Introduction:
As a community mental health nurse (CMHN), I will reflect upon a critical incident that occurred with one of my clients, using the Gibbs reflective cycle (1988). I will reflect on my learning and development through this experience, highlighting how this has enabled me to become more effective in achieving desired practice.

Description of the Incident:
Pete was a caucasian man in his early 60s, known to mental health services for the last 20-years or so and he was accepting treatment. He was regularly seen by the doctors in the out-patient clinic, by a support worker and by myself, as his CMHN. Pete used to abuse alcohol and on many occasions had been referred to local drug and alcohol services, although he inevitably failed to attend his appointments. Earlier last year, he was transferred from a third floor to a ground floor flat, which he had been wanting for some time as he suffered from chronic obstructive airways disease. However, within nine months of his move, he was admitted to a local mental health unit on three separate occasions, reporting suicidal ideas on each occasion—he had not previously acted on such thoughts. Pete was prescribed depot medication (an anti-psychotic injection), which was administered weekly, in addition to an oral antidepressant.

I attended a multi-disciplinary meeting prior to Pete’s discharge from the unit, at which it was suggested that an enhanced CPA (care programme approach) care plan be agreed, due to his level of vulnerability. This implied that Pete required a higher level of care and supervision and further exploration of his unmet needs (Marshall 1996).

Following his discharge, Pete received weekly visits from myself, his social worker and support worker, in addition to six-weekly out-patient appointments. I had seen him on the Thursday, during the week of the critical incident, to administer his depot medication. On assessing his mental state at that time, his mood was not low, nor did he express any suicidal intent. Physically, he was well and he had been managing well within his new flat. He had been compliant with prescribed medication and said: ‘I'll see you next week.’
On the Friday, one of my colleagues received a call on the CMHN telephone helpline from one of Pete’s friends, stating that Pete had consumed alcohol and that he was suicidal. His friend wanted advice about what to do, and was advised to take Pete to the local casualty department. They were seen by a psychiatric doctor and a psychiatric liaison nurse, who both assessed Pete as not suicidal. He was discharged home.

It was on Monday morning that I, as Pete’s care coordinator, was informed that he had jumped from a motorway bridge into the fast lane, and was killed. A critical inquiry was established and a formal investigation commenced.

Looking through the reflective window, I initially focused on myself, within the context of my own lived experience, in an effort to confront and understand the situation I was in. I quickly realised the differences between my expectations of the service and real-life practice—my expectation that I would receive debriefing and support were initially not met (Johns 2000).

A number of issues felt very significant:

♦ power
♦ support
♦ my response to clients receiving enhanced CPA care now
♦ oppression

According to Johns (1999), reflecting upon experience relates to the interconnectedness of looking in and out of many windows as part of the process of enlightenment, empowerment and emancipation (Fay 1987, cit. Johns 1999), in realising our visions of self and practice as a lived reality.

Reflection can be viewed as a critical social process moving through stages of enlightenment—with the purpose of understanding why things have come to be as they are. However, for various contextual reasons, this is often difficult in my area of practice. I had to focus on a sense of purpose, whilst feeling conflict and being fearful of negative consequences. Although I did become reflective, I also became increasingly sensitive to the more trivial and taken for granted aspects of my practice—things that would not usually be anxiety provoking or problematic. I had to deal with what was in my best interests as a consequence of taking appropriate action (Fay 1987, cit. Johns 1999). Yet natural reflection may only penetrate superficial levels of consciousness or may be geared only to relieving anxiety rather than learning from it.

As a reflective practitioner, I accept responsibility for ensuring that patients and families receive the most appropriate care. As such, I need to be in the best possible shape to be available to them. I thought that I had been until hearing of this tragedy. After finding out about Pete’s suicide, I did not feel supported by my superiors—my line manager seemed only interested in whether my documentation was up to date. In response, I felt angry and fearful.

On reflecting upon my experience now, I should have challenged my manager over their lack of support as I feel that they missed the point that I had connected with my client.

According to Johns (2000), the practitioner works towards collaborative ways of managing conflict even if one party may be reluctant to dance!
This is both useful and desirable, and even though the team’s philosophy is to work collaboratively, this cannot be assumed and has to be actively constructed (Johns 2000), although this may often feel like a struggle against the power gradients or more powerful others.

Feelings:
I felt extremely guilty and blamed myself for Pete’s death. I thought that there must have been a weakness in the service that I provided. I obviously had not identified anything suspicious on that day—perhaps I should have? I could not talk about it as I felt that everyone must be blaming me. I did, for the first time in my life, feel oppressed.

I felt very guilty—a feature of the caring trap or, as Ann Dickson describes it, the compassionate trap, because I felt responsible for every aspect of his care—so it must have been my fault (Johns 2000).

Nurses tend to exhibit the same personal characteristics as other oppressed groups: a lack of self-esteem (Roberts 2000); warmth, nurturance and sensitivity in contrast to the characteristics of the dominant culture’s intelligence, decisiveness and lack of emotion. Nursing, because of its lack of power (Hendel 1998) and control, except within its own group, has been viewed as oppressed again and again. I shared these characteristic feelings as a nurse amongst other team-members—consultants, doctors and social workers. They did not comment on any of the nursing aspects of Pete’s care, even though I was the care coordinator. Roberts (2000) explained that the values of nursing are barely recognisable in patient care because of the dominance and internalising of medicine and the medical model.

I believe that nurses clearly need to stress their strengths and move forward based on an analysis and appreciation of those strengths (Gordon 1998). However, throughout the period of this incident, I did not feel able to talk about my standards of care and the quality of patient care.

Evaluation:
As I had not previously experienced attending a formal interview in front of a panel of five senior professionals, three of whom were doctors, I was in a state of turmoil. I felt unable to freely assert myself and identify positive ways of dealing with the situation.

Roberts (2000) proposes a five stage model to describe the behaviours of freeing oneself from oppression:
1. Examined acceptance — this represents the passive acceptance of the dominant view without exploring other alternatives. I was over-accepting and did not question anything—I felt that someone was to be blamed and it was probably me!
2. Awareness — this involves beginning to understand the power structure. As time went on, from the death to the panel interview, I began to realise that I, as the care coordinator, was in a powerful position to raise my voice.
3. Connection — I began to make linkages in forming a new positive self-image and professional identity.
4. Synthesis — this involves the new positive image becoming internalised and more authentic. My anxiety was replaced with a stability of belief in the ability of myself and my colleagues. Once the investigation was over and I
received a final report in which my work as the care coordinator was appreciated, confirming that I had indeed provided a high standard of care, my initial anger turned into energy for making strategic efforts towards change.

5. Political action — a genuine and ongoing commitment to social change.

For nursing, the need to analyse and change systems in which nurses lack power and are devalued are most important tasks. This is the true nature of multi-disciplinary teams (Holloway 2001). Nurses need to celebrate their impact on patient care and their successes as a profession, despite the forces against them.

Although I had a bad experience with the lead up to the panel meeting and completion of critical incident forms and formal reports, the outcome was a positive experience, as I was then praised by my managers and colleagues—even receiving a letter from the Chief Executive that, importantly, gave credibility to my work.

Analysis:
Reviewing the value of life, and the meaning of after-life is a pre-requisite to explaining a person’s preference for death. The subsequent choice of suicide is one of several options. The wish to die is experienced and becomes clinically visible when the person perceives his existence as meeting self-defined criteria for death as being preferable action.

In this case, Pete did not at any time show or express a wish to die, neither did he look or state that he was clinically depressed. I saw him on the Thursday, and by the Sunday he was pronounced dead—so then, how well do I really know my clients and how well did I connect with Pete?

Conclusion:
Since this incident, I have started to use the suicide perception triangle model, which emphasises three key aspects relating to suicide (Cutter 2002):

♦ a wish to die
♦ a suicide plan
♦ sufficient distress to require relief

Together, these provide a necessary and sufficient situation for self-injurious behaviour—each is necessary but insufficient by itself.

I thought about why Pete didn't ask for help, as he usually would. Perhaps people who take their own lives regard their lives as unacceptable, because their understanding converges with self-defined criteria for death as being preferable. On reflection, I personally do not think that I could have done anything to have prevented Pete's chosen course of action—there was nothing I was particularly alarmed about. I have learned to request for time for debriefing in situations such as this, and now feel that I have a voice, no longer feeling oppressed.

Action Plan:
If the same situation arose again, I think I would request clinical supervision in gaining opportunities for ventilating my feelings. If, at the time, I have questions about nursing documentation and how best to manage the client's care, I will express my thoughts and opinions rather than feeling oppressed and disempowered.

I feel more confident in empowering my colleagues, who may find themselves in a similar situation, in offering support.
Reflecting on the lived experience, I feel that I can advance my practice by maintaining an up-to-date knowledge of current studies on suicide. However, I have also started to use the suicide prevention triangle (Cutter 2002) with clients on my caseload who express suicidal ideas.

References:
Gordon S (1998) No you are not your worst enemy. Revolution 8(1): 60-68


A Reflection on the Use of Advance Statements in Clinical Practice: a service user and service provider perspective

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SERVICE-USER INVOLVEMENT

Advance Statements: what are they?

‘An advance directive (also known as an ‘advance statement’, ‘advance refusal’ or ‘living will’) is a way of making a persons’ view known if he or she should become mentally incapable of giving consent to treatment, or making informed choices about treatment, at some future time. Doctors and healthcare workers must usually take these wishes (advance statements) into account. There are however certain conditions which need to be satisfied before an advance directive can be valid and there are some limits to what a person can direct.’ (Mind 2004)

The British Medical Association has developed a code of practice (BMA 1995) about advance directives and advance statements, the use of which has increased over recent years and has raised ethical and legal issues throughout the profession. The code takes a practical approach and acknowledges a ‘limited value’ in the use of advance directives (refusals) and advance statements (preferences) in relation to the treatment of recurrent episodes of mental illness, and