaac. It is also dedicated to their mother, and my friend, Jennifer Partington, who passed away in February 2011.

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Summary

The need for quality nursing practice with suicidal consumers in inpatient mental health units is axiomatic. Such consumers are, by the nature of their distress, often vulnerable and in need of support. However at the beginning of this study there was good evidence that nursing practices varied between individual nurses, teams and wards. This study examines why this variation occurred, by asking the research question "how is nursing practice with suicidal consumers in acute inpatient units constructed?" To answer this question a critical ethnographic research study was undertaken in four acute mental health inpatient wards across two cities in New Zealand. Data were gathered from observations, interviews with nurses, other clinicians and with consumers, and by examination of consumer and other clinical records.

The findings show differing ward or team cultures relating to the treatment/care of suicidal consumers and the expected practice of nurses. The cultural expectations in wards or teams were one significant factor in the construction of nursing practice. Two cultures, which I have labelled 'bio-medical/risk' and 'psychological', differed markedly from each other, and as such produced very different expectations of nursing practice. A third type of culture was marked by the process of struggle for dominance, and as such I have called this a ward in 'partial change' where differing understandings of suicidality and of practice had resulted in sub-groups of nurses working in dissimilar ways.

A second factor in the construction of nursing practice with suicidal consumers was the dispositions (why people behave in certain ways, and how they act). Dispositions in this thesis refers to why people act in certain ways, and dispositions were relational to dominant cultures, meaning that practices aligned, or not, in a variety of ways. A re-interpretation of the findings using key theoretical ideas of Pierre Bourdieu allowed identification of five dispositions. These are (i) *practice through passive alignment* (nurses unconsciously imbued with a dominant bio-medical/risk culture and therefore practicing in ways aligned with its expectations)*;* (ii) *practice through reluctant alignment* (nurses consciously, but reluctantly,

practicing in alignment with the dominant bio-medical/risk culture, while being critical of it)*;* (iii) *practice through deliberate non-alignment* (nurses consciously practicing in ways that were inconsistent with the dominant bio-medical/risk culture)*;* (iv) *practice through misalignment* (nurses misinterpreting a new way of understanding suicidality and practice, either by returning to previous ways of working or by practicing in new and unexpected ways)*;* and (v) *practice through deliberate alignment* (nurses consciously aligning with a new way of understanding suicidality and practice, and practicing in a way consistent with this). The findings from this study are important as they give insights into why nursing practices with suicidal consumers can vary so markedly, even within the same wards or hospitals. The results suggest that that any attempt at sustained improvement of nursing practice with suicidal consumers' needs to consider the constructing influences of both ward and team cultures and of nursing dispositions. This understanding allows for suggestions for future nursing education, practice, and research that attempt to support nursing practices that result in positive outcomes for suicidal inpatient consumers.

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