AN ETHNOGRAPHY OF CARING AND CONTROL
IN AN ACUTE PSYCHIATRIC UNIT

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ABSTRACT

The setting for this study was a 19 bed general hospital psychiatric ward serving a heterogeneous population. The objective of the study was to generate thick description of the cultural knowledge patients and nurses used to organise their behaviour and interpret their experience in an acute psychiatric unit. Further aims were to describe the nature of the service provided, and more specifically to identify relationships between caring and controlling in this social context, and the outcomes for patients of caring and controlling interventions by nurses.

Over a 10 month period primary data were obtained through participant observation and ethnographic interviews, with analysis of documentation providing secondary data. Thirty patients and 20 nursing staff acted as informants. They were selected on the basis that they had experienced the event being studied, and that they were both willing and able to share the experience. A cyclic research process was adopted, in which initial data analysis followed early data collection resulting in more focussed questions for subsequent data collection. Content analysis was undertaken to inductively derive patterns or themes from the data. Validity of data was achieved through triangulation of multiple data sources. Interpretations of the findings were verified and clarified in collegial dialogue with other psychiatric nurses, and with academic colleagues.

The central thesis which emerged from the data is that the nature of caring and controlling acts by nurses is shaped by the social organisation of care, and by the dominant belief system of that setting. A view of mental illness as a life long event for the majority of inpatients, coupled with beliefs about the "outside world" as tough, contributed to nurses' feelings of powerlessness to change situations for, or with patients, and so diminished expectations for change. Caring as a moral obligation was often interpreted by nurses as a moral obligation to provide a safe

haven, with nurturance and acceptance of patients viewed as chronically psychiatrically disabled. Additionally, features of the organisational context including nurses' lack of autonomy in their practice, the absence of both appropriate environmental controls and a clearly articulated rule structure, and the competing demands on nurses arising from the provision of the after hours crisis service from the ward, contributed to an organisational context which was not supportive of sustained therapeutic interaction between nurses and patients. There was a culture of chronicity in the ward. Implications of these findings for psychiatric nursing education and practice, and for service development are discussed.

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INTRODUCTION

The choice of topic for this study was influenced both by the sociopolitical climate of change in New Zealand at the time of the study, as will be described in chapter one, and by the interests and background of the researcher. The management of change, and the functioning of groups and social systems in health care settings were interests of the researcher which arose from prior teaching responsibilities with registered nurses undertaking university level post-basic education. Both the researcher's background as a nurse who had practised in psychiatric settings, and her current occupation as a university teacher within a Department of Nursing Studies, with responsibilities for course development and teaching within the field of psychiatric/mental health nursing practice, directed the initial focus of this study toward changes in mental health and illness services in New Zealand, and their impact on psychiatric nursing practice.

Statement of the problem

Mental health and illness services in New Zealand are undergoing extensive changes. The prevailing political and professional trend is toward community based care of psychiatric patients. Consistent with this trend, it is planned that acute care of seriously mentally ill patients will be provided predominantly in psychiatric units within or on the site of general hospitals, while care of seriously mentally ill offenders will take place within newly established regional medium secure units. These changes will enable the planned closure of psychiatric hospitals in many regions, and thus have major implications for psychiatric nursing practice. To date these changes in the location of mental health and illness services in NZ are occurring in the absence of a full understanding of the processes by which acute psychiatric units, located in or on the site of general hospitals, manage and treat the diversity of seriously ill patients referred for care, cure and control.

Discussions with psychiatric nurse colleagues identified a range of problems, which included an apparent escalation in violence toward self and others amongst acutely disturbed patients presenting for treatment, with associated problems in the management of disturbed behaviour in acute units which lacked intensive care facilities; and the management of the chronically mentally disordered population. The high rate of readmissions with this latter group (termed the revolving door syndrome) identified in NZ psychiatric hospitals (Mason, 1988, pp.136-7), is likely to create problems with throughput, and thus limit the availability of beds within the acute units for newly referred acute admissions.

There is extensive literature which critically examines the treatment of the mentally ill in large psychiatric institutions, and deinstitutionalisation and the community mental health movement in the USA have also been extensively studied and critiqued. In New Zealand, there has been a series of Commissions of Inquiry into psychiatric services, however there has been little focus on the acute units attached to general hospitals. It has been reported that these units are "well staffed" in comparison to admission wards of the large psychiatric institutions, which are of similar size (Dowland & McKinlay, 1985, p.23). However the majority of these units are not gazetted to take committed (formal or involuntary) patients, and lack the range of supporting treatment facilities such as intensive care units, sub-acute units and rehabilitation units traditionally available to acute admission wards in the larger psychiatric institutions. Such facilities enable more homogeneous grouping of inpatients according to treatment needs, and need for social control.

Society mandates psychiatric institutions and their staff to be agents of social control, as well as giving health professionals responsibility for the care/cure of the seriously mentally ill (Dowland & McKinlay, 1985). However there has been little discussion as to whether the dual mandates to care and control in this context are complementary or conflicting. While much has been written in the nursing

literature about caring as the "essence" of nursing (Leininger, 1984), there is a lack of clarity about the meaning of care. The terms care, caring and nursing care are loosely used, both in nursing literature and in nursing practice. Similarly, within the field of psychiatric nursing, the meaning of the concepts of caring and control, and the relationship of caring to control, have been little addressed.

All of these factors pointed to the need for systematic research on the functioning of acute psychiatric units, and on psychiatric nursing practice in these settings. Little is known of the culture of general hospital based psychiatric units, and of the impact of unit subculture on patient care. How does a single psychiatric unit located on the site of a general hospital, manage and treat the heterogeneity of patients who present for care, cure and control? Moreover, in the context of psychiatric nursing practice, what is the meaning of, and the relationship between, caring and control? Are these separate concepts, or is control integral to caring in an acute psychiatric setting? What is the relationship between caring and controlling acts and the social context in which they occur? And what are the outcomes for patients, of caring and controlling interventions by nurses?

Objectives of the study

In this study, ethnographic methods were used firstly to explore the issues which arise when the needs of a heterogeneous patient population are to be met in a single general hospital based psychiatric unit, and thus to describe the nature of the service provided. Secondly, the study focussed more specifically on the meaning and relationship of caring and control in psychiatric nursing practice in this setting. The objective of this study was to generate "thick description" (Geertz, 1973) of the cultural knowledge patients and nurses used to organise their behaviour and interpret their experience in an acute psychiatric unit, and to delineate the implications of this knowledge for providers and planners of mental health services.

Overview of the study

In chapter one, the sociopolitical context of change within which the study took place is outlined, and an historical overview of the development of mental health and illness services, and of the educational preparation of psychiatric nurses in New Zealand is provided. This background information enables interpretation of the study findings within the broader context of change in both mental health and illness services, and the education and deployment of psychiatric nurses in New Zealand.

In chapter two, what little New Zealand literature on psychiatric services that exists is reviewed, then literature from other countries on general hospital based psychiatric units is examined. The literature on social control as it relates to psychiatry and psychiatric nursing practice is drawn together, along with the nursing literature on caring, in order to identify existing research on caring and control in the field of psychiatry and psychiatric nursing practice. Research methods used in the study are discussed in chapter three.

Chapters four, five and six are data chapters in which the findings as to "what goes on" in the study setting (chapter 4), "why things are the way they are" (chapter 5), and issues of control arising within an open ward environment (chapter 6), are presented. In chapter seven the findings presented in the previous three chapters are compared with the literature on caring and control in order to examine the "fit" between the findings and the literature, and to generate models of caring and control in context. The implications of the findings both for nursing practice and for service development are discussed, and areas for further research identified. A detailed summary of the study is presented in chapter eight.

I

BACKGROUND TO THE STUDY

The context of change

This study was initiated at a time of major changes in the way public services in New Zealand such as health, education and welfare, traditionally controlled by government departments, were structured and funded. The bases of the changes are political and economic, and the consequences of the changes are impacting on people in all strata of New Zealand society. Those people who have least resources with which to buffer the impact of change are most affected. Changes in the organisation of health care in New Zealand have been ongoing since the mid 1970s, however over the past five years the rate of change has escalated such that new organisational structures for one reform are barely in place before another, sometimes contradictory, structural change is initiated by central government. These changes are occurring within an economic climate of recession and fiscal constraint.

The Government White Paper *A Health Service for New Zealand* (1974) proposed the establishment of 14 Regional Health Authorities to replace the 29 Hospital Boards which provided public hospital services at that time. These Regional Health Authorities would each be responsible for the provision of a comprehensive health service, including primary care, specialist and community services, for their region. A change of government in 1975 meant that this document was officially set aside as a basis for change, however many of the changes which have been instigated in subsequent years can be traced back to their origins in this White Paper.

In the following decade, changes in the organisation of health care evolved in a somewhat orderly fashion, with much use of the consultative process, wherein

input was sought from a wide range of organisations and individuals with an interest in health care. In particular, the work of the Special Advisory Committee on Health Services Organisation (SACHSO), a committee set up by central government in 1976, was instrumental in reshaping NZ health services (Department of Health, 1982). SACHSO's proposals for Area Health Boards (with a mandate similar to that outlined for Regional Health Authorities in the 1974 White Paper) were piloted in two regions, prior to the passing of the Area Health Boards Act (1983). The primary objectives of the Area Health Boards were to promote, protect and conserve the public health, and to provide health services; to provide for the effective coordination of the planning, provision, and evaluation of health services between the public, private, and voluntary sectors; and to establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education, and treatment services (NZ Government, 1983).

The transition from Hospital Boards to Area Health Boards was initially planned to take place without compulsion by central government. However the establishment of an Area Health Board in most instances required the amalgamation of existing Hospital Boards. There was considerable local resistance to this idea in the majority of smaller Hospital Board areas. Impatient with the slow progress in this direction, the government of the day passed further legislation in 1988 to force the implementation of 14 Area Health Boards across New Zealand by the end of 1989. This process included the forced amalgamation of existing smaller Area Health Boards into larger Board areas.

The pace of change in health care organisation accelerated from this time period, with increasing use of legislation to achieve change, rather than the consultative process which had predominated in the previous decade. Thus at the time of initiation of this study, the focus of Area Health Boards was on reorganisation, and

the establishment of new management structures to enable Boards to meet the performance contracts required for funding by central government.

A change in government in 1990 resulted in the instigation of changes which cut across these newly established Area Health Board structures. Thus at the end of the study, the newly established system of Area Health Boards was again to be restructured to enable a split between purchaser and provider of services. Four Regional Health Authorities for the whole of New Zealand will allocate health care funds for primary care, acute care services and continuing care services (Upton, 1991). The public, private and voluntary sectors must compete for contracts to provide these personal health services. A Public Health Commission will allocate funding for public health services.

Mental health and illness services in New Zealand which, at the time of the study, were provided by Area Health Boards, are undergoing extensive changes as a consequence of these developments in the wider health care system. Prior to a discussion of these changes, a brief historical overview of the development of mental health and illness services will be provided, in order to place current changes in the context of the development of existing psychiatric services.

The development of psychiatric services in New Zealand

European settlement of New Zealand in the early 1800s coincided with the era of the asylum movement. Sociologists such as Davis and Anderson (1983) have linked the development of asylums in western Europe to a need to achieve more order and rationality in society. This need developed in the context of increasing movement of people from the countryside to the city, and of work from the household to the factory, and also the declining influence of the church. Institutions, be they workhouses, hospitals, gaols (jails), or asylums, absorbed those who were unwilling or unable to work (Dingwall, Rafferty & Webster,

1988). However in the early years of the establishment of the colony of New Zealand, the factors influencing disorder were somewhat different from those affecting Britain, the United States, Germany and other western societies that experienced rapid industrial and urban change during the 19th century. Historical research by Fairburn and Haslett (1988) suggested that violence and other disorder in New Zealand reached "astronomical" proportions from the 1850s to the 1880s, occurring at rates much higher than those prevailing today; and that these trends could be attributed to the lack of informal mechanisms of control and mediation in New Zealand, in comparison with the well established mechanisms in other societies.

Williams (1987) clearly documented the history of the care and control of "lunatics" in the early years of the establishment of the colony of New Zealand. She reported that in the 1840s:

> Those who were considered to be socially undesirable were sent to the gaols [jails][1] for safe keeping. These included deserters, convicts, delinquents, waifs and strays, prostitutes, debtors, drunkards and vagabonds as well as lunatics. Lunatics were sent to the gaol because they upset the peace. Mentally ill behaviour was seen as a law and order problem and was dealt with accordingly...(p.3)

The Lunatics Ordinance, 1846, provided for the certification of lunatics and their admission to a gaol, public hospital or public colonial asylum. A network of eight provincial lunatic asylums was established in the period 1854-1872. The parallels between the developments in asylum care in New Zealand and in other countries such as Britain and the USA, are striking. Initially numbers in these institutions were small, the asylums under lay, not medical, control, and the treatment one of moral management and non restraint. However the asylums rapidly became overcrowded as the asylum administration had no control over admissions, being required to accept all persons who were committed there regardless of issues of space, staffing and other resources. The care reverted to custodial care with

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[1] In this thesis, explanatory material not in the original quotation is identified by its inclusion within squared parentheses.

increasing use of physical restraints. Public dissatisfaction was expressed with the failure of the asylums to cure lunatics, and the medical profession used this dissatisfaction as a rationale to acquire medical control of asylums, although the only known interventions were based on moral not medical treatments (Williams, 1987).

The provincial governments were abolished in 1876, and while general hospitals and charitable institutions passed to local control with local funding, asylums came under central control with the formation of a Lunacy Department as a department of state (Williams, 1987, p.28). Abbott (1988) quoted an early Inspector General of Lunatic Asylums who attributed the rapid increase in the asylum population from 1876 to "the strong tendency which has arisen to throw every case that can be brought within the general definition of insanity off the local rates on to the general taxation of the colony". There was a steady rise in the psychiatric hospital population from 193 per 100,000 population in 1876 to a peak of 499 per 100,000 population in 1944 (National Health Statistics Centre, 1987).

Mental health legislation

New Zealand mental health legislation draws heavily upon overseas legislation. The original Lunatics Ordinance was copied from New South Wales (Australia) legislation of 1843, while the major revision in 1868 drew heavily upon English lunacy law of 1845-62 (Brunton, 1985). It has been suggested that "the NZ Lunatics Act 1868 remains the foundation of our present law because of its comprehensive approach to the subject", and thus the present Act (1969) "remains fixed in the concepts, principles, assumptions and procedures of early Victorian Britain" (Brunton, 1985, p.50). The 1969 Act has been under review since 1983, and the new Mental Health Bill has been before Parliament since late 1987. It finally became law in June 1992, and the new Act will come into effect on 1 November 1992.

From separation to integration of psychiatric services

The separatist approach to psychiatric services was based on the assumption that "mental illness was a separate social problem for which special and total care institutions as well as separate law were needed." (Brunton, 1985, p.56). The current legacy of this policy is a network of nine public psychiatric hospitals, one private psychiatric hospital and four public hospitals for the intellectually handicapped. The majority of these hospitals remain geographically isolated, consistent with the "out of sight, out of mind" attitude to the mentally ill and intellectually handicapped which predominated when these institutions were built. The population of the nine public psychiatric hospitals includes large numbers of intellectually handicapped and psychogeriatric residents as well as psychiatric patients, as illustrated in Table 1.1.

The 1969 Mental Health Act made provision for the transfer of these psychiatric hospitals and hospitals for the intellectually handicapped from central government to local Hospital Board (now Area Health Board) control. This Act also recognised the provision of acute psychiatric units on general hospital sites. Such units began to be established in the late 1960s. In 1972 administrative responsibility for the psychiatric hospitals and for psychiatric units on general hospital sites, was transferred from the Department of Health to local Hospital Boards. One exception to this transfer was Lake Alice hospital which housed the National Secure (forensic) Unit. This hospital continued to be administered by the Health Department until 1986, when control was transferred to the Wanganui Area Health Board (now the Manawatu-Wanganui Area Health Board).

In 1991 there were 18 psychiatric units on general (public) hospital sites, with more planned in the Auckland region as part of the establishment of sector-based services. Figure 1.1 illustrates the location of psychiatric hospitals, intellectual handicap hospitals, and general hospital based psychiatric units at that time period.

Hospitals	Quarter ending 31 March 1991								1990 (quarter ending 31 March)	
	Psychiatric		Psychogeriatric		Intellectually Handicapped		Subtotal			
	beds	occ	beds	occ	beds	occ	beds	occ	bed	occ
Carrington (Auckland)	168	146.1	46	45.7	-	-	214	191.8	292	237.7
Kingseat (Auckland)	226	145.8	74	70.2	-	-	300	216.0	333	244.5
Mangere (Auckland)	-	-	-	-	335	297.0	335	297.0	426	307.4
Tokanui (Waikato)	229	173.4	-	-	300	268.6	529	442.0	583	438.3
Lake Alice(Manawatu-Wanganui)	158	129.1	55	44.8	22	19.5	235	193.4	272	189.9
Kimberley(Manawatu-Wanganui)	-	-	-	-	570	480.0	570	480.0	570	493.1
Porirua (Wellington)	456	367.0	277	220.7	66	57.9	799	645.6	808	669.5
Seaview (Westland)	83	59.7	104	78.0	33	25.9	220	163.6	220	180.1
Braemar (Nelson-Marlborough)	-	-	-	-	120	115.2	120	115.2	154	111.6
Ngawhatu (Nelson-Marlborough)	62	48.5	110	93.5	123	108.6	295	250.6	373	301.3
Sunnyside (Canterbury)	289	222.7	107	83.3	34	32.3	430	338.3	524	403.0
Templeton (Canterbury)	-	-	-	-	569	490.2	569	490.2	611	512.9
Cherryfarm (Otago)	116	78.9	113	83.3	178	163.5	407	325.7	431	367.4

Source: Health Statistical Services (1990, 1991) *Patient Throughput Statistics,* Wellington, Department of Health.
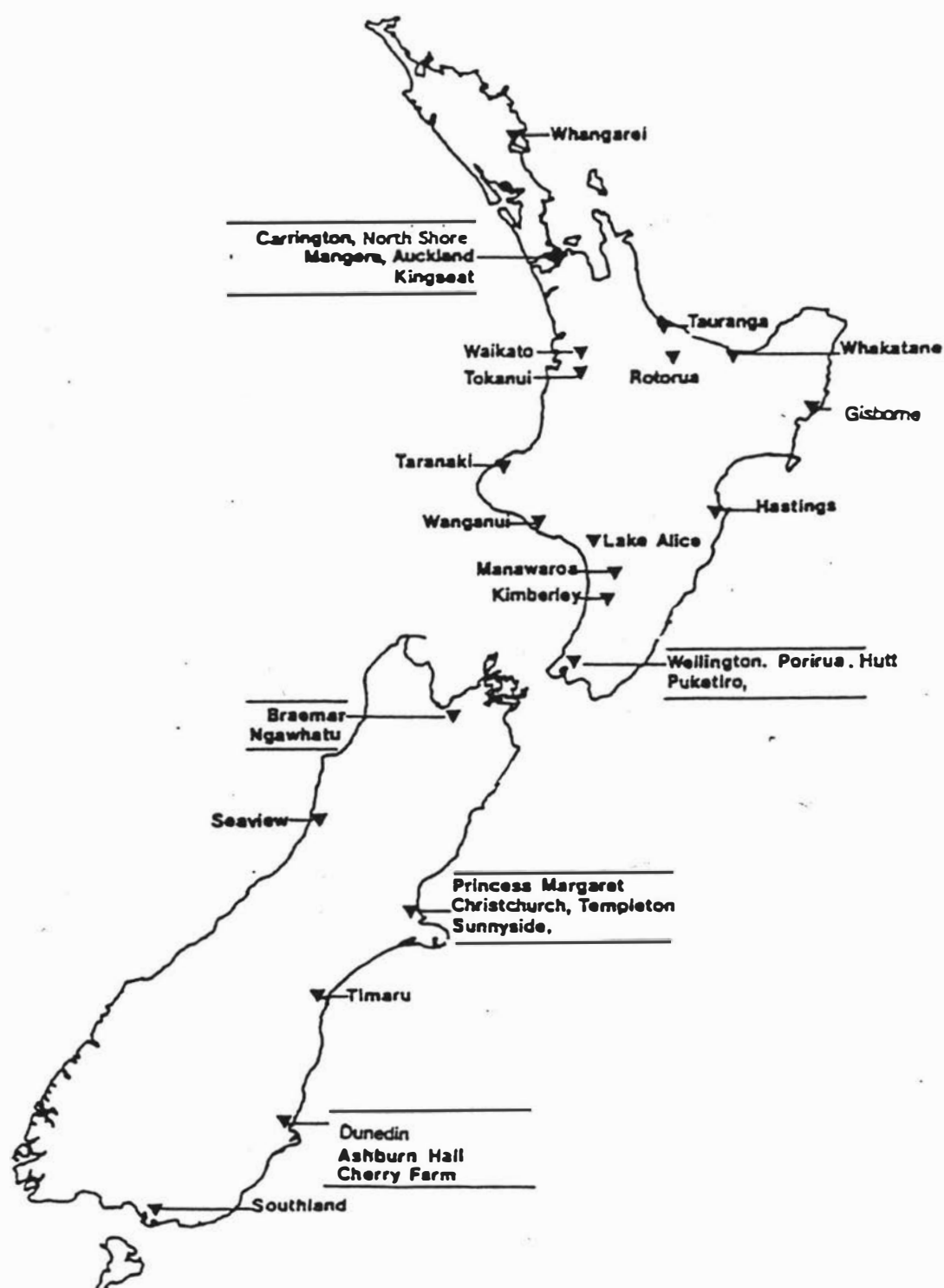
Figure 1.1 Location of psychiatric hospitals, intellectual handicap hospitals and psychiatric units in 1991

The location of psychiatric units is consistent with the distribution of the NZ population. Approximately 75% of the 3.4 million population live in the North island, with 47.5% of the total population living in the northern North island. However the location of the psychiatric hospitals is an historical legacy which does not necessarily reflect population based need. For example, Seaview hospital, which had 220 available beds in 1991, is located on the west coast of the South island which has a population of approximately 35 000. Many of the residents of this hospital were sent there from other parts of the country in earlier times.

At present few of the general hospital based psychiatric units treat committed (formal) patients. Only the Gisborne unit has been gazetted as a psychiatric hospital under the 1969 Act, because of its distance from a psychiatric hospital. However when the new Mental Health (compulsory assessment and treatment) Act comes into effect in November 1992, and many of the psychiatric hospitals are closed, all general hospital inpatient psychiatric units are likely to be required to contain and treat committed patients.

The development of psychiatric nursing

Consistent with the separate approach to the development of psychiatric services in New Zealand, psychiatric nursing developed quite separately from general nursing. Both men and women worked as untrained attendants in the asylums from the early years. The establishment of a Register of Mental Nurses did not occur until 1907. It was not until 1945 that control of the examination for registration was transferred from the Division of Mental Hygiene (formerly the Lunacy Department) to the Nurses and Midwives Registration Board. At the same time the title of mental nurse was changed to psychiatric nurse. In the 1960s three year hospital-based training programs for psychopaedic (intellectual handicap) nursing were established in the four psychopaedic hospitals, with the establishment of a Register of Psychopaedic Nurses in 1963.

The separate hospital-based training programs for psychopaedic nursing registration and psychiatric nursing registration have now been phased out, along with hospital-based training programs for general nurses. These separate programs have been replaced by 3 year polytechnic based educational preparation for nurses, leading to a comprehensive registration. Graduates from such comprehensive programs are expected to have the knowledge and skills to function as beginning practitioners in any field of nursing practice. However the belief is strongly held amongst some staff and administrators of the psychiatric hospitals that the polytechnic based programs for comprehensive nursing registration do not adequately prepare nurses to work as beginning practitioners in the psychiatric field.

The phasing out of these hospital-based nurse training programs has facilitated the employment of an increasingly qualified nursing workforce in all fields of nursing practice. However the psychiatric hospitals traditionally employed untrained psychiatric assistants to work under the supervision of registered psychiatric nurses. Many of these psychiatric assistants have subsequently been encouraged by their employers to undertake hospital-based training as enrolled nurses (a 12 month service based training program). The role and function of the enrolled nurse is presently under review, with some support for phasing out this second tier of qualified nurse, however such a move is likely to be resisted in psychiatric hospitals. Psychiatric hospital staff and administrators have expressed concern that few comprehensive nurse graduates are being attracted to, or retained by the service, and furthermore, that inadequate numbers of male nurses are being prepared in the polytechnic programs. Traditionally there have been large numbers of male psychiatric nurses and psychiatric assistants employed in the psychiatric hospitals in New Zealand. Their presence is perceived by many staff and administrators as necessary to maintain control of potentially violent patients.

The majority of nurses employed in psychiatric hospitals work a different roster system (4 days on duty, 2 days off, and rotation through all shifts) to nurses employed in general hospitals (who predominantly work 5 days with 2 days off and may work permanent shifts), and are represented by a different union. Thus the separatist philosophy has been maintained. In contrast, the nursing staff of general hospital based psychiatric units tend to have similar conditions of employment to those of nurses employed within the general hospital service.

Changes in the organisation of mental health services

As previously stated, the prevailing trends are toward community based care of psychiatric patients. As outlined in the following sections, dissatisfaction with care provided in psychiatric hospitals as evidenced by repeated Commissions of Inquiry, international trends toward deinstitutionalisation, and the cost of maintaining and staffing psychiatric hospitals with consequent inadequate funding for community services, have contributed to political and professional support for moves toward community based care for psychiatric patients.

Reviews of psychiatric services

There has been a series of Commissions of Inquiry and other Department of Health reviews of the services provided by the psychiatric hospitals. A number of Commissions of Inquiry were instigated in response to specific problems or incidents which were publicised by the media. Many of the reviews focussed on the psychiatric hospitals in the Auckland region (for example, the Hutchinson Report, 1971; and the Gallen Report, 1983), where there has been a higher media profile on psychiatric care.

In 1984 a review of all psychiatric hospitals and hospitals for the intellectually handicapped was instigated by the Department of Health. This review resulted in a publication by Dowland and McKinlay (1985) of *Caring, Curing, Controlling:*

an outsiders look at life and work in New Zealand psychiatric hospitals; and by the Department of Health (1986) of a *Review of Psychiatric Hospitals and Hospitals for the Intellectually Handicapped*. The latter review was very critical of existing services. A wide range of problems were identified, including the lack of philosophy and objectives at hospital and ward level; the heterogeneity of the patient population, including significant numbers who did not need full hospital treatment; the lack of continuity of care due to rapid rotation of nursing staff; an over reliance on medication unsupported by a psychotherapeutic approach; and a forced fall back on techniques such as seclusion and isolation in the absence of staff able to provide intensive care to the more seriously ill. The findings of the former report by Dowland and McKinlay (1985) are addressed in chapter 2 (p.25, 33). One outcome of this review process was the development of national guidelines for service development of a comprehensive mental health service (Department of Health, 1989, 1991).

The most recent Commission of Inquiry examined problems around the interface of psychiatric services and the justice system in the Auckland region where, since the closure in 1987 of Oakley hospital (which had served predominantly as a forensic hospital), the psychiatric hospitals stated they had no secure facilities for psychiatrically disturbed prisoners and therefore refused to admit them. The findings of the inquiry were outlined in the *Report of the committee of inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients*, hereafter referred to as the Mason Report (1988). One outcome of this report was the provision of government funding for the establishment in 1990-91 of seven regional medium secure units, and the development of plans for an integrated forensic service.

Increased attention to bicultural issues in the provision of psychiatric services

Indigenous Maori people account for 12% of the total New Zealand population, however Maori are over-represented in most New Zealand institutions with the exception of private schools and hospitals, and institutions for the elderly (Social Monitoring Group,1987). Over the past decade there has been increased attention to bicultural issues throughout all aspects of NZ society including the provision of psychiatric services. The report of a Commission of Inquiry into procedures at Oakley Hospital, instigated after the death of a Maori patient following the administration of ECT, commented on the high proportion of patients at that hospital who were of "Polynesian background" (Gallen Report, p.115). The special cultural needs of Maori patients were highlighted and it was recommended that these needs be addressed within psychiatric treatment and in the area of penal reform. Oakley hospital served largely as a forensic hospital, and Maori people are overrepresented amongst committed and special[2] populations of psychiatric patients. For example, in 1986 Maori accounted for 31% and 67% of total remand[3] and special patients respectively (Mason Report, 1988, p.191).

The need for changes in the provision of psychiatric services for Maori was identified by Maori people and reiterated at a number of Hui[4] focusing on Maori health which were held during the mid 1980s. The issue was again highlighted in the Mason Report (1988) which recommended the development of an "integrated, bicultural psychiatric service" (p.178). This recommendation has been adopted by the Department of Health and is reflected in separate Tangata Whenua[5] Reports within recent publications (*National Mental Health Consortium*, 1989; *Quality Assurance in Mental Health Services*, 1991). A number of Area Health Boards

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[2] Special patients are persons admitted to a psychiatric hospital from a penal institution because they are in need of psychiatric care and treatment.

[3] Remand patients are sent to a psychiatric hospital from a penal institution for assessment of a mental disorder prior to sentencing by the Court.

[4] Formal meetings which provide a forum for discussion, consultation, and decisionmaking for Maori people.

[5] People of the land, indigenous people

have developed Bicultural Units within their inpatient services and have appointed Maori psychiatric liaison workers.

Plans for closure of psychiatric hospitals

Several Area Health Boards have put forward proposals to close the psychiatric hospitals within their region. For example, within the Auckland region Oakley Hospital was closed in 1987, and Raventhorpe Hospital in 1988. In its 1990 strategic plan the Auckland Area Health Board indicated its intention to close both remaining psychiatric institutions (Carrington and Kingseat) within a period of five years. Only specialist forensic services would remain on these sites. New acute units are being set up on existing general hospital sites in the Auckland region to meet the needs for acute psychiatric services on a sector basis. In 1989 the Wellington Area Health Board proposed closing the psychiatric hospital in its region (Porirua) as a cost cutting measure, although these plans appear to have been shelved. The Manawatu-Wanganui Area Health Board in 1991 announced its intention to close the only psychiatric hospital within its region (Lake Alice) within a period of three years, and to review the ongoing requirement for the National Secure Unit for NZ forensic services which is located on this site. Similarly, the Otago Area Health Board plans to close Cherry Farm hospital.

These moves toward deinstitutionalisation are consistent with the prevailing political, economic and professional trends toward community based care of psychiatric patients. However the implementation of these proposals at a time of severe financial constraint in the health services, evokes the fears of both professionals and the community about the availability of community resources for the care of the seriously mentally ill. Such fears are well grounded, given reports of the North American experience where deinstitutionalisation of resources did not follow the deinstitutionalisation of patients (Talbott & Lamb, 1987). The

chronically mentally ill were discharged to communities, but not necessarily integrated into a community based system of care (McCausland, 1987).

In New Zealand deinstitutionalisation is not a recent phenomenon. The rate of psychiatric hospital patients per 100,000 population peaked at 499 in 1944, and there has been a steady decline in this rate since that time period. In 1984 there was on average slightly less than 200 residents per 100,000 population in NZ psychiatric hospitals; a rate which matched that reported in 1876 (National Health Statistics Centre, 1987). Thus the process of deinstitutionalisation began as early as the mid 1940s. Large numbers of patients have already been moved into the community without the provision of adequate community support. The concerns of health professionals were acknowledged in the Department of Health (1986) *Review of Psychiatric Hospitals and Hospitals for the Intellectually Handicapped [NZ]* where the review team reported "...there is some resistance [by hospitals and staff] to pursuing a policy [deinstitutionalisation] which in the absence of resources, and allocated responsibility and accountability leads less to community care than community neglect."(p.9)

Nevertheless, the "down-sizing" of most psychiatric and intellectual handicap hospitals is in process, as is illustrated in Table 1.1. A comparison of the available beds at 31 March 1990 and 31 March 1991 reflects this process. The reclassification of the residents of psychiatric hospitals into psychiatric, psychogeriatric or intellectual handicap patients paved the way for plans to create an age related service for the elderly in some Area Health Boards, and to move geriatric and psychogeriatric care to the private sector. Similar plans are in process to move care of the intellectually handicapped to the private sector. This would include existing voluntary organisations such as the Intellectual Handicapped Society which already manages group homes, hostels and sheltered workshops for this population. The transfer of psychogeriatric and intellectual handicap residents

to other services in the private sector facilitates closure of the psychiatric hospitals which are uneconomic to maintain for the smaller numbers of psychiatric patients.

Funding for community based mental health services

In August 1990, a national policy on mental health services was announced. This included a list of principles and objectives to be followed by Area Health Boards in developing comprehensive, community based mental health services. A $50 million fund additional to existing Area Health Board funding was allocated to (in the words of the Minister of Health), "kick start" mental health service development and "tackle head-on the legacy of decades of neglect". This fund was to be allocated to boards on a population basis over a two year period. However the subsequent change of government in November 1990 resulted in the funds being "frozen". Following extensive negotiation, agreement was reached between central government and the Area Health Boards to release one year's funding of the original package. This loss of the second year of supplementary funding for fundamental changes in the delivery of mental health services occurred at the same time as cuts were made to welfare benefits, to public housing, and to health care subsidies.

Closure of the large psychiatric hospitals is seen as necessary by most Area Health Boards, in order to release funding for the development of community services. Yet these hospitals cannot close unless alternative services are in place. At present psychiatric hospitals consume the majority of funds allocated by Area Health Boards for mental health services, yet meet the needs of comparatively few of the population within the boards' regions. For example in the 1990-91 financial year, Carrington and Kingseat hospitals in the Auckland region accounted for 63% of the operating costs of the mental health service (AAHB, 1990). As the process of down-sizing psychiatric institutions continues, there is already a shortage of beds for acutely disturbed psychiatric patients in some regions, particularly in

Auckland. In the absence of adequate bridging finance from central government, fears have been expressed that Area Health Boards may be faced with "refilling our Victorian psychiatric institutions and chopping back fledgling community services or continuing with an underfunded and poorly developed mix of community and hospital services" (Abbott, 1991, p.3). Also evoked are community fears about the dangerousness of psychiatric patients (Mason, 1988, p.138). The urgency with which Government funding and expertise was channelled into the development of new regional forensic psychiatric services in 1990-91, in the absence of funding for other areas of the general health service, suggests recognition at a political level of these fears.

Community attitudes toward psychiatric care

Community attitudes reflect support for continued care and control in rural institutions. There is widespread reluctance amongst people in the community to accept either halfway houses for psychiatric patients, or medium secure units for forensic patients being built in their neighbourhood. The latter was particularly evident in Wanganui during the period of the study. These attitudes are supported by the news media which focuses almost exclusively on negative aspects of psychiatric care, such as the potential dangerousness of psychiatric patients who leave psychiatric institutions without permission, with resulting community pressure for tighter security. Furthermore, rural towns and communities in the vicinity of many of the psychiatric hospitals are economically dependent on the continued existence of these institutions because of the employment opportunities they afford, thus there is local community resistance to Area Health Board plans for closure of rural psychiatric hospitals (for example, Lake Alice hospital). Some authors argue that the prevailing community attitudes toward the mentally ill will work against plans for deinstitutionalisation and community care. "At best, the large institutions might be abandoned and the patients placed in more conveniently located new and smaller institutions" (Green, McCormick, Walkey & Taylor,

1987, p.422). Psychiatric units attached to general hospitals may be used in this way.

Implications for nursing practice of the changes in mental health services

Opportunities for employment of registered psychopaedic nurses in NZ have markedly diminished with the changes taking place in the care of intellectually handicapped persons. These changes include the employment of generic workers rather than psychopaedic nurses, the planned closure of psychopaedic hospitals and the placement of intellectually handicapped residents from these hospitals and the psychiatric hospitals in supervised housing in the community, and the proposed transfer of funds and responsibility for services described earlier.

Observing the impact of these changes on psychopaedic nursing, psychiatric nurses are concerned about loss of job opportunities which are likely to follow the planned closure of psychiatric hospitals. However the establishment of the regional forensic service has created alternative job opportunities, and the 1990 strategic plan of the Auckland Area Health Board (the largest board in NZ) indicated that the proportion of the mental health budget allocated to nursing services would markedly increase following closure of the psychiatric hospitals. Mental health service managers in this and other Boards have identified the need for retraining of psychiatric nurses formerly employed in psychiatric institutions in order to prepare them for more autonomous practice in community settings.

Summary

In the account of the ongoing review of psychiatric/mental health services given above, the omission of any detailed examination of the role and functioning of acute psychiatric units on general hospital sites is apparent. While Dowland and McKinlay (1985) reported visiting some psychiatric units as a part of their review of psychiatric services, their focus remained on the psychiatric hospitals. Little

attention appears to have been given to the implications for the functioning of psychiatric units, and for psychiatric nursing practice, of the proposed changes in mental health services. More attention has been paid to the development of community psychiatric or mental health services (Hall, 1988, Kearns, 1989; National Mental Health Consortium Report, 1989) which are seen as "the lynch pin of all psychiatric services" (Mason, 1988, p.156).

Changes in this country do not take place in isolation from trends occurring in other countries. Moves in New Zealand to close psychiatric hospitals with increased reliance on general hospital inpatient psychiatric units follow trends established in Britain and the USA. Therefore a broad overview of the literature on general hospital based psychiatric units was undertaken to place the present developments in psychiatric services in New Zealand in the context of developments in other countries. This literature, and the literature on caring and control in psychiatry and psychiatric nursing practice, is reported in chapter two.

II

LITERATURE REVIEW

Introduction

In this chapter, the literature on NZ psychiatric services is outlined, then literature from other countries on general hospital psychiatric units is reviewed, in order to identify trends which may have implications for the functioning of New Zealand psychiatric units, and for nurses working in those settings.

As has been illustrated in the previous chapter, issues of care and control are integral to the development of psychiatric services in New Zealand as in other western countries. In this chapter, the concepts of social control and caring are examined, and a review of psychiatric and nursing literature undertaken to explore the application and relationship of these concepts in psychiatric nursing practice.

New Zealand literature on psychiatric services

The literature on psychiatric services in New Zealand is focussed around two main areas, mental health law and the functioning of psychiatric hospitals. Not surprisingly, the length of time the present Act has been under review, and the new Bill has been before Parliament, has allowed ample time for review of existing procedures and debate over the provisions of the new Bill (Dawson & Abbott, 1985; Legal Research Foundation, 1986; Dawson, 1986, 1987). The literature on NZ psychiatric hospitals is largely limited to statistical data, and the reports of Committees of Inquiry and reviews initiated by the Department of Health, as described in the previous chapter. One ethnographic study of social relations in a NZ psychiatric hospital has been reported (Park, 1985), however the fieldwork on which this report was based was undertaken in the mid-1970s.

There is little published literature about general hospital based psychiatric units in New Zealand. Dowland and McKinlay (1985) commented on the favourable levels of staffing of all categories in psychiatric units compared to admission wards of the psychiatric hospitals. They also noted the availability of day programs, the allocation of a primary therapist or nurse to each patient, and the absence of the traditional psychiatric nursing roster in the units they visited. Another study examined organisational factors and perceptions of climate in three NZ psychiatric units. Patients' scores on the ward atmosphere scales were closely associated with their perceptions of staff receptiveness and interest, along with patient involvement in decision making and satisfaction with the degree of patient staff communication (O'Driscoll & Evans, 1988). While the literature on NZ psychiatric units is very limited, there is extensive literature on general hospital psychiatric units in other countries, in particular, the USA.

General hospital psychiatric units: development and trends

The establishment of general hospital psychiatric units in New Zealand followed much earlier developments in the USA. Black and Winokur (1988) outlined the development of such units during the early 20th century. Growth in the number of inpatient units was stimulated by World War II, and by the process of deinstitutionalisation which occurred in the USA from the mid 1950s.

Brown and Cooksey (1989) suggest that general hospital psychiatric units in the USA have become the counterbalancing service to the shrinking state hospital, a process which has facilitated the conversion of excess beds in other services in the general hospital. These changes are mirrored in the changes occurring in the NZ health service, particularly in the Auckland region, where new psychiatric units are planned in general hospitals as part of an over-all rationalisation of general hospital and psychiatric services. In this process, general hospital psychiatric units move from an "adjunctive" to a "pivotal" position in the mental health service

(Richman & Harris, 1985). This move makes possible the planned closure of psychiatric hospitals. Keill (1986) suggested that the widespread change in the USA from the adjunctive to the pivotal mode could be related to the "increased effectiveness and accessibility of general hospital services", and was "an inevitable response to the deinstitutionalisation movement." (p.351)

In the USA general hospitals treat approximately 60% of all patients hospitalised with a primary psychiatric diagnosis (Summergrad, 1991). Such patients are treated both in "scatter beds" on other units, and in discrete psychiatric units. As a comparison, in 1985 NZ psychiatric units treated 34% of all admissions, but 40% of first admissions, with a primary psychiatric diagnosis (National Health Statistics Centre, 1987).

Trends identified in USA general hospital psychiatric units include a rise in the number of inpatient care episodes, and in the percentage of such episodes handled by general hospital psychiatric units rather than state hospitals; shortened length of stay and increased levels of readmissions (Black & Winokur, 1988). General hospital psychiatric units tend to have high occupancy rates and the average length of stay is reported to have fallen from 20 days in 1963 to 11 days in 1982 (Frank & Lave, 1985; Black & Winokur, 1988). In comparison, the average length of stay for NZ psychiatric units (excluding one unit for children) was 24.6 days in 1985, and 25.4 in 1987 (National Health Statistics Centre, 1987, 1989). Of note was the variation in average stay between NZ psychiatric units; a range from 17-51 days was reported in 1985, and 15-39 days in 1987.

The focus on brief hospitalisation in the USA is influenced by the limitations on psychiatric hospitalisation enforced by private and federal insurance policies, a situation which does not yet exist in New Zealand. However brief hospitalisation has been demonstrated to be effective. For example, Schwarz and Vallance (1987)

reported a comparative study of 108 patients admitted to a 10 bed short stay unit and 136 patients admitted to three 20 bed teaching units in a three month period. The mean length of stay was 6.15 days for the short stay unit patients, and 29.14 days for the teaching units. In an 18 month follow up period 25% of the short stay unit patients and 32% of the teaching unit patients were readmitted to the original, or another psychiatric unit or hospital. When the first admission was to the short stay unit, readmissions to other hospitals tended to be shorter. These findings are in contrast to earlier studies which linked shorter stays with increased readmission rates (Davis, Butts & Lindo, 1972). It has been suggested that shorter hospital stays tend to decrease the infectious spread of acting-out behaviour and to promote a norm against violence (Keill, 1986), as maximum patient responsibility is encouraged (Schwarz & Vallance, 1987).

Readmissions and the revolving door syndrome

One reported outcome of the process of deinstitutionalisation in the USA has been increased rates of readmission to state and county mental hospitals. Readmissions as a proportion of all admissions were reported to have increased from 47.1% in 1969 to 60.3% in 1975 (Weinstein, 1983). A Canadian study which followed a cohort of 747 patients discharged from 12 psychiatric units in four different hospitals (including two general hospitals) in Metropolitan Toronto, reported a readmission rate of 33% within six months and 62% within two years (Wasylenki, Goering, Lancee, Fischer & Freeman, 1985). Weinstein (1983) reanalysed admission data for New York state, in which the percentage of readmissions increased from 35% in the mid-1960s to 67% in 1980. He found that most of the rise in the readmission percentage in New York state mental health facilities was due to a drop in first admissions. The apparent increase in the numbers of readmissions was accounted for by several statistical artifacts, including an improved ability to identify individuals as previous patients, and separate classification of patients returning from "convalescent care". When rates were

adjusted to include the latter group, there was no appreciable increase in the rate of patients' rehospitalisation within given periods of time after their release.

From NZ mental health data for 1985 it is possible to calculate that 28% of all admissions to psychiatric hospitals were first admissions, with 72% being readmissions (including replacements from leave of formal patients). In comparison, 36% of all admissions to psychiatric units were first admissions, with 64% being readmissions. However there is no information as to the time-frame of such readmissions.

There is limited information on readmission rates in general hospital psychiatric units in other countries. However the rate appears substantially lower than those outlined above for state psychiatric hospitals in the USA, and for NZ psychiatric hospitals and psychiatric units. A Dutch study found a readmission rate of 38% in a one year follow up of a cohort of 795 patients discharged from either a general hospital psychiatric unit, mental hospital or addiction services between 1974 and 1978 (ten Horn, 1984). Black and Winokur (USA, 1988) reported 1982 data for a 58 bed facility with two closed adult inpatient units as having an average stay of 23.5 days and a readmission rate of 30.9%. A Canadian study focussed on the readmission of psychotic patients to 75 psychiatric beds and 20 forensic beds in a general hospital. In a cohort of 150 patients there was a readmission rate of 35% in a two year period (Pablo, Kadlec & Arboleda-Florez, 1986). However few of the patients in the latter study fitted the "revolving door" description. Only eight of the 150 patients had three or more admissions in the two year period which followed the first readmission.

Reasons cited in the literature for the prevalence of readmissions included noncompliance with medication and after care (Green, 1988), the quality or type of after care and community services (Schanding, Siomopoulos, Godbole & Smith,

1984; Wasylenki, Goering, Lancee, Fischer & Freeman, 1985; Johnson, 1987), and diagnosis and treatment history (Pokorny, Kaplan, & Lorimor, 1983). A range of community based interventions has been described to lower rates of readmission. These include intensive case management for the seriously mentally ill (Degen, Cole, Tamayo, & Dzerovych, 1990), the provision of continuity of care (Harris & Bergman, 1988), social network interventions (Harris & Bergman, 1985) and work readiness and life skills programs taught by community organisations (Mauras-Corsino, Daniewicz & Swan, 1985).

Heterogeneity of the patient population

Another outcome of deinstitutionalisation is the increased heterogeneity of the patient population. There are marked differences between the institutionalised chronic psychiatrically disabled patients who once populated psychiatric hospitals, and the young adult chronic patients who have never been institutionalised, but who make heavy demands on psychiatric services. There is a growing body of literature on the latter group who are described as geographically mobile, use services in a revolving door manner and exhibit "active and aggressive, but ambivalent, patterns of service demand on a system that, preoccupied with its own changes, has not found a place for them." (Bachrach, 1984, p.383). It is reported that many traditional after care services have been developed to meet the needs of formerly institutionalised patients, rather than the non institutionalised group who fit poorly into traditional service structures and tend to present in acute treatment facilities for crisis or emergency care (Chafetz, 1988).

Another group of patients who are poorly served are patients with a dual diagnosis, for example psychiatrically disturbed, developmentally disabled patients (Marcos, Gil, Vazquez, 1986). Where once these patients would have been placed in psychiatric hospitals, deinstitutionalisation, and the separation of developmentally disabled services from those of psychiatric services has resulted in considerable

problems in locating appropriate care. Such patients may be refused placement in both psychiatric and developmentally disabled services. Patients with both psychiatric and physical illness have been better served in some areas in the USA by the establishment of medical-psychiatric units.

Innovations in the organisation of care

Efforts have been made to restructure treatment programs and systems of psychiatric inpatient care in both general and psychiatric hospitals to respond to the trends identified above. Changes in acuity and length of stay of inpatients, and the increasing diversity in the patient population have required adaptation of treatment modes. The psychiatric nursing literature demonstrates nurses' responses to these changes. Models of nursing care for short term hospitalisation (Nix & Dillon, 1986; Carr, Farran & Maxson, 1988; Farran, Carr and Maxson, 1988), and milieu-oriented management strategies for chronically mentally ill patients on acute care units (Kahn & Fredrick, 1988) have been developed; alternative techniques such as behaviour modification (Stokes & Keen, 1987), or new roles for nurses such as case managers (Mound, Gyulay, Khan, & Goering, 1991), or in working with particular client populations (Chafetz, 1988; Johnson & Silver, 1988; Puskar, McAdam, Burkhart-Morgan, Isadore, Grimenstein, Wilson, & Jarrett, 1990; Drew, 1991) have been proposed. Regular scheduling of "respite care" for chronically psychiatrically disabled patients who live with a family member has been explored as a way to reduce acute readmissions (Geiser, Hoche & King, 1988). Much of the nursing literature reported above reflects nurses' responses to practice issues related to the trends identified earlier in this chapter, and is predominantly descriptive of practice, rather than research based.

One qualitative study was reported by nurses (Farran, Carr, & Maxson, 1988). Interviews were conducted with ten psychiatric inpatients, the primary nurses and physicians responsible for their care, and the patients' families, to explore goal-

related behaviours in short term psychiatric hospitalisation. Grounded theory methods were used to analyse the data. The authors found that nurses and physicians often did not clearly communicate their goals to patients; that patient and/or family goals were often inferred by staff from what was said, from behaviour or symptoms without clarification with patients or family members; and that family members expected that the patient would have intensive psychotherapy whereas the focus of short-term hospitalisation was on diagnosis and medication management. Nurses, physicians, patients and families all reported that relationships were the most beneficial aspect of hospitalisation.

The medical-psychiatric literature, which includes articles written by nurses, predominantly focuses on structural changes in the provision of the service to respond to the trends previously outlined; although literature reporting alternative treatment strategies for particular settings or patient groups is also included. Studies have explored the impact of establishing a psychiatric emergency service treatment unit on the subsequent utilisation of inpatient resources (Kaskey & Ianzito, 1984; Gillig et al, 1989). Psychiatric intensive care units have been established to enable constant observation in a safe secure quiet environment for the most acutely disturbed patients (Warneke, 1986, 1989; Birnie & Matsuno, 1988; Musisi, Wasylenki & Rapp, 1989). Psychiatric short stay units have been developed (Schwarz, 1988), and a Day Hospital-Inn Program (coupled with an intensive care unit) established as an alternative to inpatient care (Gudeman, Dickey, Evans, & Shore, 1985). This literature is descriptive and focussed toward evaluation; statistical data is used to evaluate the effectiveness of innovative modes of care delivery in terms of variables such as rate of hospitalisation, length of stay, dosage of medication, rates of seclusion and restraint, and readmission rates.

One British study compared single ward (continuous-care) and two-ward (acute admission and continuing-care) systems of organising inpatient care in a general

hospital psychiatric unit (Long, Blackwell & Midgley, 1990). The continuous care ward was associated with lower levels of behavioural disturbance and shorter admissions, and was preferred by staff, however patients progressing through the two-ward system were less likely to be readmitted within three months. Patient satisfaction was not reported.

An Australian study (Hoult, Rosen & Reynolds, 1984), compared comprehensive community based care including 24 hour crisis service support, with standard hospital care and after care. One hundred and twenty patients presenting for admission to a state psychiatric hospital were randomly allocated to the community treatment or hospital admission groups. During the 12 months of the study, 96% of the hospital (control) group were admitted - 51% more than once. Sixty percent of the community care (experimental) group were not admitted at all, and only 8% were admitted more than once. Control patients spent an average of 53.5 days in hospital, while experimental patients spent an average of 8.4 days. Community care was thus judged to achieve clinically superior outcomes, and was perceived as more helpful by patients and relatives. Indeed the authors hypothesised that "prevention of the first psychiatric admission may well prevent a patient starting on a career and identity as a mental hospital patient" (pp. 1008-9). This idea is supported by another study which found that prior hospitalisation of non schizophrenic patients markedly increased the likelihood of rehospitalisation (Pokorny, Kaplan, & Lorimor, 1983).

The primary function of inpatient psychiatric units in a changing mental health service has been a matter of debate. One suggestion by some USA authors is that these units change their focus from symptom removal, comprehensive therapy or rehabilitation, toward a consultancy service to the outpatient therapist (Roy-Byrne, Pynoos and Glick, 1986). Such units would provide expanded evaluation and treatment assessment for patients.

Care, cure and control

As earlier stated (pp.2-3), society mandates psychiatric institutions and their staff

to be agents of social control, as well as giving health professionals responsibility

for the care/cure of the seriously mentally ill. The Social Monitoring Group of the

NZ Planning Council, in its 1987 publication, *Care and Control. The role of*

institutions in NZ, acknowledged the dual roles of care and control for all

institutions. Dowland and McKinlay (1985) in their study of New Zealand

psychiatric hospitals, described three coexisting models or frameworks upon

which psychiatric health professionals based their practice - a *custodial-control*

model, a *custodial-caring model* and a *curing model:*

> ...whatever the emphasis of the hospital's overall philosophy, all three models
> of care are reflected to some extent in its services since the task vested in the
> psychiatric hospital by the community involves all three. Our psychiatric
> hospitals are charged with containing the behaviour of those thought to be
> dangerous, giving care and protection to those unable to care for themselves
> and offering the possibility of cure to the mentally ill. The programmes in all
> wards reflect aspects of all three models to varying degrees and in different
> combinations, with one model predominating and setting the style of care for
> the programme. (pp.186-7)

The concept of care

As earlier stated (p.3) there is a lack of clarity about the meaning of the term *care*

as it is used in the literature. The mandate to "care" as used by the above authors

refers to *taking care of* people who, at that point in time, are unable to take care of

themselves, or take responsibility for their own actions. Within health services the

term *care* is commonly used in relation to service provision, as in community care,

intensive care unit, continuing care team, safe care unit, and respite care beds, all of

which are designations for parts of a mental health service. Care as used to refer to

service provision (taking care of) can be distinguished from *caring,* a concept

which is variously conceptualised in the nursing literature, and is addressed later in

this chapter (pp.38-40).

Deinstitutionalisation has not altered the mandate for mental health services and

their staff to provide care and control of psychiatric patients. Chronically

psychiatrically disabled patients discharged to the community are "better but not well" (Klerman, 1977). They have limited capacity to lead independent social lives and are poorly integrated into the community. In some areas there has been a community backlash calling for reinstitutionalisation of such patients (Scheper-Hughes & Lovell, 1986). It has been suggested that social control may be a "necessary evil" in community care of chronically psychiatrically disabled patients (Aviram 1990). One example is the practice of outpatient committal, enabling compulsory treatment of mentally ill individuals in the community. The [NZ] Mental Health Act which comes into force on 1 November 1992, makes provision for this practice. Scheid-Cook (1988) identified the ideological contradictions inherent in such a practice which may be seen as giving the mentally ill greater liberty by providing treatment in the community, or as a means of controlling the mentally ill in a community.

The concept of social control

The concept of social control is embedded in the sociological literature on mental illness. Horwitz (1982) used the term to encompass "the entire range of reactions to behaviour that is defined as mental illness and to people who are defined as mentally ill" (p.2). He limited his definition of *therapeutic social control* to psychotherapy described as "the persuasive social control of the personality". This definition stems from dividing styles of social control along two dimensions; whether the control is coercive or persuasive and whether it is directed at changing conduct or the personality. Such a distinction excludes the use of medications, electroconvulsive therapy (ECT), or other measures such as physical restraint or seclusion from the category of therapeutic social control. Horwitz described techniques such as ECT, the forced administration of drugs, operations such as lobotomies and the use of restraints or seclusion as coercive and adjudicatory in style, being focussed on conduct rather than personality. Adjudicatory control, he suggested, encompasses both the repressive and restitutive styles of social control.

The voluntary taking of medication he categorised as fitting within a conciliatory style of social control; that is, when persuasive means are used to secure conformity in conduct. Thus Horwitz applied a very narrow definition of therapeutic social control which excludes many of the interactions around the issues of care and control which occur in the treatment of persons with a serious mental disorder in a psychiatric institution.

In contrast, Black (1984) described four styles of social control: penal (repressive) as seen in criminal law; compensatory (restitutive) found in tort and contract law; therapeutic found in juvenile justice and psychiatric care; and conciliatory as seen in negotiation, mediation and arbitration. The style of social control is identified by "the language and logic by which it responds to deviant behaviour."

> Whereas in the penal style the deviant is regarded as an offender who has violated a prohibition and who should therefore suffer pain, deprivation, or humiliation, in the compensatory style the party in jeopardy becomes a debtor, liable for damages resulting from a failure to fulfil an obligation. In the therapeutic style the deviant is understood as a victim who needs help, and in the conciliatory style, as a disputant in a conflict that needs to be settled.(p.8)

Thus in Black's analysis, the therapeutic style focuses on the person:

> A course of treatment depends on the particular nature of the deviant's condition, not the conduct that is associated with it or the consequences that result from it. In fact the deviant is not viewed as responsible for what happened; it was not chosen; it could not be avoided. When the person has been helped back to normality, the conduct and its consequences will disappear. (p.9)

It has been suggested that "therapeutic control is often associated with the response to the problems of dependents in relationships" (Horwitz, 1990, p.90), a factor which might contribute to the predominance of women patients in therapeutic facilities. This idea is consistent with the analysis of Williamson, Shindul and Evans (1985), who stated that "at its root, social control reflects a tension between the group and the individual, between coercion and self-containment. Not incidentally, social control also reflects unequal power, authority, and ability to influence or define appropriate behaviour." (p.13)

Psychiatry and social control

It has been stated that "Anglo-American psychiatry addresses social behaviour that is deviant and potentially stigmatising" and therefore is said to "uniquely engage in social control" (Fabrega, 1989, p.588). Furthermore, there is overlap between the concerns of psychiatry and those of other regulatory institutions of the state, as evidenced by the problems around the interface of psychiatric services and the justice system in NZ (as outlined on p.16). For these reasons, Fabrega suggests, "the manner in which psychiatry operates is subject to challenge, criticism and controversy" (p.588).

The theoretical bases and practices of psychiatry have been subjected to extensive criticism since the 1960's, both from within the discipline and from without (Goffman, 1961; Szasz 1961, 1970; Laing, 1965, 1967; Laing & Esterson, 1970; Scheff, 1966; Foucault, 1973; Conrad & Schneider, 1980). Psychiatrists have produced counter-arguments in defence of psychiatric practice, for example Roth and Kroll's (1986) book entitled *The Reality of Mental Illness*. The major debate occurs around competing explanations for mental disorder. Traditional psychiatry holds fast to a biomedical illness model in which the locus of the disorder is intrapersonal and the focus is on medical treatment, while opposing critics put forward sociocultural models (labelling theory, the societal reaction model, social construction model) where the locus of the disorder is interpersonal, and psychiatry is viewed as a form of social control.

The issue of low reliability and validity in psychiatric diagnoses has been a more recent focus (Townsend, 1982; Brown, 1990), while other authors have focussed on the impact of acceptance of the label on patient functioning or self perception (Antonio, 1975; Warner, Taylor, Powers & Hyman, 1989; Beiser, Waxler-Morrison, Iacono, Lin, Fleming & Husted, 1987).

Townsend (1982) suggested that "psychiatry is not unique among medical specialities in its performance of social control functions" (p.793). All physicians have a "gate-keeping" function in that they decide what is legitimate illness and what is not; they can expand definitions of illness to include new conditions; they may treat patients against their will (Appelbaum & Roth, 1984). However Townsend suggested that psychiatry is more concerned with social control because "symptoms consist of disruptive behaviour rather than demonstrable organic pathology", "patients tend to resist psychiatric diagnoses more than medical diagnoses" and "mental patients' symptoms can be suppressed involuntarily" (p.793). Over the past decade psychiatry has moved more strongly toward a biological view of mental illness, asserting its identity in medicine (Summergrad, 1991) rather than social control.

Nursing and social control

A computer-based search of the nursing literature focussed on psychiatric nursing and social control failed to locate any articles of significance except those addressing the concept of "least restrictiveness" (Garritson, 1983, 1987; Garritson & Davis, 1983). The literature on violence and psychiatric nursing includes articles addressing particular control techniques (Morton, 1986; Navis, 1987), or practices such as the use of seclusion or time out (Leopoldt, 1985; Kendrick & Wilber, 1986; Russell, Hodgkinson & Hillis, 1986; Hammill, 1987; Morrison & Le Roux, 1987; Craig, Ray & Hix, 1989). More recently Morrison (1990a, 1990b), has examined the characteristics of violent psychiatric patients, and organisational influences on violent behaviour.

The nursing literature thus reflects the practice focus of nursing. Issues of control in nursing practice are examined in terms of problems encountered in day to day work with patients (eg Hermanstyne, 1984; Swindall & Molnar 1985; Hardin et al, 1985; Aidroos, 1986), and control practices such as the use of seclusion and

restraints are being challenged. However there is a paucity of nursing literature which examines social control in broader terms as a function of nursing, consistent with the analysis of Horwitz (1982, 1990) and Black (1984) outlined earlier (pp.34-35). Dingwall, Rafferty and Webster (1988), in an analysis of the social history of nursing, identified the social control function of nursing:

> In modern societies, medicine and nursing are among the occupations which help define what will be socially accepted as normal experiences of the human body and their permissible expressions in behaviour. They also offer the means for returning the deviant to normality, or at least, limiting the impact of their disorder on others. (p.24)

Wilson (1986) more directly acknowledged the social control function inherent in psychiatric care in her study of Soteria House, an anti-psychiatric community. She described Soteria House as having "a noncontrol system when contrasted with conventional control structures in mental hospitals" however "in doing away with elaborate control arrangements problems of social control are not eliminated" (pp.133-4). Wilson's research investigated how problems of social control were solved in the absence of conventional psychiatric arrangements for social order, a question which has relevance for the present study. The author identified a concept of "presencing" (being physically present with others) as being central to the infracontrol process which operated at Soteria House.

One interpretation of the paucity of literature which addresses social control as a function of nursing could be that this view of nursing is ideologically unacceptable to nurses who view caring as the essence of nursing.

The concept of caring

The nursing literature emphasises the concept of caring rather than curing or controlling as the primary focus of nursing practice (Watson, 1979; Leininger 1980, 1981; Gaut, 1983; Griffen, 1983). Condon (1988) describes caring as a fundamental moral value of the culture of nursing, while Brody (1988) identifies caring as "the central virtue for nursing" (p.87). As Forrest (1989) commented

"caring is inextricably bound to the belief system and practice of nursing" (p.815). Benner and Wrubel (1989) wrote about the "primacy of caring" in all areas of nursing practice, while Krauss (1989) stressed its importance for nurses working with the chronically mentally ill.

Until very recently there has been little critique in the nursing literature of the concept of caring and its centrality in the ideology of nursing. It has been questioned whether caring is a ubiquitous way of being or a concept unique to nursing (Smith, 1990). The existence of an *Interdisciplinary Guide to the Literature for Human Caring* (Smerke, 1989), points to the extent to which this concept is shared between disciplines rather than unique to nursing. There is now a small body of literature which critically examines the existing theory on caring in nursing (Boykin & Schoenhofer, 1990; Morse, Solberg, Neander, Bottorff & Johnson, 1990; Morse, Bottorff, Neander and Solberg, 1991; Bottorff, 1991), however the relationship of caring to control is not addressed.

Five epistemological perspectives of caring have been identified in the nursing literature: caring as a human trait; caring as a moral imperative; caring as an affect; caring as an interpersonal interaction; and caring as an intervention (Morse et al 1990). In the first perspective caring is seen as part of human nature, an essential way of being. Theorists who consider caring to be a moral imperative express concern about "maintaining the dignity and respect of patients as people", while theorists using the third perspective describe caring as an emotion, a "feeling of compassion or empathy for the patient which motivates the nurse to provide care for the patient" (Morse et al, 1991, p.123). When caring is viewed as an interpersonal interaction the focus is on a reciprocal relationship of trust, respect and communication, while the therapeutic intervention in the fifth category is focussed on meeting patient needs regardless of how the nurse feels. These perspectives of caring are not mutually exclusive; in their analysis of differing

nurse authors' perspectives of caring, Morse et al (1991) identified both direct and implied linkages between these categories.

Swanson (1991) described a middle range theory of caring derived from three phenomenological studies in perinatal contexts. She defined caring as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p.162), and outlined five essential caring processes: *knowing* (striving to understand an event as it has meaning in the life of the other); *being with* (being emotionally present to the other); *doing for* (doing for the other as he/she would do for the self if it were at all possible; *enabling* (facilitating the other's passage through life transitions and unfamiliar events; and *maintaining belief* (sustaining faith in the other's capacity to get through an event or transition and face a future with meaning). The definition outlined above is consistent with a perspective of caring as an interpersonal interaction, however the caring processes Swanson describes are consistent also with a perspective of caring as a therapeutic intervention, as defined by Morse et al (1991).

Necessary conditions for caring

Kahn and Steeves (1988) explored the meaning of the caring relationship for nurses. Nurses in this study saw caring as "essential to the identity of the nurse" (p.205). Caring required viewing persons as unique individuals, compassion and empathy. Caring relationships were believed to be therapeutic. However while the majority of nurse informants in the study believed caring should be unconditional, they described necessary conditions for caring. "Caring depends on having enough time, getting along with each other, not having too many demands" (p.213). It was reported that nurses in this study found it easier to care for patients whom they liked, and indicated that "those patients who made it easier for them to do the caring activities, to engage in praxis, more readily elicited caring" (p.214). This finding is consistent with that of May and Kelly (1982) in an earlier study

which explored the relationship between psychiatric nurses and "problem" patients. The authors found that "what is critical in determining nurses' categorisation of some patients as 'problems' is not so much the level or nature of patients' demands ... but rather the patient's willingness to legitimate the nurses' therapeutic aspirations" (p.279). Thus while nurses may feel a moral obligation to care, other factors may intervene, resulting in ideological conflict for nurses (Kahn & Steeves, 1988; Lützén, 1990), and noncaring experiences for patients.

Patients' perceptions of noncaring

Rieman (1986) reported results of a phenomenological study of ten patients' descriptions of nurse patient interactions. When asked to describe a caring and a noncaring interaction with a nurse, the patients consistently and immediately described the noncaring interaction first. Nurses' behaviours which the patients perceived as noncaring included being in a hurry and efficient, being there to "do a job", being rough and belittling patients, not responding, and treating patients as objects. Rieman suggested that as a result of noncaring interactions the patients felt humiliated, frightened and out of control of the situation. The power of these negative feelings contributed to the immediacy of recall of the noncaring interactions.

The relationship of caring and control

The relationship of caring and control is unclear. While the relationship of care and cure in medicine and nursing has been addressed (Gadow, 1985, Stevens Barnum, 1990, Jecker & Self, 1991), caring and control are addressed as separate concepts in the literature. They may be viewed as dichotomous activities (as for example, Watson, 1991); certainly caring is more positively valued than controlling in the nursing literature. However, controlling patients or situations which are "out of control" is integral to psychiatric nursing practice, and in such situations,

interventions to control "out of control" behaviour may be viewed as a form of caring.

The impact of the context on caring and controlling behaviours

The impact of the context on caring and controlling behaviours has also received little attention in the literature, although Gouse (1984) reported a study which demonstrated the effects of organisational stress on inpatient psychiatric medication patterns. Greenleaf (1991) examined the impact of the context on caring and not caring, and suggested that caring is influenced by the social context in two ways; firstly, by the expectation that caring acts will occur within that context, and secondly by the resources brought to support such acts. A recent qualitative study of caring by Euswas (1991) identified six factors which were described as "care inhibiting"; these included a heavy workload, limited collegial collaboration, knowledge gaps and inadequacies related to caring practice, limited autonomy, limited facilities, and everyday work stress (p.199).

As previously stated (p.3), little is known of the culture of general hospital based psychiatric units, and the impact of the unit subculture on patient care. There has been a series of studies of psychiatric hospitals as total institutions (eg. Goffman, 1961; Stanton & Schwartz, 1954; Rosenhan, 1973); in NZ the work of Park (1985) and Dowland and McKinlay (1985) followed in this ethnographic tradition. However the majority of the research based literature reviewed on the functioning of general hospital based psychiatric units has used quantitative research methods to examine trends such as length of stay, or rates of readmission.

Two recent qualitative studies of locked psychiatric units in public general hospital settings in the USA have been reported by nurses (Morrison, 1990a, 1990b; Kavanagh, 1988, 1991). In both of these settings there were multiple units (3 or 4)

on the one site; and much of the care was provided by psychiatric technicians and other "nonprofessional staff". The patient population in the three 20 bed units studied by Kavanagh was reported to be mostly male and acutely disturbed. Many of the patients were homeless or medically indigent, with a high percentage reported to be members of minority ethnic groups. Fifty percent had histories of violence associated with their admissions. Despite the acuity of illness in this population, the average length of stay was 9 days. In this setting, institutionalised sexism and racism were reported to impact on issues of caring and control (Kavanagh, 1988).

In the three 20 bed units studied by Morrison, one third of all admissions were involuntary; the majority of patients had diagnoses of schizophrenia, manic depression, personality disorder or substance abuse. Morrison (1990b) described a "tradition of toughness" with a dominant medical ideology which placed values on control and safety within the settings in which she observed. Unit norms were described as "the need for physical restraint" (rather than using verbal therapeutic techniques to "talk down" potentially violent patients) ; and "its not you we don't trust", (a justification for applying environmental controls to all patients in the unit). Peer pressure was used to socialise new staff into the use of physical methods to control patients, rather than using verbal therapeutic techniques. The primary role of nonprofessional nursing staff was that of "enforcer". Morrison suggested that the emphasis on control could promote violent behaviour in patients through the rigid rule structure and strict adherence to the enforcement role.

Kavanagh (1988, 1991) similarly described an "ethos of control" in the settings in which she observed. However, this study focussed predominantly on the experiences of nurses who worked in these units. These nurses had responsibility for maintaining control in the unit, but little control over their own practice and limited authority in the hierarchical staffing structure of the psychiatric facility.

The outcomes of caring

Much of the literature on caring has focussed on the nurse's rather than the patient's responses. There is little literature on the outcomes for patients of caring and noncaring interactions with nurses. Morse et al (1990) raised the question as to whether some forms of caring can be nontherapeutic. While most nurses unquestioningly accept the focus on caring in their practice, and assume that caring has positive outcomes, behavioural psychologists have suggested that some behaviours by nurses result in the reinforcement of illness behaviours of psychiatric patients.

Sanson-Fisher and Poole (1980) cite four studies which "tend to support the assertion that treatment institutions may be centres in which negative, rather than positive, behaviour is encouraged" (p.145). In their own study of naturally occurring interaction patterns between 20 target psychiatric patients, their peers and staff observed in a short-stay psychiatric unit, Sanson-Fisher and Poole found that "more than half the time that the subjects were observed, they were engaged in solitary activities. Staff interacted with them for 15.9% of the total observation periods and responded with positive attention to both inappropriate and appropriate subject behaviour during 98.1% of that time" (p.156). Thus nurses were viewed as reinforcing illness behaviour.

A more recent study (Positano, Sandford, Elzinga & James, 1990), which evaluated the naturally occurring behaviour of psychiatric patients in an acute psychiatric setting, also found that for much of the time no interactive behaviour was observed to occur, but that much of the behaviour exhibited by patients was socially appropriate. However when social interactions did occur, both fellow patients and staff tended to reinforce appropriate behaviour. Nurses reinforced inappropriate behaviour much less (6%) than did fellow patients (20%) or non-nursing staff (32%).

There is some support in the nursing literature for the idea that some forms of caring may support illness behaviours. Slavinsky and Krauss (1982) examined the outcomes for chronically ill psychiatric patients treated over a two year period in either a nursing social support program or a medication clinic staffed by medical residents. Contrary to their hypotheses, patients treated in the medication clinic had improved socialisation and satisfaction with care ratings and lowered depression and agitation ratings, while the ratings of patients in the social support program either stabilised or diminished. Slavinsky and Krauss commented that "nurses may have been more tolerant of lower levels of social and occupational functioning in their efforts to deliver supportive and empathic care. They may have viewed the group meeting as a substitute for social interaction in the community, fostering institutional dependence and not demanding enough from the patients." (p.289)

Summary

Although in NZ, acute psychiatric units on general hospital sites will increasingly play a pivotal role in the provision of acute psychiatric services, there is little research literature in this area. The few research reports that are available have been outlined in this chapter. It is apparent that little is known about the issues and problems which arise for nurses in attempting to meet the needs of the heterogeneity of patients who present for care and treatment in such a setting. Plans for closure of state psychiatric hospitals and changes in mental health legislation to require such units to contain, assess, and treat committed patients, will increase the diversity of treatment needs which the staff of single acute psychiatric units on general hospital sites must attempt to address. The literature on general hospital based psychiatric units in other countries was reviewed in order to place the present developments in psychiatric services in New Zealand in the context of developments and trends in other western countries. The majority of the research reviewed on the functioning of psychiatric units was quantitative, using retrospective analysis of records or other statistical data to examine trends in

length of stay, or rates of readmission, or to examine the effectiveness of changes in the structure of or utilisation of inpatient services.

Issues of caring and control have been shown to be integral in the provision of psychiatric care. Yet there is a lack of clarity about the meaning of the concepts. Moreover, little is known about the relationship of caring to control, of the outcomes of caring and control for patients, and of the impact of the culture or dominant ideology of the setting on caring and controlling behaviours. Two recent qualitative studies by nurses (Morrison, 1990a, 1990b; Kavanagh, 1988, 1991) described an ethos of control in locked psychiatric units on general hospital sites in the USA. These units had a predominance of committed patients and nonprofessional staff. New Zealand psychiatric units as they are presently structured are significantly different from the units described by Morrison and Kavanagh. Therefore, at this time of extensive change in NZ psychiatric services it is timely to undertake a qualitative study using participant observation and informal interviews to examine the nature of the service provided by an acute psychiatric unit on a general hospital site; and to explore issues of caring and control which arise in that context.

III

METHODS

Introduction

The diversity of themes and sources of literature which have been drawn together in the literature review illustrate the complexity of the human situation to be studied. This complexity, and the paucity of research which addresses the research questions, led to the selection of ethnography as the research methodology for this study. Ethnography has become a popular research method for gathering data on human behaviour across a range of disciplines including education, nursing and medicine. As Hughes (1992) comments "the perspective that informed its historical development and provides a continuing intellectual rationale is often dulled through excessive familiarity" (p.439). Hughes provides a useful review of the traditions of ethnography.

The goal of ethnography is to discover the cultural knowledge people use to organise their behaviour and interpret their experience (Germain, 1986, p.149), or as Leininger (1985) suggested, the identification of "patterning in care, in lifeways, and in dealing with crises" (p.40). Using ethnographic method, the researcher enters the research setting with the broad question "what goes on here?". Thus this method is uniquely suited to the exploratory nature of the study questions outlined in the introduction (p.3), and the broad objective of the study. In attempting to understand and describe what goes on, the ethnographer takes account of the multiple levels within the health care system and the wider society within which factors impact upon the experiences of patients and nursing staff in the research setting. As Germain (1986) described the research process:

> ...the ethnographer participates in the events of the subculture and, with the help of cultural informants [persons with particular knowledge of the subculture], looks for connections, patterns, themes, or relationships that have meaning for the people in it. These themes include but are not limited to

> the shared knowledge, norms (rules of behaviours), values, belief systems,
> language rituals, economics, role behaviours, or patterns of social interaction
> among the members of the subculture. (p.148)

Although this study focussed on caring and control as particular domains for in-depth analysis, these foci arose from the initial observations in the study setting, and were examined within the broader cultural context. The subculture of the unit selected for the study was explored from an 'emic' point of view, that is from the perspective of the participants (nursing staff and patients) in the setting under study, rather than from an 'etic' point of view, a framework imposed by the researcher (Harris, 1969; Jahoda, 1977). The setting for the study was an acute psychiatric unit located on the site of a general hospital. This chapter outlines sampling strategies and the methods of data collection and data analysis used in the study. Ways of assessing reliability and validity in qualitative research are reviewed, and the manner in which ethical issues were handled is discussed.

Sampling strategies.

The sampling strategy appropriate for ethnographic research method is that of purposive (or theoretical) sampling, where the researcher selects a participant according to the needs of the study (Morse, 1989). Initially informants (nursing and other professional staff and patients) with a broad, general knowledge of the unit were informally interviewed about "what goes on here?". Then as the study progressed and more specific information was required, participants with that particular knowledge were sought. Finally, informants with atypical experiences were sought, so that the range of experiences and the breadth of the phenomena being studied could be understood.

Basic to this sampling process is the requirement that the researcher is able to select the informants to be interviewed (Morse, 1989). Informants were selected on the basis that they had experienced the event being studied, and that they were both willing and able to share that experience with the researcher. Many patients were

too disturbed on admission to be approached by the researcher even for informal discussion, and the average length of stay for inpatients in that setting was two weeks, thus the researcher was involved in an ongoing process of getting acquainted with, and establishing relationships with patients in the ward. Locating informants who were not only able and willing, but available to act in that role, was not always easy. As the researcher became a familiar figure around the unit and was seen as someone available to talk, some patients volunteered to participate in the study. However not all of the patients who offered to participate by asking "are you going to talk to me?" were included as informants in the study. Because of the setting in which the study was carried out, it was necessary for the researcher to use clinical judgement, based on previous experience working as a nurse in psychiatric settings, to make decisions about whether or not to include particular patients as participants in the study. Patients presenting in an acutely disturbed psychotic state were not approached at that time, although some were included when the acute phase of the psychosis had resolved. Patients in a hypomanic phase of their illness often requested involvement, however a brief discussion was sufficient to clarify whether such patients were *able* as well as willing to participate without escalating their elevated mood.

Thirty patient informants participated in the study, although with varying degrees of involvement. Two thirds of the patient informants were women, a proportion which is consistent with the gender mix of inpatients in the ward (as will be described in chapter four, p.71). The age range of the informants was 18-70 years. Twentyfour patient informants were of European origin, four were Maori, and two had other ethnic backgrounds (the ethnic mix of inpatients during the period of the study is described on p.71). Of the 30 patient informants, 23 patients had multiple admissions (2-6) to the ward during the study period. For seven of the 30 patient informants, their first admission took place during the period of the study, however the remainder of the patient informants had experienced readmissions to the ward

over periods from two to 15 years. The high numbers of readmissions in the patient informant sample (and in the patient population as a whole, as will be described in chapter four, p.71) enabled repeated informal interviewing of patient informants during the period of the study, which assisted in clarifying and confirming emerging themes and patterns of interaction. Two patient informants had no inpatient admission during the period of the study, but were regularly on the unit either as day patients, or as outpatients who "dropped-in" to visit, or attended for medication (as will be described in chapter four, pp.88-89). Audiotaped interviews were carried out with nine of the patient informants in the latter part of the study to assist in clarifying the phenomena of caring and control. One family member of an inpatient was also interviewed in order to clarify the family's perspective of a situation which had been observed on the ward which had posed dilemmas for staff around the issues of caring and control.

Twenty nursing staff who worked either as ward staff on morning or afternoon shifts, or in the continuing care service, acted as informants in the study. Although the same broad question as to "what goes on here" was the focus of informal discussions with nurses, these respondents were aware from the outset of the researcher's interest in caring and control. Prior to access to the setting being granted, the research proposal had been discussed with ward nursing staff, and a copy of the proposal was made available to staff. Repeated informal discussions took place with nursing staff, and with staff from other disciplines who had contact with the ward, during the period of the study. Audiotaped interviews with 10 nurses, which focussed on issues of caring and control, were undertaken during the last two weeks of data collection. Audiotaped interviews were also undertaken at this time with two psychiatrists, a psychologist and a social worker who were involved in the care of inpatients in this ward. Three nurses who had previously worked in the ward were used as secondary informants to clarify and confirm emerging themes and patterns of interaction which were identified in data analysis.

Methods of data collection

Participant observation and ethnographic interviews were the primary methods of data collection, with analysis of documentation providing secondary data. The study was planned to extend from 1 July 1990 to 30 June 1991. However, for reasons unconnected with the study, participant observation during the first five months of the study was less regular than planned. The period of the study was therefore extended until 31 August, 1991, although the original 12 month period was adhered to for the analysis of documentation, and calculation of statistical data.

In the eight month period from January to August 1991, approximately three days per week were spent on the ward by the researcher. Periods of observation lasting between five and nine hours took place between the hours of 8.30 am and 9.30 pm, predominantly on weekdays, although approximately 20 hours of observation took place on weekends. To minimise disruption of ward routines no observations were made on night duty. Inpatients were expected by staff to be asleep at this time unless they were acutely disturbed.

Establishing a "not staff, not patient" role

In ethnographic research, the researcher enters the field as a stranger and learns about the subculture by asking questions and seeking clarification from cultural informants, both patients and staff in this study. This required the establishment of a role as "not staff, not patient", a process well described by Estroff (1981).

One requirement of access was that the researcher wear a name badge identifying her name and status as a researcher at all times while in the unit. Because this badge resembled those worn by nursing staff at the beginning of the study (they later changed to identity cards with photographs which were not always worn), and because nursing staff did not wear uniforms, the researcher was occasionally

mistaken by patients or visitors as a staff member. On each occasion this occurred, the status of researcher, not staff member was explained as a reason for not providing the service they requested (eg. information, permission to do something, access to cigarettes, and/or lighter, or medication). Often this refusal was softened by suggesting where a nurse might be found.

It was necessary to establish a "not staff" identity with nursing staff as well. While the researcher's background as a nurse who had worked in psychiatric settings contributed to a ready acceptance by most ward nursing staff, the researcher was initially seen by nurses as potentially able to be co-opted into a staff role. For example, nurses jokingly asked would the researcher like to work a weekend shift when they were short of staff, or would she like to fill in on the roster for constant observations, or asked an opinion about proposed changes in the management structure of the mental health services. The researcher responded by emphasising a not staff role, and attempted not to express opinions, rather to only ask for explanations in discussions with nurses.

One effective way of emphasising a not staff role was to never answer the telephones in the ward office even if the researcher was the sole occupant of the office. Telephone calls took priority in this ward (as will be described in chapter four, pp.91-94), and all staff in the ward, including psychiatrists, student nurses and polytechnic tutors on the ward to supervise the students, would answer the telephones in the ward office if ward nurses were not available. Staff never questioned the researcher's failure to "help" by answering the telephone, and there was only one occasion (when asked by an aide to answer the phone if it rang, as there were no nursing staff in the ward) that it was necessary to articulate this position by refusing to agree to the request.

While in the early phases of the research some of the many meetings held by nursing staff were attended, including the change of shift "handover" meetings, a choice was later made to remain in the ward to experience "what goes on" when nurses go off the ward. Similarly, the structured occupational therapy groups which were held off the ward, and attended by day patients as well as inpatients, were not regularly attended by the researcher; the exception being the 9.15 am "goal setting" meeting (described in chapter four, p.80).

As an observer, the researcher "hung around" in public places in the ward and the wider unit, and also sat in the ward office to read nursing notes and the daily log (described in chapter four, p.97) and to write fieldnotes. In this location the researcher could observe the staff in their "backstage" work role (Goffman, 1959). Nurses would occasionally joke "don't write that down!", but they never questioned what was written, or requested information about patients with whom they had observed the researcher to spend time.

Patients were curious about the researcher's status and activities, and on their first encounter, often in the corridor, would question "what are you researching?", "who are you working for?", and "what will happen to the results?" The research questions were explained to patients in general terms relating to "what goes on" and "what it is like to be a patient in the unit". Once these questions were answered many patients began straight away to talk about the ward and their experiences of being a patient. The topics of caring and control were not initiated by the researcher, in discussion with patient informants early in the research. Rather such topics arose from the informants' discussion of their experiences as patients.

A few patients made comments such as "don't ask me questions, I won't be able to answer them". Reading the researcher name badge was often the stimulus for this process, thus while the name badge set the researcher apart from the patient group

it also facilitated contact. A few patients appeared to avoid contact with the researcher, as they did with staff. It was not possible to ascertain whether the researcher was perceived as "staff", or whether this behaviour had some other meaning. Occasionally the researcher was mistaken by patients either for an inpatient, or an outpatient visiting the ward. When this occurred other patients would correct them as to her status, or the researcher would explain the research role. On one occasion when "hanging around" in the corridor the researcher was told by a nurse that she looked like a patient, and on another occasion this behaviour resulted in a small group of patients and the researcher being told to "move on" (ie not to hang around the corridor area, which was a popular meeting place for patients) by another nurse. Bedrooms were the only places to which patients could retreat when they wanted to be alone, therefore the researcher would "visit" with patients in their bedrooms or dormitories only when a relationship was established with them through prior contact in public spaces, and their readiness to talk could be assessed.

While it was initially intended to audiotape the majority of informal interviews with patients, this proved impossible because of the spontaneous nature of many of the interactions, and the public places and group context in which the majority of these interactions occurred. Usually patients who were well enough to act as informants shared bedrooms or a dormitory with other patients, so finding a quiet place to talk was difficult. Occasionally a staff office was used on the evening shift when that staff member had gone home, however the very fact of the researcher having access to that office, and a staff key to open it, compromised her not staff status.

Almost without exception, audiotaped interviews with patients on the ward were interrupted by the entrance either of other patients or staff. Some interviews were conducted outside the unit after the patient had been discharged, for this reason. Thus much of the informal discussion with patients was recorded in fieldnotes, as

close to verbatim as possible, using the language of the participants. Fieldnotes, which included observational data, were either dictated on a tape-recorder or written in a note book shortly after the interaction had taken place. Observed events were described in detailed concrete terms. As suggested by Lipson (1989), a personal field diary was kept to record feelings, reactions, questions or biases which might influence the process of data collection and analysis.

Nursing notes and patient files provided information on the day to day care of inpatients from the perspective of the staff who cared for them, while the daily log (described on p.97) provided information on other patients of the mental health service who contacted the unit. Data related to patients in the daily log was transcribed for the period 1 July 1990 to 30 June 1991. Each patient identified in the daily log was assigned an individual code number prior to transcription, to protect the identity of the patient, and to enable individual patient contacts to be tracked over the 12 month period. Transcription of the daily logs did not begin until March 1991, thus the content of these documents was unlikely to have been influenced by the researcher's request for access to retrospective daily logs. Toward the end of the period of study, statistical data, strategic planning documents and service development reports were read to provide a more complete picture of the wider context of the regional mental health service within which the acute ward was located.

Focus of the study

While some study questions had already been formulated to give focus to the study, the direction of ethnographic research is not as fixed ahead of time as it is with the more linear quantitative designs (Germain, 1986, p.149). As Spradley (1980) stated, "in doing participant observation for ethnographic purposes, as far as possible, both questions and answers must be discovered in the social situation being studied" (p.32). It quickly became apparent when observations in the

research setting began that there was enmeshment of parts of the service (as will be described in chapter four, p.92), and thus it would not be possible to understand what went on in the ward if it was viewed in isolation from other parts of the mental health service. Therefore, early in the period of observation a tour was arranged of the existing community mental health facilities with a nurse from the continuing care service. Half way houses, a residential rehabilitation centre, and community houses used by continuing care patients either as drop-in centres or for regular group discussion were visited. It was immediately noticeable how little infrastructure there was in the community for patients after discharge. Later in the period of observation a visit was arranged to the ward at the nearest psychiatric hospital where "committed" patients from the research setting were sent.

Informal discussions were held with nurses who worked in the continuing care service, staff of the child and family unit and the outpatient service, and nurses from community mental health teams which were being established during the period of the study. Contacts were also made with outpatients who dropped in to the unit for "something to do"; patients at one of the half way houses were visited, and participant observation at a morning group session in one of the community houses was included. The daily log and nursing notes were read, and references to contacts with police, and with individuals from voluntary agencies who provided accommodation or counselling for patients prior to, or following admission were followed up with nursing staff. These observations and discussions facilitated a focus on the functioning of the ward in the wider context of the mental health service.

Data Analysis

Ethnographic research involves a cyclic process where data analysis follows initial data collection and results in new ethnographic questions to be asked. Often it is unexplained or unexpected data - what Agar (1986) described as "breakdowns",

which form the basis of new questions or directions in the research, an example being the idiosyncratic use of the term "time out" in this setting (as discussed in chapter four, pp.73-74). During the initial phase of the fieldwork broad descriptive observations were made in order to get an overview of the situation and what went on there. After recording and analysing the initial data, new questions arising from the data led to more focussed observations in the search for cultural patterns and themes. Analysis of these data resulted in the refining and revising of research questions focussing more specifically on issues of caring and control, so that more selective observations were required to fill in gaps in the data. However, broad descriptive observation occurred alongside these focussed observations until the end of the field study.

In undertaking ethnographic research large volumes of written data are generated. Fieldnotes and audiotaped interviews were transcribed onto files on a Macintosh computer so that data could be categorised using Microsoft Word software with multiple windows open, as described by Morse (1991). Content analysis, as described by Field and Morse (1985), was undertaken to inductively derive patterns or themes from the data. These themes are used as subheadings in the data chapters (4-6). Then alternative ways of framing the information were explored using existing theories as "perceptual templates" through which to view the analysed data (Morse, 1992). Interpretations of the findings were verified and clarified in collegial dialogue with psychiatric nurses from outside the research setting, and with academic colleagues.

The aim of this cyclic process of data collection and analysis was to generate what Geertz (1973) described as "thick description" of the cultural knowledge patients and staff used to organise their behaviour and interpret their experience in an acute psychiatric unit, and to delineate the implications of this knowledge for providers and planners of mental health services. Thick description is a written record of

cultural interpretation (Fetterman, 1989) which grounds the meanings of human actions and language in their sociocultural context (Mishler, 1979).

Issues of reliability and validity

Qualitative research methods differ from quantitative research methods in the means used to assess methodological rigor. Brink (1989) suggested that "in qualitative research...measurement refers to the series of judgements made by the researcher about collected information in relation to its truthful representation of the desired content, its comparability with known information, and its verifiability across subjects and situations"(p.155). Because of the longitudinal nature of the research design, the repeated informal interviews with informants, the research focus on the underlying cultural or social rules for behaviour, and the question formats used to elicit the emic perspective, the study was not likely to be affected by constant errors of "social desirability" or "acquiescence response set".

Care was needed to ensure that the informants selected had the requisite knowledge of the issues under study. Morse (1989) suggested that the method of purposive sampling is evaluated for appropriateness and adequacy, where:

> appropriateness refers to the degree to which the choice of informants and method of selection "fits" the purpose of the study as determined by the research question and the stage of the research. Adequacy...refers to the sufficiency and quality of the data...The test for adequacy is: was saturation achieved and does the theory make sense". (pp.122-3)

Validation of data collected was achieved through the use of multiple data sources. Information obtained through interview was verified through observations and vice versa. The information from one patient informant was verified with other patient informants, while the information from one staff informant was verified with other staff informants. However, because of the discrete populations of staff and patients it was not possible to directly verify information from patient informants with staff informants and vice versa. Data from informants were compared with those in

written records such as nursing notes, the daily log, and patient files. Because initial data analysis occurred simultaneously with data collection, potential sources of bias or inconsistency in data collection could be detected and corrected in subsequent data collection.

Guba and Lincoln (1981), described four criteria by which the methodological rigor of qualitative research might be evaluated - credibility (rather than internal validity), fittingness (rather than external validity), auditability (rather than reliability) and confirmability (rather than objectivity). Credibility is ensured when the report presents thick description or interpretation recognisable to participants of the subculture as their own experience. Credibility is enhanced when the researcher includes discussion of her own behaviour and experience as researcher in relation to those of the participants. The criterion of fittingness is met when the study's findings can 'fit' into other contexts, and when readers view its findings as meaningful and applicable in terms of their own experiences. The findings must also be well grounded in the life experiences studied and reflect both typical and atypical elements. Auditability is assessed by the clear documentation of the "decision trail" used by the researcher in the study so that any reader can follow the progression of events and understand the logic. Confirmability is achieved when auditability, credibility and fittingness are established (Sandelowski 1986).

Ethical Considerations

Several levels of clearance and consent were required before the researcher could gain access to the selected setting - an acute psychiatric unit. Support and approval were initially sought from the Director of Psychiatric Services and from Heads of Departments of each professional discipline. With their support, the research proposal was submitted to the University Human Ethics committee and to the Area Health Board ethics committee for ethical approval. Once this was granted, access rules, such as the frequency and hours of coming and going, the means of

identification of the researcher, the range of participant-observation activities permissible, and access to supplementary data sources such as patient records, nursing notes, statistical data and planning, policy and procedure documents were clarified with senior personnel of the unit. A liaison person was initially identified to guide the researcher's entry and orientation to aspects of the subculture and to fulfil the gatekeeper role as suggested by Germain (1986). Other issues addressed prior to entry to the field setting included the confidentiality of information shared with the researcher by patients and staff, and ways to manage situations where the researcher might be privy to information, or may witness situations where a patient was at risk, or there were situations of conflict between staff and patients, and therefore be required to give information, or intervene in some way.

The issue of informed consent to participate is not as clear cut in ethnographic research as it is in biomedical research. Cassell (1980) pointed out that in fieldwork, the researcher has relatively little power over those who are studied, and little control of the setting and context of research; interaction flows in two directions, and calculable harms and benefits are comparatively low. As Robertson and Boyle (1984) suggested, "data collected through on-going association with community residents in a variety of private and public circumstances must depend more on the ethics of the particular researcher than on the concept of 'informed consent' followed in studies involving limited, defined behaviours from the subjects" (p.48).

Factors such as the emergent design of the study (Ramos, 1989), the lengthy time period during which data were collected, and the changing population of patients in the study, meant that obtaining informed consent from participants was an ongoing issue. Written consent forms were used for audiotaped interviews with patients, however oral consent was used for informal discussion with patients and staff; and for audiotaped staff interviews. The role of researcher ("not staff, not patient") was

regularly explained to newcomers with whom the researcher had contact, the aims of the research were clearly communicated to informants, and the researcher periodically reminded patients of the ongoing nature of the study.

On the recommendation of the Area Health Board Ethics committee and the Director of the unit, the researcher was granted honorary staff status at the psychiatric unit, with concomitant ethical responsibilities as a staff member. This status was conferred in order to address concerns expressed by members of the Ethics committee, that many patients would not be able to give meaningful consent on admission. The honorary staff status was viewed by the committee as a way of ensuring access by the researcher to the setting as an observer at all times. In order to maintain a not staff, not patient role, this honorary staff status was not discussed with participants in the study.

The protection of privacy, anonymity and confidentiality of members of the subculture during the period of data collection and at the time of publication of the report is an important ethical consideration (Spradley 1980; Germain 1986). It was explained to patients that anything they discussed with the researcher would be confidential, unless there was concern about the safety of the informant or another person. This situation did not arise in the study, however the researcher did intervene by giving feedback to nursing staff on three occasions when incidents were observed in the unit which were perceived to place patients or staff at risk. All fieldnotes, audiotapes, computer files and other data sources were stored securely, and the anonymity of participants and the location was ensured as far as possible by the use of identity codes in all data sources. Audiotapes will be erased on completion of the study.

In writing up the research, a choice was made to refer to informants by their status (eg patient, nurse, psychiatrist) without pseudonyms. Only broad identifying data such as kind of patient or psychiatric diagnosis, or service within which a nurse

was employed are included. This decision was made because of the "revolving door" population of patients in the unit studied, and the likelihood that this document will be read by both managers of the staff informants, and by staff who provide ongoing care for patient informants. Davis (1991) describes the tension between privacy (anonymity of the staff and patient informants) and thick description as a powerful paradox. Protection of the privacy of informants is important. Patients attend the unit because of illness or dysfunction and, given the Area Health Board ethics committee's recommendation re honorary staff status for the researcher (p.61), could be said to have had limited choice about being a part of the study, although they could choose not to talk with the researcher. Similarly staff, by virtue of working in the unit, became a part of the study. While they could choose not to be interviewed by the researcher, it would be difficult to avoid the researcher during the periods of participant observation on the unit. Therefore the informants' rights to anonymity were given priority over the reader's need for more descriptive detail of informants in association with verbatim quotes. This decision limits the ability of the reader to audit the weighting placed on the information provided by any one informant. However, because of the nature of the study setting, information was obtained from a large number of informants (as described on pp. 49-50), rather than from a small number of key informants. Particular care has been taken in writing up the study to include quotations from a range of staff and patient informants.

Summary

Ethnography was the research methodology selected for this study. This methodology is uniquely suited to the exploratory nature of the study questions about the nature of caring and control, and the broad objective of the study. Although this study focussed on caring and control as particular domains for in-depth analysis, this focus arose out of the more general question as to "what goes on here", a question which is addressed in the chapter which follows.

IV

THE RESEARCH SETTING: WHAT GOES ON

Introduction

This chapter provides a broad overview of what goes on in the research setting. A detailed description of the physical environment of the inpatient unit is provided, followed by a description of the staffing of the unit, and the patient population. A recurring theme which was identified early in the phase of data collection was that of staff concern over the availability of beds. Ways of managing the bedstate are outlined and the implications of these strategies for the functioning of the ward are identified. Early questions as to who is admitted, and ways they are admitted, led to identification of pathways to admission, and ways of categorising admissions as "social" or "psychiatric", and as "known" or "not known" to the service[1]. The daily routine in the ward is described, and the impact of the limited availability of beds and a revolving door population of inpatients on the ward milieu and functions are examined. The related themes of "being in the system" and the idiosyncratic use of the term "time out" in this setting, are explored, and the provision of an after hours service by ward nurses is described.

In the study setting, the inpatient unit was known to staff, patients and visitors as "the ward". This was consistent with the designation of other inpatient units in the general hospital as wards, each distinguished from the other by numbers. The term "unit" was reserved for more specialised services such as the intensive care[2] and coronary care units. The use of the term "the ward" helped to distinguish the inpatient facility from the building as a whole, which was referred to as "the unit". On occasion these terms were used interchangeably by staff and patients, perhaps because of the diffuse boundaries between the inpatient service and the outpatient

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[1] In the data chapters of this thesis emic descriptors are enclosed in double quotation marks.

[2] The term "care" uniformly refers to service provision in this chapter (refer p.33).

and continuing care services, as will be outlined later in this chapter. Thus in the description of the research setting which follows, the inpatient ward will be described in the context of the broader environment of "the unit".

Similarly, in the study setting the generic term "staff" was commonly used by patients and medical and nursing staff, particularly when referring to ward nurses, but also when referring to staff in other parts of the service. For clarity for the reader, in the chapters which follow the term "staff" will be used when the reference is to more than one occupational group. When the reference is to a particular occupational group, that group will be specified.

The research setting

The research setting was a psychiatric ward located on the site of a general hospital in a medium sized city in NZ. The psychiatric ward provided adult inpatient services for a population of approximately 150,000. Almost half of that population resided within the city boundaries, while the remainder was geographically widely dispersed in smaller towns and rural areas. A range of mental health and illness services was based within the same building as the inpatient ward. These included an adult outpatient service, staffed primarily by psychiatrists and psychologists; an acute or crisis assessment service staffed by psychiatrists; liaison psychiatry with one psychiatrist providing a consultancy service to the general hospital; a continuing care service staffed primarily by psychiatrists, nurses and occupational therapists; and a child, adolescent and family outpatient service staffed by a psychologist, social workers, and child psychotherapists. All of these services were available within the usual Monday to Friday 8 am to 4.30 pm working week. Outside of those hours an after hours crisis line telephone service was provided by nursing staff of the inpatient ward with support from the on-call psychiatrist. Only voluntary (informal) admissions were accepted by the ward, which at the time of the study was not gazetted to contain and treat "committed" patients. Involuntary

admissions were sent to a psychiatric hospital which was located at a considerable distance from the study ward.

The physical environment of "the ward"

The ward was located in one wing of a single story H-shaped building which housed the diversity of services outlined above. A map of the building is included in figure 4.1 (p.66). There were 19 inpatient beds consisting of six single rooms, three double rooms, one three bedded room and one four bedded room. One of the single rooms, referred to by staff as the "de-stim room", had been adapted for use with acutely disturbed patients. It was an internal room with dark coloured carpet padding the walls and light via a skylight in the roof. The ventilation equipment for this room was noisy and its proximity to other noisy areas such as the ward kitchen, the ward office and the filing room, limited its usefulness. It contained a bed and a moveable locker as it was also used as a regular bedroom.

The single bedroom adjacent to the "de-stim" room was larger and more attractive than the other single rooms, with additional seating and a desk. It was used for anorexic patients who may be confined to the room for a lengthy period of time until weight gain was established. The room was also used for patients of different status in terms of social class or professional background. This room, the de-stim room and a file room shared a common entrance or access area off the ward corridor. The three and four bedded rooms, referred to as "dormitories", had curtains which could be pulled between the beds for privacy. The three bedded dormitory had a door which opened out onto a paved area facing an area of lawn and shrubbery, bordered by two busy roads which met at an intersection controlled by traffic lights. At the far end of the corridor (which ran almost the length of the ward), were situated two beds referred to as the "end" beds or "day" beds which were not allocated to inpatients, and therefore were not included in the 19 bed occupancy.
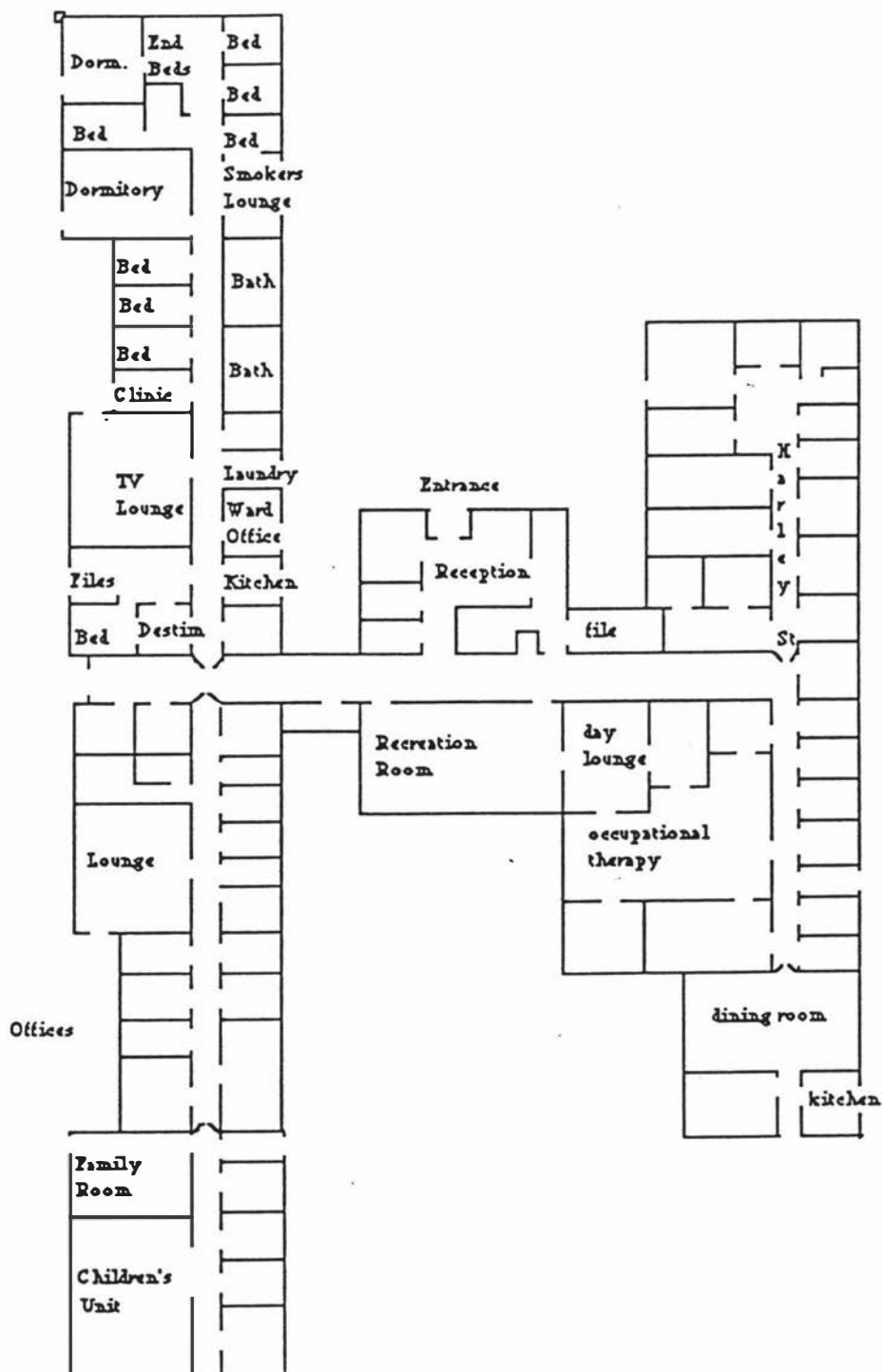
Figure 4.1 Map of the ward

Occasionally family members would be admitted as "boarders" with an identified patient and were likely to be accommodated with the patient in the "family room" which was located in the wing directly opposite the ward adjacent to the child and family unit. The beds in this room were also not counted as a part of the bed occupancy, therefore a bed would be left vacant in the ward if the family room was used, and the bed occupancy recorded as 19 +1 (boarder). The location of this family room at such a distance from the ward had clear limitations for the provision of supervision and support of persons admitted there, despite the existence of an intercom system for communication between that room and the ward office.

Facilities for patients' use within the ward included a patient laundry with automatic washing machine and dryer, iron and ironing board, and a small ward kitchen with an electric water heater, microwave, toaster, refrigerator, cutlery and crockery and washing up facilities. The sharp knife was kept in the ward office next door. Tea, coffee, Milo (drinking chocolate), milk, bread and spreads for toast or sandwiches, and food left over from meals in the unit dining room (or from other sources such as drug representative luncheons or staff farewells) were available in the ward kitchen for patients to make their own snacks. Both the male and the female bathrooms were fitted with a spa bath.

There was a large lounge with comfortable chairs, a television set, tables at which patients read the newspaper, did jigsaw puzzles and played cards, and occasionally some patients had their meals there. Smoking was not permitted in this area, nor in the bedrooms. The lounge had large windows facing an extensive area of landscaped lawn and shrubs, beyond which was the busy road and intersection. A door opened from the lounge onto a patio with deck chairs, which faced the lawn and gardens. The wall of the lounge which adjoined the corridor also had large windows which were used as observation windows by nursing staff as they moved

up and down the corridor in the course of their work. A seat at the desk in the ward office adjacent to the lounge, also provided nurses with a good overview of activity in the lounge and the adjacent corridor.

A second smaller "smoker's lounge" was located approximately two thirds of the way down the ward. It faced the car park located between the two wings of the building and was a somewhat dingy room, with only a radio to provide entertainment. However patients were permitted to smoke there, and it was a private place to sit compared to the main lounge. This second lounge doubled as a room for "treatment", that is the administration of electro-convulsive therapy (ECT).

An alcove with comfortable seats was located outside one of the single rooms just prior to the entrance to the three bedded dormitory and the end beds. This alcove provided another quiet place for patients to sit or to meet with friends or relatives. Another area where patients often gathered was in the corridor around the telephone provided for inpatients' use. The telephone was located on the wall between the ward office and the patients' laundry, and adjacent to the main lounge and the medication clinic. Gathering here was discouraged by nursing staff, who would tell patients to "move on".

Inpatients shared occupational therapy, recreational and dining facilities with outpatients and day-patients from the continuing care service. The unit dining room (which included a piano and table tennis equipment) and the unit occupational therapy rooms were located in the wing diagonally opposite to that in which the inpatient ward was located. The unit reception area, the unit recreation room (containing a pool table, exercycle and indoor bowls and designated a smoking room) and the public phone box, were all located off the corridor which linked the four wings.

The OT "day lounge", a room for day patients located between the recreation room and the main occupational therapy room, was also used by inpatients, particularly in the evenings when day patients had gone home. This was an internal room with curtained windows facing the corridor and the occupational therapy room. Smoking was permitted in this room, thus inpatients could smoke while watching television, and its location away from the ward made this an attractive venue for some patients. However the smoky, poorly ventilated atmosphere made this room unattractive to others.

Offices used by staff for interviews with inpatients, were located in the wing directly opposite the ward, thus inpatients might be found in three of the four wings of the building. The remaining wing contained offices and larger meeting rooms used by staff who worked predominantly in the adult outpatient service. Some staff referred to this wing as "Harley Street".

During the day and the early evening, patients from the continuing care service also used some of the ward facilities, in particular the ward kitchen for tea and coffee, the medication clinic, the patients' lounges, particularly the smokers' lounge, the spa bath, and the two end beds.

Staffing of the ward

The ward was staffed by registered nurses, with six to eight nurses on the morning shift, three or four nurses on the evening shift, and two nurses on night duty. One male hospital aid worked the morning shift, while a female hospital aid worked 4-9 pm. The nursing staff did not rotate through the shifts, instead permanent staff were employed for each shift. Some of the nurses employed on evenings and weekends were part-time staff who worked two or three shifts a week. Morning nurses were termed "primary nurses" who were responsible for planning care for inpatients allocated to them, while nurses who worked on other shifts or at the

weekend were "associate nurses" who assisted with the care of patients. The ratio of male to female nurses on mornings was approximately equal, however on the pm shift there were at times no male staff, with three female nurses and a female hospital aid on duty. On night duty the full-time nursing staff were one male and one female.

One occupational therapist and one part-time social worker had responsibilities for inpatients, however neither of these staff were based in the ward. One psychiatrist took clinical responsibility for inpatients with assistance from a psychiatric registrar. Medical staff offices were located outside the ward.

There was a small core of psychiatric nurses (trained prior to the introduction of comprehensive programs), dispersed across the three shifts, who had worked in the ward for many years. However there was reported to have been a high turnover of nurses, occupational therapists and psychiatrists over recent years. The majority of recently appointed nurses were graduates of the NZ polytechnic programs with comprehensive nursing registration. Some had little post-registration experience in a psychiatric setting. The ward nursing staff also included psychiatric nurses who had emigrated from Britain, Germany and the USA. There were only two Maori nurses and one Samoan nurse working in the ward during the period of the study, thus the nursing staff were predominantly of European origin. Supernumerary to these staff during the academic term, were student nurses from the local Polytechnic: four students on morning shift and three students on the afternoon shift. These patterns of staffing had implications for the day to day running of the ward which will be addressed in chapter five, and for issues of caring and control, which will be addressed in chapters five and six respectively.

The patient population

The ward provided adult inpatient beds for acute psychiatric services as well as for general psychiatry for the region served by this unit. Annual statistics showed that approximately 90% of patients referred to the unit were of European origin, 8% were of Maori or Pacific Island origin, while 2% had other ethnic origins. These referrals were consistent with the population structure of the region.

Three features of the inpatient population were most noticeable when observing who was admitted; the first characteristic was the heterogeneity of the patient population in terms of age and presenting problems; the second was the disproportionate gender representation - 62% of individuals admitted were women; and the third was the high number of readmissions so that the majority of patients were "known" to the service.

There were 421 patient admissions to the ward in the 12 month period 1 July 1990 to 30 June 1991 during which this study was undertaken. These 421 admissions were accounted for by 281 individuals, of whom 189 (67%) had single admissions during this time period, while 92 individuals (33%) had more than one admission. Sixtythree individuals had two admissions; 16 individuals had three admissions; nine had four admissions; two had five admissions; and two had six admissions in this time period.

This admission data, which was calculated from the daily log recorded by nursing staff, does not take account of involuntary admissions to another psychiatric hospital, and provides only a cross-sectional account of patterns of illness and readmission spanning periods ranging from one to 20 years. As one nurse commented, "it's only a very small part of the community that are actually using these services that are existing for so many people."

As previously mentioned, all patients were considered "voluntary" or informal admissions, although some were committed patients discharged on "trial leave" from one of the large psychiatric institutions gazetted to take involuntary patients. These patients were referred to this ward from the psychiatric hospital for further care prior to discharge to the community, or readmitted to this ward from the community while remaining on trial leave.

Most people with alcohol or drug dependence as their primary disorder were excluded from admission, or re-routed when possible to the detoxification ward located in the general hospital, then followed up by community based alcohol and drug dependency counselling services. No children were admitted except as boarders with an identified patient, and no adolescents under 16 years were admitted. Children and adolescents were admitted to wards in the general hospital when inpatient care was essential. Beyond these very limited criteria for exclusion, any person referred for assessment could be admitted for care, dependent on the availability of beds.

The availability of beds

The availability or nonavailability of beds for acute admissions was a constant concern of nursing and medical staff. A whiteboard in the ward office mapped the allocation of patients to beds, and recorded the current bed occupancy and the names of patients on a waiting list for admission. Outpatient psychiatrists frequently checked the whiteboard to ascertain whether there was a bed available either for an acute admission, or for one of their patients on the waiting list. Negotiations occurred between psychiatrists, and with nursing staff to determine whose patient was allocated the available bed. Psychiatrists expressed concern at the "risk taking" which occurred when people who need to be admitted were not, because the ward was full, and estimated the frequency of this occurrence as "several times a week". Psychologists working in the outpatient service expressed

similar concern. As one informant described it "if [psychologists are] to see outpatients in a clinically autonomous way, then [the unit is] going to have to provide backup [available beds] to ensure that [we] can do that."

Bed Occupancy

The average bed occupancy for the 12 months 1 July 1990 to 30 June 1991 was 92.42% (or 17.56 of the 19 available beds), while the average length of stay was 14.31 days. Length of stay ranged from less than one day (usually where the individual was initially admitted to the ward, then committed to a psychiatric hospital), to 129 days (in one case). Many of the patients with three or more admissions in that 12 month period, had brief stays; less than the average admission, although there were exceptions to this finding.

Ways of managing the bed occupancy

There were a number of ways staff managed the pressure on available beds. Patients might either be admitted to beds in the detoxification ward in the general hospital which were also classified as psychiatric beds, or a "paper transfer" might be made of a patient who was on leave. Either way, such patients needed to be transferred back when beds in the ward became available. A patient on leave might be discharged, or a patient in the ward might be discharged to make room for an acute admission. One patient was admitted and discharged to the care of his parents on the same day, when a "more urgent" acute admission presented.

A psychiatrist might tell the patient and family or friends that although an admission was advisable, there was no bed available, then document this situation in the patient's chart and hand over responsibility for care to family or friends. An outpatient might be invited to phone the nursing staff in the ward for support, or to come up to the unit for "time out" from worry and stress in their home or work environment. It is important to note that this idiosyncratic usage of the term *time*

out in this research setting differed from the usage of time out in the psychiatric literature, and in other psychiatric units. Time out in this study meant time in the ward, that is to say, time out from the outside world.

The end beds described earlier in this chapter were used by patients in for time out or day care, and occasionally known patients who presented in distress late at night would be allowed to "rest on the end bed" until they were reassessed by psychiatric staff in the morning. In many instances this averted an acute admission.

The waiting list operated as a filtering mechanism where names of people who might need to "come in", were placed by a range of clinical staff including community mental health nurses. Admissions would also be "booked" for a particular day, subject to the availability of beds. Patients referred following an involuntary admission to a psychiatric hospital also had to "wait" at that hospital until beds were available in the ward. Priority on the waiting list was continually renegotiated by staff.

Committal of acutely disturbed patients in the ward was also used to create beds, although if there were no available beds at the receiving psychiatric hospital an exchange of patients would be negotiated. The ward would admit patients from that institution who were currently on the ward's waiting list, which would allow a transfer of patients from the ward to the psychiatric hospital. This process was observed on one pm shift when two patients were committed and transferred to the psychiatric hospital, and in exchange, two were admitted.

While the high occupancy rate of available beds in the ward created some problems for staff wishing to admit patients, it also provided one screening mechanism for excluding patients staff did not wish to admit.

Pathways to admission

There were a number of pathways which led to people being admitted when things started "going wrong". Those not known to the service could present themselves in distress, or be taken by family or friends to their general practitioner (GP), the after hours medical service, or to the Accident and Emergency Department (A&E) of the general hospital. Alternatively they might phone the ward directly, out of normal working hours (Monday to Friday, 8 am to 4.30 pm). Any of these routes could lead to a request for psychiatric assessment and subsequent admission.

When the patient was an unwilling participant in this process, particularly if violence was involved and the patient was male, police involvement resulting in committal to a psychiatric hospital, rather than admission to the ward was likely to occur. Such patients were referred for admission to the ward from the psychiatric hospital as soon as the acute disturbance had settled.

Patients who were known to the service came in through a variety of pathways. A medical referral from outside the mental health service was no longer required. Patients might make a request for admission to staff of the outpatient or continuing care services, or directly to the ward nursing staff who involved the on-call psychiatrist. Alternatively an admission might be suggested to a patient by staff from any of these services, however all admissions were routed through a psychiatrist from one of the services. Not infrequently, coming up for time out was the pathway to admission, as illustrated in the following examples.

> This time I only came in as a rest. I was coming in daily [for time out] ... Now I was kept in, not, you know, because I didn't want to - I did want to. I wanted somebody to take responsibility for me. That was just for a few days and here I am, 2 weeks later.
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> •••••
>
> I went for a swim in the rehab pool this morning, and was in tears there. ____[continuing care nurse] suggested I spend time on the ward and see the doctor at 4.30 pm [resulting in admission].

Time out might also be offered by nursing staff as an alternative to admission when a known patient requested an admission which the staff concerned believed was inappropriate. Alternatively such patients might be told that there were no beds available. It was not uncommon for known patients to phone to enquire whether there were any beds available. Admission was an attractive option for a few patients who saw the ward as a haven from the outside world. Such patients tended to present with safety issues such as feeling suicidal, or having overdosed on medication. As will be illustrated later in the chapter (pp.98-100), these people might involve multiple helping agencies in their efforts to gain admission.

Not all patients viewed admission to the ward as an attractive option. More than one patient reported "I never come here voluntarily". Many admissions were initiated by family or friends who could no longer cope with or tolerate "out of control" behaviour. When a patient was reluctant to come for assessment, the family might be advised to request the assistance of the police in bringing the person to the unit. Agreement to stay, rather than agreement to come, underpinned voluntary admissions to the ward. On occasions when a patient was reluctant to stay, one or more family members might remain with the patient in the ward to, as staff described it, "assist with care".

Admissions could also result from transfers from other parts of the general hospital. When patients known to have a psychiatric history presented to Accident and Emergency, or were admitted to other parts of the hospital such as medical wards, maternity wards, or surgical wards, there was considerable pressure for the psychiatric ward to take these patients. Other wards were reluctant to admit such patients although they might present with medical or surgical problems as great as any psychiatric disturbance. One informant described her actions after being stopped by a traffic officer and given a ticket:

> So I sat in my car. He must have given me a burst of gas or something because I got really nervous. [I] shut the window, [and I] sat in the car for

three quarters of an hour before I felt better. And then I drove straight up to Accident and Emergency and admitted myself there. I parked in the Mobility [disability] short term parking area. Put my Mobility card in the window, and when I'd been in there, Accident and Emergency, for some time talking to a male nurse ... I said "Well ... just give me a bit of paper while I am waiting. I'll write out my complaints about the Traffic Dept" ... Anyway! ... they must have rung [the unit] because I said something about ___ [outpatient psychiatrist]. ___[nurse] came and got me. That's how I came to [the ward].

While this patient clearly presented with paranoid ideation, she also had high blood pressure which warranted investigation and treatment. Another patient during the period of observation had chronic obstructive pulmonary disease and, until his transfer back to a medical ward for treatment of secondary heart failure, was nursed in bed with oxygen from portable tanks as the psychiatric ward was not equipped with piped oxygen. A third patient required twice daily dressings of a large bedsore over a period of months, which required the acquisition of equipment for surgical dressings and the teaching of psychiatric trained nurses to carry out the procedure which involved debridement and packing of the wound. Patients with mixed medical and psychiatric presentations thus added to the heterogeneity of the population admitted to the ward.

Ways of categorising admissions

Two ways of categorising patients emerged in discussion with nursing staff: "psychiatric" versus "social" admissions, and "known" patients versus those "not known", either to the service or to individual nurses. *Psychiatric admissions* included patients with a major mental disorder such as schizophrenia, or a bipolar disorder or other psychotic state, who presented in an acute phase of their illness. *Social admissions* included both patients with neurotic disorders, that is people for whom the depression or anxiety with which they presented was secondary to the stressful life circumstances in which they lived; and patients with a major mental disorder who were not in an acute phase of their illness, but presented as being unable to function on a level adequate to ensure day to day survival. The latter group, described by staff informants as the *chronic psychiatrically disabled*

formed a large proportion of the patients *known* to the unit. A further group who might be included in the broad category of social admissions by nurses were patients described as having personality disorders, a label which, as used by ward nurses, had overtones of "difficult patient"[3].

While the categories of psychiatric admissions and social admissions were acknowledged by medical staff, the latter operated on a more inclusive description of psychiatric admissions which also encompassed neurotic disorders. One psychiatrist commented in relation to inpatients with problems of "placement":

> ...that's a major problem for a small number of patients - they don't have their own accommodation. That's where the social admissions come in. I can think of a couple in the ward here. There's no psychiatric, medical reason for them to stay in the ward, but it would become that way if you forced them out from here.

Another psychiatrist explained the category of social admissions as follows:

> ...I think what's happened is that we were not seeing so many chronically psychotically ill people being admitted in the past, and now we are. It's changing.... The reality is that nowadays the housing, the support care services for the chronically ill are crumbling ... And so the people whose toe hold on life is fairly tiny any way are going to find it more difficult to manage. But the pressures on us to admit are higher, because people don't want disturbed people around. But I don't think anybody has really thought through what we do with the personality disorders, the recurrent self injuries, the "histrionic". The person who, on an acutely disturbed ward like this, just adds to the chaos, and maybe they don't get handled in the best way for them.

One clinician from another discipline distinguished between people admitted to the ward in terms of *volition*, and categorised "patients" who have "major psychiatric illness ... psychoses and major disorders of mood in particular. People who are clearly not volitional, who are out of touch with reality, and who require caregivers, primarily nursing staff to meet their needs" and "clients" who are volitional. Social admissions, for the most part were volitional. However within the inpatient setting all admissions were treated as patients as defined above.

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[3] A finding consistent with the work of Gallop, Lancee and Garfinkel (1989).

Patients too, distinguished between people who have a major mental disorder and others who, as one informant described it "have a mental breakdown but aren't schizophrenic" or as another informant described it are "not really psychiatrically sick". When asked what kinds of patients come in to the ward, a patient suggested "elderly middle-aged women with empty nest syndrome, people like myself with manic depression, people like ___ [a young chronic schizophrenic patient] who aren't going anywhere, and people who are admitted frequently".

The ward thus acted as a repository for people who were "out of control", or whose life situations were "out of control" (social admissions), and for those that people in the community feared might lose control. "Coming in" stabilised situations in the community, or other parts of the health service, and the ward milieu itself was assumed to be therapeutic. Treatment comprised medication, rest, freedom from expectations to perform within the ward, or to be responsible for things outside of the unit, and permission to be "crazy"[4]. As one nurse explained:

> ... a lot of patients just feel safe knowing they can be here, knowing they can let out steam, knowing that they can be themselves for a few days or a week or whatever. And that's enough for them to know that.

Daily routines of inpatients

On week days the majority of patients were up and dressed around 7-7.30 am and went to the unit dining room for breakfast at 8 am. Patients who were newly admitted, or remained quite disturbed, or who required considerable nursing assistance with washing, dressing and other daily activities, would have their breakfast served to them in their rooms on trays. Some patients would be left to sleep if they had had a very disturbed night.

After breakfast in the dining room, patients returned to the ward, and "filled in time" around their rooms, the bathroom and laundry areas, and the lounge until the

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[4] A descriptive term used in this context to mean being psychotic or visibly bizarre, behaving and speaking incomprehensibly (Estroff, 1981, p.xiv).

first scheduled activity of the day. This was the 9.15 am "patients' meeting" with occupational therapy (OT) staff, which was held in the day lounge adjacent to the occupational therapy rooms. Some patients waited around in the corridor outside the ward office prior to this meeting, hoping to "catch" their primary nurse as he or she came out of a patient review meeting (which ran from 8.45 - 9.15 am), to ask questions or to get permission for an activity such as going to the shop.

The 9.15 am patients' meeting included both day-patients from the continuing care program and inpatients from the ward. Occupational therapy staff and a nurse from continuing care attended this meeting, however ward nursing staff did not attend. The meeting was very low key. Patients and staff introduced themselves by stating their name and a personal goal for the day. "My goal is to get through the day" was a common response from depressed patients. Occupational therapy staff encouraged each patient to make a different response from others who had spoken before them. Goal setting had a day by day focus rather than incremental steps toward a larger goal. This was probably influenced by the changing membership and fluctuating attendances of patients in the OT program. Volunteers might be sought for housekeeping tasks such as watering the plants in the OT department, or setting the tables for lunch. The OT program for the day might be clarified, especially if a community outing was planned and patients' suggestions for the outing were sought. The meeting generally lasted 15-20 minutes, then a break was taken for morning tea.

At 10 am patients who wished to go, and who were assessed by ward nursing staff and OT staff as fit, were escorted over to the gymnasium and heated pool in the rehabilitation unit of the general hospital. Patients chose either to swim or to join an exercise program. Half an hour was scheduled for this activity. A nurse from the ward went to assist with supervision of patients in the hydrotherapy pool. At 10.30 am an hour of groupwork was scheduled on the OT program. The focus of

the group varied each day, and included stress management, communication skills, self awareness, leisure skills development; and on the Friday, living skills such as budgeting, cooking and so forth. The groupwork was followed by half an hour of relaxation.

Lunch was served in the unit dining room at 12 midday, then inpatients returned to the ward for medications, and to fill in time before the afternoon activities. Again some patients would have their meals served on trays either in their rooms or in the patients' lounge in the ward. The occupational therapy program resumed at 1 pm with activities such as "projective art", an outing in a hospital minibus to places in the community such as the art gallery, the museum, or mini golf, a trip to a gymnasium in town, fun physical activities; and on the Friday, indoor bowls. The afternoon activities finished around 2.30 pm.

There was no compulsion for inpatients to attend the OT program, although patients were encouraged to do so. Numbers of inpatients attending the program fluctuated widely, from three or four to 13. Patients were likely to remain in the ward for two to three days before being considered for the OT program. They were then assessed by nursing staff and the ward occupational therapist for their readiness and ability to participate in aspects of the OT program, particularly activities which involved leaving the unit, or required good cognitive functioning such as the morning groupwork sessions. A number of known patients declined to attend the OT program although they would be assessed as fit to participate by staff. For these patients and for patients assessed not fit to attend OT activities, there were no structured therapeutic activities in the ward.

Younger patients enjoyed the physical activities in the OT program. One young male patient on his second admission commented "its all right in here, though its fairly boring for the younger patients since its mainly elderly patients in OT. I

enjoy swimming in the pool and the gym ... its boring otherwise." While another young male patient on his first admission stated "I've just started going to OT today [he had been an inpatient for four days], and got involved in a few things; went for a walk, played basketball this afternoon which was fairly exhausting, but I actually thoroughly enjoyed it! Took my mind off things for a while."

A number of female informants, all of whom had had multiple readmissions to the ward chose not to go to OT. They gave a variety of reasons for their decision. "It doesn't do anything for me". "I don't feel that it helps me, not the program that they've got ... Personally I think OT is geared at people going back to work. And I don't work.". "I've made so many baskets and things ... so I've done that, well and truly." The lack of any structured therapeutic program in the ward left a lot of time to fill for patients who chose not to go to OT. One informant on her fifth admission in a period of eight months commented:

> All I do is sit here all day, I hate it! I am not interested in O.T. I go to the meeting at 9.15, but ... I don't want to do art work and draw pictures ... [there is] no structure, you are just left here. And I think "Oh, I could just half kill myself right now if I wanted to".

Most patients spent a period of time talking with their primary nurse each day. Because primary nurses worked on the morning shift, this individual time might well overlap with organised OT activities. Patients routinely saw the ward psychiatrist once a week with their primary nurse, for about 10 minutes, either on a Monday or a Tuesday morning depending on the nursing team to which they were allocated. If crises arose individual patients might be seen more frequently than that. Patients might also have appointments scheduled by their primary nurse with a social worker or psychologist; or for other examinations or tests in the general hospital for diagnosis or treatment of physical conditions. Inpatients might have visitors in the afternoon, or in the evening. There were no organised activities after afternoon tea which was served around 3 pm.

The evening meal was served in the unit dining room at 5.00 pm. Patients started to gather in the dining room 10 to 15 minutes before that time. Meals in the dining room were served at one long table with no fixed places to sit, although early in the period of observation one continuing care patient had a regular seat near the head of the table and organised the seating of other patients around her. As many as five continuing care patients would join the inpatients for the evening meal, although the continuing care day-program finished at 3 pm. Again, trays would be taken around to the ward for patients who were assessed by staff to be unfit to go to the dining room. Medications were administered after the evening meal, then patients were left to structure the evenings for themselves. Around 6 pm, when the hospital aid had cleaned up in the dining room after the evening meal, the multiple external doors to the building, with the exception of the main entrance into the unit reception area, were locked. The dining room was locked, as was "Harley Street", so that the nurses on the evening shift had fewer areas to cover when "keeping an eye on" the inpatients.

Ways of filling in time

Ways of filling in time for patients in the evenings included solitary strategies such as sitting in one's room with the door shut, or finding a quiet place in the unit to sit (such as a corner of the unit reception area) and read, or think, or do embroidery. Some patients smoked and watched television in the OT day room, or listened to the radio in the smoker's lounge. Other patients "paced" the corridors, or watched the activities of others from a distance (eg. through the observation window of the lounge). Small groups of patients gathered together and talked about their problems, shared cigarettes, went for a walk to the shop, played card games or other board games, and talked about the unit and the staff. Some patients seemed drawn to more disturbed patients and enjoyed the bizarre discussion and escalating behaviour which eventuated until a nurse intervened and dispersed the group. Patients might have visitors, others made phone calls to friends or relatives.

Others did their laundry. Frequent cups of tea and coffee were made in the ward kitchen. Occasionally one of the patients would decide to do the dishes in the ward kitchen, otherwise these were left piled up for the hospital aid to wash.

A comparatively small number of patients chose the patients' lounge as a venue for their solitary or group activities, although a number of patients and nursing staff did gather after the evening meal to watch the 6 pm news on television. The hospital aid would gather together a small group of patients to play pool or indoor bowls in the early evening. At 8 pm, visitors, including continuing care patients who "dropped in to visit" or "spend time out" in the evening, were asked to leave, and the "front" door was locked. Supper was served by the hospital aid shortly after 8 pm, on a trolley in the ward just outside the lounge door. There was tea, coffee and Milo (a chocolate drink made with hot milk), plus sandwiches usually made with salad left over from tea. By 9 pm the majority of patients were collecting their night time medications from the medication clinic and preparing to go to bed.

The ward milieu

The ward had a comfortable, open environment, with low expectations for performance or participation by patients. Patients variously described it as "a safe place where you can forget your worries". "Only minor things here - I shouldn't say that. This place is open and free, you can do what you like." "Its like a cocoon in here." One male patient described it as "a good place. It's open, comfortable, relaxed, a safe place to get 'unscrewed' (psychically I mean)". He added a cautionary note "Don't be too critical of this place. It does a good job, it's always busy. Lots of patients come through here, though some stay too long. They should have a clean out every two weeks". One father of a young adult patient commented as he collected his son to go on leave, "its like he is moving between motels".

Other patients were less happy about the safe haven the ward provided and suggested there should be "a more active program", "more active therapy, not merely medication". One patient suggested that "people get lost ... in the system, or lost in the security of the place."

A lot of people came in and out of the ward during the day. Patients and nurses wore everyday casual clothes, and nurses did not consistently wear name badges. The distinction between nurses and patients, and between inpatients and other patients who might come in to the ward to visit or to use the facilities, was not easy for newcomers, be they patients, family members, students, or the researcher. One person regularly entered the ward office in the morning, placed his bike helmet and jacket under a chair and left, returning around 3 pm to collect them. The researcher assumed he was a staff member of sorts, maybe a student. A considerable period of time elapsed before it was discovered he was a patient in the OT day program.

Around meeting times such as the 8.45 am staff meeting and the changeover period between morning and afternoon shifts there could be so many people around the ward office area that the milieu was like that of a railway station, busy and anonymous, with many people milling around. As one nurse commented "there are times [in the ward] when there are just so many people, you haven't a clue who's who or what's what." Nursing staff recognised the stress this caused both for inpatients, "so many of them when they are really disturbed, hold to their rooms"; and for outpatients. "If you come in here for time out, to collect your thoughts, and you find this conglomeration of people and strangers are walking around and you wonder who they are ..." Finding a quiet spot or a private space to "cry and let it all out" was not easy.

In the mornings and early afternoons there was often as few as four or five patients in the ward. The remainder of the patients were at occupational therapy or

out for other reasons. One outpatient commented "that's why I like coming to the ward [for time out in the day time] because most people have gone out". From 3.30 pm onwards most inpatients were back in the ward, visitors were around, continuing care patients dropped in to visit or see who they knew, and patients gathered in little groups.

Around the time other staff were going home the workload of the afternoon nursing staff increased. The two phones in the ward office rang frequently, the on-call psychiatrist came in, and the ward nursing staff took over as the after hours service. Messages and patient files were left in the ward office in case patients in the community or in the general hospital who were known to be disturbed presented in crisis. Between 4 and 8 pm the atmosphere in the ward could be quite "charged" if there were one or more disturbed inpatients. This was a time when, as identified by some patients, impulsive behaviour such as leaving the unit, or "cutting" oneself could go undetected. One of these patients commented, "once the doors are locked [at 8 pm] the visitors are gone, outpatients are gone, a lot of people start going to bed, things seem to calm down a lot."

Weekends differed from weekdays in that they were totally unstructured, except by meals and medication. A large number of inpatients went on leave for part or all of the weekend, so that patients remaining "in" were those for whom placement was a problem, although they might otherwise be reasonably "well" in themselves; and those patients who were "too disturbed" or "not safe" to be allowed leave. For these patients "filling in time" on the weekend was a problem. They described the weekends as "very boring" and many patients commented that "a lot more activity should be organised". A larger number of outpatients dropped in to the ward on the weekends for a chat, to get a "depot" injection[5] or to talk with a particular

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[5] A long-acting form of antipsychotic medication - the drug is injected intramuscularly in a heavy oil solution, and is released slowly into the body over a period of weeks.

nurse. During the normal working week most of these contacts were handled by the continuing care service.

While weekdays and weekends were markedly different, there were also differences in the patterning of activities and mood during the week. Most patients came back from leave on Sunday night or Monday morning. Weekly interviews with the ward psychiatrist took place on Monday or Tuesday, with some reviewing of plans for the weekend on Thursday. Fridays were seen as the end of the working week, so that even the OT program had more practically focussed activities in the morning, while indoor bowls scheduled in the afternoon was described as a "wind down" activity. One nurse described the ward as having moods.

> Monday [there is] a bit of apprehension, [with] people coming back from leave. Sometimes [there is] an admission following the "yellow file" being left on Friday [confidential records of an outpatient who may need to "come in"]. People [may be] somewhat reluctant to be back in the ward following a successful weekend leave, or sometimes, the weekend leave can be quite stressful.... Tuesday, Wednesday, there's some resignation and reassessing where they are. Thursday, I get an impression that there's some optimism, if only I imagine it.... Some of the patients are looking forward to the possibility of weekend leave and/or discharge. So that I think there are areas of mood, that are peculiar to [the ward].

Readiness for discharge

Length of admission, patients' readiness for discharge, and their beliefs about "how you get discharged" varied considerably. Patients who had had multiple admissions reported "You tell them when you're ready to go home, you don't wait for them to tell you." These patients often had quite short admissions - five to ten days. Often, from an observer's perspective, little had changed for these patients. The admission was "for a rest", medications were adjusted, the ward functioned as a safe haven, providing a temporary respite from outside pressures. As one nurse explained :

> ...you will find the majority of people that do come through here ... on the psych. circular thing that come and go and come and go, know how to use the unit as far as time out and thinking "right I need to be admitted". Then

they'll also be discharged usually within a week or two weeks. They'll say to the doctor "Okay I'm ready to go now". Because we know them well and they know us well and they know what services are out in the community for them as well as up here for time out, they know when they are ready to go out and be able to cope with things. So a lot of [these] patients ... take responsibility for their own care after the first 24 or 48 hours.

However the experience of patients on their first admission was very varied. One patient, who felt well after an acute admission as an involuntary patient to a psychiatric hospital, followed by five days in this ward, commented "I want to go home, but nobody is telling me ... the nurses reckon I shouldn't be here, but it's basically up to the doctor, not them". Asked what he was doing to get out he responded "I'm just behaving myself, helping out, talking to anybody who wants to talk to me." Others, particularly volitional patients, who got "lost" in the security of the ward, and whose external stressors which precipitated the admission were not dealt with, felt unready to go home even after a lengthy admission - "nothing has changed". They described feeling "pushed out".

Prior to discharge most patients went on leave overnight or more often for the weekend. The purpose of leave was to assess their readiness to cope in "the outside world". Nurses routinely told patients "If you have any problems, phone the unit, or come back early". This message was reinforced on discharge, when patients were told that "the unit is always available - if you have any difficulties you can phone in or come up for time out".

Some patients after discharge did "keep in touch" with the ward, fellow patients and ward staff by coming up for time out to temporarily escape from the realities of life, by making phone calls to ward staff, by attending the day program run by occupational therapists, or by hanging around the unit as if it was a drop-in centre. A few patients were given permission to come in for an evening meal on a regular basis. There was a group of patients, younger people diagnosed as having schizophrenia or bipolar disorder, for whom visiting the unit had become a way of

life. These patients were "not going anywhere" in their lives from a "normal" perspective, or alternatively they could be described as developing the institutionalised behaviours of chronic psychiatric patients. Toward the end of the observational period, the latter group were being actively discouraged by continuing care nursing staff, from using the unit as a drop-in facility during the working week. This represented a change in policy for these patients.

Reasons that outpatients who were *not* in crisis gave for coming to the unit could be grouped into needs for social assistance " for a meal, I don't have any money left"; for entertainment or socialisation "I came for a break" or "to play pool" or "to see friends or visit"; or needs for treatment "to join the program, you're a day patient then", or "to collect daily meds" or "get a depot injection" or "if you're not feeling well, to see staff". While in the unit such patients used ward facilities such as the kitchen for tea and coffee or snacks. One patient often had a bath in the ward, while others, if feeling stressed might ask to use the spa bath.

Being "in the system"

Being "in the system", for many patients, provided lifetime access to the service. As one nurse described it "we are accessible ... and we are always here, and there's familiarity and perhaps some security in that too. If all else fails they can come here." "Sometimes people arrive in a taxi, get out and then just emotionally collapse once they are inside the building. They've held themselves together pretty well [to get here] but [its] just the sheer relief of being here at times." The ease of access in terms of re-entry was further described as follows:

> ____ [Discharged patient] could turn up at the unit claiming she's not well, feeling suicidal. Because she's already in the system, ... on the files, we probably recognise she seems to have a problem over the years, and she's seeking us out for help. She has a right to do this.

One nurse expressed concern about people's ability to "get into the system":

...until they come to us they can't get into the system... You've got to go to a GP [general practitioner]. If you can't go to a GP what do you do? You go to all the neighbours and the family. And eventually someone takes them to the GP, they get into the system, and once they are in the system [pause] they are fine, everybody carries them. But it's all those ones that don't get in the system, those are the ones that I feel are really needing our help.

Another nurse questioned whether admission was easier the second time around. "Is it easier for them to get back into the system once you've been in it once?... I think it would be...because ___ [current inpatient with a bipolar disorder] hasn't been unmanageable [on this admission]." In talking about being in the system a patient informant, who had had several admissions during the period of the study, commented "I am sure its worse once you have actually been an inpatient...You are more likely to fall back on them once you've been an inpatient. For me, I never actually rang them out of hours, or anything like that until after I'd been an inpatient." When asked whether staff told her to phone in or come up for time out, she responded "Yeah, I came in for time out and got back in." Another male patient with a bipolar disorder talked about having to choose between "taking the easy way out, getting dependent on the unit, being passive, versus taking the hard way out, breaking free". Nurses' expectations of patients leaving "the system" in an ongoing well state were not very high. For example, when asked what she expected of patients in terms of outcomes a nurse responded:

Well I think my expectations were quite high in the beginning, but they are [pause] not so great at the moment. I mean I have been here [eight months], and already, there are clients here ... that have had previous admissions. I mean that revolving door continues, and no matter how much and how good the intervention, and how enthusiastic, and how motivated they leave [pause] they are going to be back.

Readmissions: The "revolving door" syndrome

The category of *known* versus *not known* patients was highlighted early in the period of observation, when it was noted that the majority of patients in the ward had had previous admissions. When nursing staff were asked how they referred to those patients, were they "old hands" or "regulars", a nurse responded "they are the ones I know. I always look at the board [ie the whiteboard listing patient

information] to see who I don't know. The others I already know. I don't call them anything." Nursing notes on admission not infrequently stated "This well known man [or woman]...", or "patient well known to the unit..." It was accepted in this unit that usually one third of admissions were new patients, two thirds were readmissions of known patients. The story of one young woman with schizophrenia illustrated this process.

> Yes. Well I went into [the ward] in January the year before last. I was there for about three months and then I went to [residential rehabilitation] for about 7 months, and then I got sick again or something happened and I had to go down to [committed to psychiatric hospital] and then I came back [to the ward] and went to [residential rehabilitation] I think. Then I got sick again and went to [psychiatric hospital] again and came back [to the ward] and came here [half way house]. No, the last time after I was at [the ward] I went to [half way house] and then I went back to [residential rehabilitation] and yeah back to [psychiatric hospital] - and its a long story, eh! Came back here, yeah.

Another informant with depression and chronic suicidal thoughts over the past twelve years, related being told by the psychiatrist that she had been admitted 24 times in the last two years though she said it was only 17.

> ...I know I've been in a lot ... I mean, I'm desperately trying to find something that will just cure me so that I won't have to go in at all, it would be wonderful. But I don't think telling people how many times they've been in over a period of time is exactly the way to keep you out. In fact I think it sometimes has the reverse effect. I'm one of these people who tends to do things like that so if it got to the stage again ... that I need to come in, I will be thinking "but I've had so many admissions this year, perhaps I shouldn't go in", and that would get very bad.

This patient overdosed before her next admission. The revolving door population included a wider group than those patients with a major mental disorder who were described as the *chronically psychiatrically disabled* in planning documents. Social admissions, "people with social problems more than a psychiatric illness" as one nurse described them, might also have repeated admissions. When asked what happens to those people, she replied:

> Sometimes things are resolved for them. Other times they are just put back into the same circumstances from which they came ... Then they either come back, or ... some of them wise up a bit, and are a bit stronger, so they use other community agencies. And some of them just keep coming back.

The functions of the ward

The ward provided inpatient care both for the acute service and for the general psychiatric service. However, the assumption made prior to the beginning of data collection that the ward functioned primarily as an "acute" ward, was clearly unfounded. An outpatient, in for his fortnightly (once every two weeks) injection, talked with the researcher while making himself a cup of coffee in the ward kitchen. When it was explained that the researcher was interested in learning how an acute ward like this functioned, he responded "I don't think this is an acute ward any more, it might have been once, now there are so many people here who've been around a long time.[pause] Maybe its good for people who are new - negative reinforcement maybe".

With the revolving door population making up two thirds of all admissions, staff described an important function of the ward as "maintaining chronically psychiatrically disabled patients in the community" by intermittently admitting them or providing time out. Some patients had been maintained that way for 10 to 15 years or longer. "Keeping people safe" was another function identified by staff. Thus the objective of admitting a patient might not be treatment, as in making the person better, but rather to provide for immediate safety. A view of the ward as "last resort" for the community prevailed. As one nurse explained it:

> We are generally open to most people that are referred here. I think we are consistent. We are one place that is clearly identifiable as a resource centre in [city] anyway. If all else fails they can try [the unit]. And as a resource, perhaps we have some moral obligation to try and address the problem.

However the unit also functioned as a place of "first resort" for some patients, such as the previously mentioned (pp.88-89) younger group of patients diagnosed as having a major mental disorder. Thus the *ethos* of the ward was one of humanitarian caring. There was enmeshment (diffuse boundaries) of crisis services, continuing care services and inpatient care. This blurring of boundaries was particularly marked after 4.30 pm on week days and during the weekend when

nursing staff in the ward, with the backup of the on-call medical staff, provided the after hours crisis service for all parts of the mental health service, except for patients with alcohol and drug dependency problems who were referred to the detoxification ward.

For other parts of the service, the ward functioned as a backup facility so that staff working 8 am to 4.30 pm Monday to Friday, could go home with a degree of comfort, having advised their at-risk clients or patients that staff on the ward were always available and that they could "phone in" for support or come up to the ward for time out if necessary.

The after hours service

The boundaries between the ward and the service were blurred, so that ward staff said "we are a 24 hour service" or "we are an acute centre which includes phone calls". After 4.30 pm, all incoming calls to the unit were received in the ward office, thus the ward office became the communication headquarters of the mental health service after normal working hours. The ward operated as the hub of the mental health service, with the nursing staff on the alert to receive incoming requests for help. One nurse always needed to be available to answer the two telephones in the office. The majority of phone calls were from known patients, or from the family or friends of known patients. The description of the content of these phone calls which follows is derived from nurses' reporting of the conversations, either in discussion with the researcher or colleagues in the ward office, or recorded in the daily log.

Known patients called for a variety of reasons, not necessarily because they were in crisis. Patients often phoned to leave a message for staff who work Monday to Friday 8-4.30 pm. "I won't be in to OT in the morning, don't collect me in the van". They might want to change or arrange an appointment with a psychiatrist,

social worker, psychologist, or community nurse. They might request a routine prescription for more medications. Sometimes patients called to leave a message for, or pass on information for, or about, another patient, particularly if that person was causing a disturbance in the community, or in one of the halfway houses.

Some patients phoned for a chat. They might have been lonely and seeking social contact, or they wanted to report progress. "I'm feeling better", "I've got a job". They might report the outcome of a visit to Accident and Emergency department or their general practitioner. They might report their location. "I'm on way to the unit", "I'm at a friend's house", "I got home safely". They might request advice about family disputes, problems in relationships, or dosage and combinations of prescription and over the counter medications. Sometimes patients requested to talk with a particular nurse, or would time their calls when they knew that nurse was on duty. Night staff in particular received regular calls from patients.

When patients were feeling stressed they called to ventilate feelings "I'm feeling low", "I'm angry about..." "I feel suicidal"; or to report symptoms "the voices are telling me to...", "I have the 'flu'", "I can't sleep", "I'm feeling dizzy", "my neck has gone stiff", "I've got a terrible dry mouth", "I'm feeling restless and can't settle". When in this stressed state, patients might call to report intentions or decisions. "I'm not having any more injections", I am moving", "I'm not coming back to the unit any more", "I'm going to take an overdose." Alternatively, they might request urgent assessment. "I need extra meds". "This new medicine doesn't suit me". "Can you check my blood pressure?" "I need to see the on-call doctor". "Can I come up for time out?" "I need to be admitted".

Family and friends of known patients called when they were concerned about deterioration in the patient's condition, unable to make contact with the patient, or to cope with the behaviours of the patient, or sought clarification or guidance about

medication. People also self-referred in acute distress and often were reluctant to identify themselves. As one nurse described the situation:

> ...a lot of the time people won't give their names and so you will spend half an hour or so talking on the phone to someone you don't know, who is saying they are suicidal, taking tablets, or whatever. And you don't know who they are at all ... where they live or a phone number, and all you can do is listen to what they are saying. You can't hang up on them, because certainly that would make them feel even worse. But all you want to do is say "tell me your name, tell me where you live, so that I can send you someone to help you more effectively". But after you have talked to them for half an hour or so, you will get that information out of them, ... the majority of the time.

Other phone calls came from the Police, GPs, the After Hours Medical Service, voluntary community agencies; or from staff from other parts of the hospital such as Accident and Emergency, the detoxification ward, or other wards; from other hospitals who had contact with known patients, or from caregivers of known patients in the community (eg. supervisors of IHC [intellectual handicap] hostels, rehabilitation and supervised living houses). Requests for information included "do you have any record of [person] receiving treatment at the unit?", "can you give me the name of the on-call doctor?", "do you have any beds?" or "____ [a known patient] is being physically or verbally aggressive or destructive. What can we do?". A request for assessment usually accompanied the latter request. One nurse explained what happened:

> Basically most of the work we do in that way on the evening shift is time out, rather than trying to get someone admitted via a phone call. We may get a phone call [that] someone is disturbed, they need to be admitted. We'll advise that they come up for time out and we'll assess them and then we'll get the doctor to come if we feel its necessary ... People in the community ... are in a situation themselves of seeing it all happening around them, this person going "off their tree" so to speak. And they start getting a bit panicky as well. So a lot of the time if you take the person that is causing the upset away and tell the other person to "go away and leave this person here for some time out, while you go and have a cuppa and do whatever you have to do" - that will often diffuse whatever is going on. But there are other times when we assess people as soon as they come to the door, and ask the relatives or whoever brings them up to stay so that the doctor can see them. You can usually tell within the first five or ten minutes whether someone is going to need admission or, just ask them in - have a cuppa, have a chat, go from there.

As well as responding to phone calls and persons presenting for time out or for assessment by the on-call psychiatrist or registrar, nurses on the ward made phone calls out, and went off the unit to make "out-calls". Phone calls "out" to known patients were made to check on the well-being of patients who had presented during the day or the previous night as somewhat disturbed. Such calls might be initiated by the nurse, or were made at the request of another health professional involved with the patient, such as a psychiatrist, or nurses from the continuing care service. Ward nurses also phoned outpatients to pass on messages, for example that a continuing care patient's "depot" injection was overdue. Other phone calls out might include notifying the Police that a situation existed in the community where the family of a known outpatient might request their assistance to bring the patient to the unit, or that a committal might be necessary; calls to family members of the patient, and calls to the on-call psychiatrist requesting an assessment, or forewarning of a crisis situation unfolding in the community.

Nurses also went off the ward for out-calls. On the morning shift nurses left the ward primarily with inpatients for whom they were primary nurse, to enable those patients to sort out things at home, or to meet personal and social needs. Or these nurses might go out to search for at-risk inpatients who had "gone AWOL" (absent without leave). Out-calls on the afternoon shift and at weekends tended to be related to outpatient needs. Nursing staff, or the hospital aid, might go out to collect outpatients to come to the ward for time out, or to take such patients home. Nurses would go out to check on the well-being of an outpatient they had been unable to contact by phone, or who had called in a distressed state, or about whom neighbours had called, and might bring that patient in for time out or assessment by the on-call doctor. As one nurse described it "someone's 'gone off' like ___ [a known patient with paranoid schizophrenia] and all the neighbours are complaining like mad, and ___ is sitting there screaming away. You know the patient well, that [she] will let you in..." A nurse might also go off the unit to give

an injection of Cogentin[6] to a known patient with a dystonic reaction who was unable to come in to the unit. Because of lower staffing levels outside the regular working week, usually only one nurse went out on an out-call to known patients.

The work of the after hours service was recorded in a daily report book which "logged" the majority of inward and outward phone calls, people in for time out, for meals or for acute assessment, along with messages from other staff about patients who may contact the ward after hours, or about whom nurses from other wards might wish to consult. Confidential patient files of outpatients who were likely to contact the ward after hours, were left in the ward office for nursing staff and the on-call psychiatrist. The bed occupancy of the ward, including admissions, discharges and the number of patients on leave was also recorded in the daily log.

In the 12 month period 1 July 1990 to 30 June 1991 approximately 690 different patient's names were recorded in this book, of whom 281 (41%) were inpatients one or more times during that period. When an individual code number was allocated for each patient name recorded over that time period, 63 code numbers were allocated in the first week; 144 in the first month. Thereafter, the number of new names logged each week ranged from 5-22 with a median of 13. The majority of the patients listed would have their names recorded in the daily log once only, or infrequently. However this log reflected the outward focus of the unit to the community, and to other parts of the mental health service. The implications for inpatient care of the provision of an after hours service from the ward, will be discussed in the next chapter (pp.117-121).

With the exception of new referrals for acute assessment, most people who used the phone-in, time out and on-call assessment facilities of the after hours service were *known* patients, part of the revolving door population of patients described

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[6] Benztropine mesylate - anticholinergic medication used to treat parkinsonian side effects of antipsychotic medications.

earlier in this chapter, patients who were already in the system. Thus, for both inpatients and outpatients, the ward functioned as a place of asylum from society, a place where patients found acceptance and social contact with other patients, a safe place to be when feeling out of control. The daily log recorded innumerable contacts with outpatients:

> ____ popped in for a chat and a warm meal. Felt "pissed off". Felt like in a sandwich between society and the unit, felt unable to do anything. Frightened he wouldn't be qualified for a job he had applied for...

For the community, the ward function was to maintain order in society in cooperation with family members, other community agencies and the police. The police in particular had a reciprocal relationship with the staff of the psychiatric unit in diffusing trouble in the community. A few of the patients maintained in the community periodically caused considerable disturbance in their neighbourhood, with upset community residents and police involvement. Such patients were not necessarily psychotic. The following selected extracts from the daily log which track the contact recorded with one patient, illustrate this process.

> 1850 ____ [a patient discharged from the ward 6 days previously] phoned, concerned about not sleeping/not eating and the medication not working - would like someone to phone her tomorrow - would ____ [nurse] oblige?

> 2322 P/c [phone call] from a friend of ____ , concerned re suicidal, weak malnourished state - is going to take to A & E.

> 0230 P/c A & E re ____ - looking for overnight accom[modation]. Advised of bed state [19] and disruptive nature of ward. He agreed to look elsewhere. Admitted [detoxification ward -length of admission not known].

Six months later:

> 1830 P/c from Ambulance [service] re ____ [patient] - feeling down, wanting admission. Discharged from [detoxification ward] yesterday after being seen by ____ [psychiatrist]. Ambulance will bring her here for assessment by Psych Reg[istrar].

> 1845 ____ onto ward. Seen by Psych Reg[istrar] - not for admission - taken home.

> 0030 P/c____ - exasperated at the inefficiency of her nocte meds. Given the night nurse's insomnia-busting advice - seemed cheered by this!

1415 Went out to pick up ___ from [address]. Was found lying in bed clutching phone. Not wanting to let it go. Appeared very distressed - stated "I want to go out on the road. If only I can get on to the road everything will be okay" - when I asked "what do you mean?" She replied "A car will hit me hopefully". Says she has been feeling suicidal for the last 3 weeks but has been trying to cope. Over last few days "have felt worse". Stated x 2 [twice] "I feel suicidal". Said she took all the med[ication]s which were dispensed to her from ward last night.

addit Seen by Psychiatrist. For admission to [detoxification ward -ward bed occupancy 19 -discharged eight days later.]

10 days after discharge:

2030 P/c re ___ : Friend rang saying ___ had rung her at home wanting company. Friend went to ___ 's to find her holding a sharp knife. Had managed to "disarm" her but didn't want to leave her alone and they couldn't stay there. They also felt ___ had been drinking alcohol. ___ [Psychiatric Registrar] notified. He will ring [her] friend.

2230 ___ brought to unit by neighbours. ___ has been threatening suicide and neighbours were worried about overnight. ___ very ambivalent about suicide O/A [on arrival] at unit. Advised to go home and take nocte meds. Neighbours will take all her meds home with them and also all knives. They are happy to do this. Will ring here when they leave ___ . ___ [Psychiatric Registrar] notified.

addit Re ___ : if arrives on unit or calls she is to be referred to [detoxification ward] and A&D [alcohol & drug] centre.

four days later:

1640 P/c from ___ 's son in [another city] as she had rung him to say she'd taken Ponstan[7]. GP contacted - he will assess. See yellow file. [resulted in 3 weeks admission to ward].

10 days after discharge:

0455 P/c Constable re ___ - the police were called to ___ 's home and found her in a "depressed and suicidal state" and felt she needed to be in care. Advised to bring her up for assessment. ___ phoned the police herself.

0520 ___ arrived accompanied by 2 police. "Weak and staggering" as she has spent "so long in bed without eating". Managed to stumble to the end bed to rest until more adequately assessed...

0900 ___ - seen by [psychiatrist] and to go home after lunch. Given Script and appt [appointment] card for next Tuesday - can have time out in unit if stressed.

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[7] Mefenamic acid - nonsteroidal anti-inflammatory analgesic and antiprostiglandin agent.

4 days later:

2330 P/c ___ . Police with ___ - she called them again - police reluctant to leave her as she was threatening suicide - advised to bring up for assessment/time out.

2350 ___ arrived - drunk - Hystrionic [sic]. Shouting and remonstrating with police and staff not to hit her! Duty Dr informed, see yellow file ___ bedded overnight awaiting assessment.

[am] ___ s/b [seen by] psychiatrist. Not for admission but is to spend day here and come up again tomorrow. To see psychiatrist again on Thursday. Has meds charted for nocte to take from ward.

2000 ___ taken home. Given house keys and meds for the night.

A nurse explained the ward's involvement:

> Those situations are very hard, because as much as we want to say to them "For God's sake get on with your life", we can't. We have to help the community, and if the community is not there to help these people then we are going to be the only help. So if we make it so that the community want nothing to do with these people we are making a rod for our own back as well, and defeating the purpose of having community agencies.

The ability of a few patients to mobilise the concern of friends, family members, neighbours, and to call out the Police, the Ambulance service, GPs, Samaritans and nurses from the ward, suggested that for such patients "coming in" was a goal in itself. Considerable pressure was exerted by people in the community upon medical staff to "do something", and upon the ward to receive such patients. The timing of these events was significant. Almost all of the contacts in the previous example occurred out of normal working hours. An admission allowed people outside of the unit, both professionals and other people in the community, to feel comfortable that the situation had been resolved. Patients who used the service in this manner could be viewed as victims of their illness (consistent with the dominant belief system operating in the ward, as will be described in the next chapter) or alternatively they could be seen as active players in the maintenance of an identity as a chronic psychiatric patient (an issue addressed further in chapter seven, pp.168-170).

Summary

This chapter addressed the question of "what goes on" in the study ward. A broad descriptive overview of the research setting has been provided, including the physical environment of the ward, the staffing and patient population of the ward, the daily routines of inpatients, the ward milieu, and the processes of admission and discharge. A discussion of the way care in the ward was organised in response to the problems of limited availability of inpatient beds and the existence of a "revolving door" population of patients in the research setting, led to descriptions of the functions of the ward, and of the "after hours" service provided by nurses. The chapter which follows explores in more depth the dominant belief system operating in the ward, in order to understand the basis for the organisation of care as described in this chapter. Then the impact of that organisation on both nurses' work and the provision of care to patients is further examined.

V

THE ORGANISATION OF CARE:
WHY THINGS ARE THE WAY THEY ARE

Introduction

Having addressed the question as to "what goes on" in the research setting, a further question was raised as to "why things are the way they are?", particularly in relation to the central function of the ward in maintaining chronically mentally ill patients in the community as outlined in the previous chapter (p.92); and the acceptance by medical and nursing staff of the "revolving door" pattern of admissions, which included not only patients with a major mental disorder in an acute phase of their illness, but "social admissions" as described in chapter four (pp.77-78). These findings were unexpected, contradicting an assumption held prior to the onset of data collection, that the inpatient population of an "acute" ward would demonstrate high levels of acuity of illness, requiring intensive caring/controlling interventions by nursing staff. However, as will be shown, the findings were consistent with the underlying belief system in the ward.

This chapter outlines the dominant belief system operating in the ward which included an expectation of ongoing mental illness, of chronicity over the lifetime, for the majority of patients admitted. The impact of this belief system, and of the organisation of care described in the previous chapter, on both nurses' work and the provision of care to inpatients, is further explored.

The dominant belief system operating in the ward

Early in the period of observation, the researcher became aware of discrepancies between the meanings attributed to patient behaviours by nurses, patients and the researcher. Thus questions such as "what is 'normal' behaviour?" were explored,

particularly in relation to young male patients with a major mental disorder. Patient behaviours which the researcher interpreted as responses to boredom, and attention seeking, nurses responded to as signs of illness, "going high", and as a consequence of this interpretation, offered prn (as necessary) medication. Patient behaviours which the researcher interpreted as helping others, and behaviours viewed as concern about the researcher's presence (such as frequent looks darting at the researcher) were defined by nurses as "intrusive" behaviour. Yet what counted as signs of illness in the subdued atmosphere of the ward, could be normal or acceptable behaviours in an outside context, for example amongst university students or unemployed youth.

Patients also experienced discrepancies between their understanding of their experiences, and nurses' interpretations of their behaviour. For example, a young male patient, a university student with a diagnosis of bipolar disorder, greeted the researcher with "Hi, I feel good, I have had my tranquillisers cut and mood stabilisers, Tegretol[1], decreased 50%. I'm normal!" Asked "What were you like before your illness?" he responded "Like this only more energy". Asked "How can you tell what is high and what is normal?" he responded "High includes pacing and restlessness, normal doesn't." A few days later this patient greeted the researcher with "I'm cured! I was better last time you saw me, then I went down again so I cut out the last tranquilliser and I'm better again. I'm not high am I? They [meaning the nursing staff] reckon I'll 'flip out'".

On another occasion this patient and another young patient who had a diagnosis of schizophrenia, were observed one evening as they walked and talked together, moving in a repetitive track between the dining room doors and the doors at the entrance to the ward. Nurses described their behaviour as "pacing", a term used by staff and understood by patients to be a sign of psychiatric illness. After watching

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[1] Carbamazepine - an anticonvulsive medication which has been found to be effective in treating elevated mood in mania or bipolar disorder.

for a while, the researcher joined them and asked "Is this 'pacing'?" "No its not pacing - its just walking together and communicating" one responded. The other explained "Pacing, when it comes from restlessness from inside you, or from medication - you can stop like this [we stopped in the corridor] for a few minutes. Then restlessness builds up. You have to pace again." Thus in the context of a psychiatric ward, patients and nurses may have different perceptions as to the meaning of behaviours. The dominant model within which reality in this setting was framed or interpreted was that of the psychiatric medical model, as illustrated in the following section, thus patient behaviours were monitored by nurses for signs and symptoms of illness.

Mental illness as a lifelong disorder

Two incidents further focussed the researcher's attention on beliefs about illness in this setting. One was the comment by a psychiatrist that "mental illness is increasingly seen as a lifetime event". This statement was made in the context of a discussion of an 18 year old young man recently admitted to the ward, whom the psychiatrist described as "bright, a high achiever, pushed too hard and now this psychotic break". The other was finding a photocopied title and abstract of a journal article entitled "Early onset schizophrenics and psychotic mood disorder: a clinical outcome", pasted in the clinical notes of the confidential file of a young female patient diagnosed as schizophrenic. The conclusion of the abstract was "that early onset schizophrenia is often a lifelong disorder resembling Kraepelin's dementia praecox." While the incidents cited referred to the group of patients who have the worst prognosis, these expectations appeared to flow on to a larger population. Thus, for example, when questioned about the expectation that mental illness was a life long disorder, a psychiatrist responded:

> Well for some people yes ... You are also seeing the acute people who have their acute admission, and then stay well. Or the person in the first depressive illness ... [who] gets well and doesn't ever come back in again. I think the difficulty for the ward [staff] is that ... two thirds of them [patients] are readmissions, so they [nurses] are seeing the chronically ill who are in an acute phase and are acutely disturbed. And so they [nurses] may well get to

feel that nothing ever works. But then that's how people are. They [nurses] are dealing with the small proportion of the number of schizophrenics or bipolars or whatever that are very hard to treat and have prolonged disability with acute failures. No matter what you do, as well as you can.

The high readmission rate was therefore regarded as inevitable by psychiatrists and many of the nursing staff because of the "fluctuating nature of psychiatric illness". Yet, as described in the previous chapter (p.77), many of the patients in the ward did not have a major mental disorder, or were admitted because of problems in coping with the outside world, rather than because of an acute exacerbation of their illness. Another psychiatrist explained the all encompassing embrace of psychiatry:

> Now in psychiatry where you have got to, of course, have the medical approach, but we have the behavioural and the other approaches as well. And really you can fit in any kind of illness, whether you are suffering from a real physical illness, or other illness which can be explained in terms of your personality and behaviour. I think that is where psychiatry is more challenging, and more broad in that ... you cannot really define mental health.... you cannot have definite boundaries for mental health, because it encompasses all these difficulties in life.... So we say "all right, we'll try it", and we know even if we have a firm diagnosis of schizophrenia for example, we cannot say "we can definitely treat you, cure your illness". Certainly though some people do get better. Some people do have to [come back]. Same thing applies to depression. You can treat the depression, and some people get better, and others go into a chronic state. And whilst they are maintaining their sickness status [pause] we get to this [point] where [there are] other factors that may look like behavioural model, personality model and all those things. So that's why here we take, you know, the rejects of the other systems.

Patients' beliefs about their illness

Patients did not necessarily perceive themselves as having a psychiatric illness. Often they described stressful life situations and conflict or losses in relationships as the reason for admission. The father of one acutely psychotic patient on his second admission commented:

> It's not an unknown illness for young teenagers just feeling their way in the world to over commit themselves. Its happened before, it can happen again...the thing is that time keeps on going. Every hour and every day it keeps going on, and the longer you are sort of in this state,... it seems to me to be self perpetuating, and it gets harder and harder to get out [of it]...I at this stage of the game still think it's the result of stress - I'm not convinced its schizophrenia and the doctors haven't said that it is schizophrenia.

Patients newly diagnosed with a major mental illness attempted to come to terms with the meaning of this illness in their lives, and their hopes and expectations for the future. One young patient commented "I have a bipolar disorder. I should be able to cope with life with that ... Its just managing the highs and lows." On another day when he was feeling "down" he stated "I lie here and think I'm never going to get a job. I'll be a dole bludger, never achieve anything" (he had one year of study to complete a first degree). Another young patient with a schizophrenic diagnosis responded "You mean a beneficiary like me." A continuing care patient who "dropped in" to the unit, said she had been staying at home in bed watching TV a lot of days since her last discharge. "They [staff] have given up on me so I have too". When asked about their illness, patients with a schizophrenic diagnosis did not use the term schizophrenia. Rather they talked about the voices or thoughts which bothered them, whether they were present or not, and the difficulties of getting on with life outside the unit.

> The only thing you can do is ignore them [the thoughts] - it could be why I'm finding it hard to get better eh?...the doctor said that I might not get better...yes, they said that I won't. My friends reckon I might, but you don't know who to listen to. I suppose you should listen to the doctors, eh?

Young schizophrenic patients, even when their symptoms were gone, often found themselves stuck, unable to move back into the ordinary stream of life. As the young woman quoted above continued:

> ... I find it hard to do things ... I was speaking to a friend today, because sometimes you feel awful or guilty because you are like that - or not guilty but you feel lazy. I do do things, but you are not quite up with it, [with] other people, if you know what I mean. And my friend said that you can't help it and that it's not your fault...

These patients dropped in to the unit for company, and for "something to do". As one young male patient described his reason for dropping in: "I'm just passing time away, so that I can keep getting well in myself. Just something to do during the day. I don't think I'm well enough to do a job or anything like that at the moment." Another day patient with a diagnosis of schizophrenia, when asked "Are you still sick?" responded "No". Asked "Do the doctors see you as sick?" she

replied, "They still prescribe medication and the injection, so I suppose they do ...
I'm stuck in a rut, I want a job [pause] I feel suicidal sometimes." Suicide was
sometimes seen as the only way out of "the rut" of schizophrenia, or the "highs
and lows" of an affective mood disorder, and a number of patient informants had
set a time frame for such an event.

The expectations of nurses

The beliefs held by psychiatric and nursing staff about the nature of mental illness
as outlined in the earlier section, coupled with the high readmission rate to the
ward, resulted in a lowering of expectations that nurses held about people admitted
in terms of cure, or their ability to move back into the mainstream of life without
ongoing dependence on the unit. Thus when nurses were asked to describe
success stories, they were taken aback by the question; for example, one nurse
paused, then responded "Oh, isn't that terrible when I've got to sit and think. My
immediate reaction is all those people come back ... and the successful ones are the
ones that haven't come back". Others, after hesitation, identified patients with
postpartum psychoses; patients with agitated depression who had
electroconvulsive therapy (ECT) and recovered well; patients who came in acutely
psychotic and were managed on the ward without committal, and whose psychosis
resolved very quickly; and patients with a toxic psychosis. Thus the stories they
eventually told were typically around psychotic (nonvolitional) patients for whom
an acute disturbance was resolved, but who were not necessarily "cured". A
psychiatrist who walked in on one of these discussions in the ward office jokingly
said "Well we've got ___ [patient] discharged", and then went on to comment "If
you are thinking about cure, then you can't look at success in that way, it just
doesn't happen."

Nurses' perceptions of the outside world

The outside world was viewed by nurses as tough, a realistic view given the
economic climate of recession and benefit cuts described in chapter one. There

was little expectation by nurses that chronic psychiatric patients would function well in the outside world; that they would get a job, or could establish a support network outside the unit. In talking about the revolving door phenomenon one nurse commented:

> I don't think it's any reflection on my standard of work, personally, [pause] I think it's more a reflection of our economic state. Of our social welfare system and of our poor getting poorer. I mean there's something wrong there, something dreadfully wrong...It's those people ... that don't have the support system; no matter how many [monetary] benefits you can give them, ... the majority of them don't have family support and [pause] they can never get anywhere.

In this context, nurses aimed to "teach patients ways of living within their means and coping with what they've got ... otherwise its too unrealistic and that just sets them up to fail, and then they come back again. And before you know it you've made them dependent on you."

The outcomes of the organisation of care

The organisation of care, as described in the previous chapter, impacted on both nurses' work and patient care. A recurring theme in the data was that of a lack of "boundaries". Thus, in discussing a known patient with paranoid schizophrenia whose behaviour in the community was causing concern, a nurse commented "... this place has no boundaries. She needs to go to [psychiatric hospital]. She does really well there." The following sections describe boundaries on the service and on nurses' work. Nurses' perceived inability to place boundaries (limits) on patients' behaviours in the study ward will be described in chapter six.

Establishing boundaries on and within the service

The difficulties in defining mental health and illness (illustrated on p.105), contributed to an apparent inability of psychiatric and nursing staff to set boundaries on the mental illness service, resulting in the *enmeshment* of parts of

the service, and the identification of the ward as a place of last resort for some patients and first resort for others.

The diffuse boundaries between the inpatient and outpatient services were illustrated early in the observational period, when an elderly patient who was discharged earlier that day, was noted to be in the unit for the evening meal. Although she was observed to walk home, she returned to the ward later in the evening to say she had lost three packets of cigarettes on the unit. The hospital aide found these for her in the unit kitchen, however the patient continued to smoke and sit around in the ward corridor by the telephone, as was her customary place. As the evening wore on, her conversation deteriorated and she began calling people perverts. The hospital aide intervened by offering to drop her home. She lived in a flat close by. When questioned as to how this patient could be discharged, yet still be in the ward, a nurse explained that the ward was supporting this patient until she was old enough to qualify for rest home accommodation. Thus throughout the observational period the patient spent much of her time in the ward, whether or not she was an inpatient or an outpatient. The nurse explained that when this patient was not followed up consistently, she discontinued her medication and required re-admission. Two other psychotic patients were also observed to be "maintained in the community" in this way.

Informal criteria for admission were established around issues of safety of the individual, and the amount of chaos created by, or lack of any alternative support for, a particular patient in the community. The full bed occupancy at times provided the only mechanism for avoiding an admission. When asked about the apparent inability to set boundaries on the service, a nurse demonstrated both the *moral imperative of caring* which underpinned decisions about care provision and was expressed by psychiatrists and nursing staff in the study ward, and the consequent functioning of the ward as a place of last resort:

I suppose there are moral obligations to that in some respect. If they have tried the other agencies ... most outside agencies want people exhibiting a fair element of control. They don't mind problems, but if they lose control, or are acting-out in some way, and/or are sick in a sense of really so obsessional or very paranoid, they become a problem. And they have got peer problems then, at the half-way house or refuge. Yes, to turn someone away from the door that's tried everywhere else. There's some sort of moral thing, and logistic too in some ways I think ... We have turned people away ... I have seen certain doctors turn people away and we spent hours ... sorting it out. Its the degree of lateral support that person has, because people are just dumped here and left.

The extent to which the moral imperative of caring underpinned decisions about care provision was again reflected by the comments of another nurse in relation to the provision of the after hours service from the ward, "but then again, that comes back down to being the caring person, its your job to do that." Thus as earlier stated (p.92), the ethos of the ward was one of humanitarian caring.

Setting boundaries on nurses' work

Nurses who worked in the ward were also unable to set boundaries on their work - they did the work no-one else wanted or was able to do. "Who picks it up if we don't?" The multiple competing demands on their time, coupled with the moral imperative of caring, resulted in nurses continually assessing and responding to incoming requests and crises, alongside their day to day work in the ward. Nursing work thus mirrored the position of the ward in the mental health service, receiving and responding rather than initiating, always "on the back foot". While nurses and other clinical staff who worked outside the ward were able to set boundaries on their work when there was limited staffing or time available, or overtime was cut, ward nurses felt powerless to do so. As one nurse informant commented when interviewed:

I think the nurse's role is so diverse sometimes, that it is hard to put a finger on it and say "this is what the nurse's role is" - I mean, we are bits of everything.... I don't know what are the definite things and what are the things that really aren't ours to do. Yeah, its amazing.

... when people come up for time out and you are trying to look after the ward and watch these people as well, it is too much. Going out to things in the community ...You know, you just plug along there ... you do what you

can - put a few bandaids on. And if the seams burst then that will be your fault. [pause] I don't think that there is any appreciation.

I think there is too much expected of the nurses that work here ... I guess its that old thing, the more you do, the more ... they - management I guess - expect that you can cope with and, don't draw the line. Then it becomes your own self thing. If I don't do this, then people will think that I'm not a good staff member. So it gets into that as well. And then it keeps going around and around and things don't change. So I guess that a part of that is our own responsibility to say.

Another nurse informant explained how he saw nurses' work:

You see I think we are like a receiver thing. You know we receive a clientele, and it doesn't matter how they present, we have got to come to terms with it. Or take a step back or sideways, or surround it sometimes, if its really psychotic. And quickly ... try and make an assessment, to prioritise. You have got to be quick on your feet for that - sort out what's what.

Nurses who worked the morning shift described their roles with inpatients as ensuring safety, establishing a relationship with "primary" patients, coordinating between different disciplines, educating patients particularly in relation to their illness and medication, acting as an advocate for patients, and acting in a "go-between" role with patients and their families.

These nurses valued talking with the patients for whom they were "primary nurse", however "therapy" was seen to occur outside the ward in the OT program, in individual counselling by social workers or psychologists, or in follow-up work by other helping agencies after discharge. Nurses reported an interest in being involved in group work with inpatients, however regular attendance at, or responsibility for, group work was precluded by the need to be available to respond to acute situations which arose on or off the ward, and required attendance at a range of meetings about, and psychiatrists' appointments with, inpatients.

Limited availability of nurses to inpatients

The competing demands on nurses time meant that nurses were not always available for inpatients. Thus a research question that arose early in the period of observation was "how do patients get attention in this ward?" Nurses seemed busy

and patients appeared to spend time alone or with other patients. As indicated in chapter four, there was no organised therapeutic activity or group work on the ward. There appeared to be limited interaction between inpatients and nurses except that initiated by patients. Patient behaviours which got attention from nurses included complaining of physical symptoms or side effects of medications, asking for information or assistance, or requesting permission to go to the shop or on leave. Acting out behaviours also got attention. Actions such as smashing a window, leaving the ward without permission, suicidal gestures or statements that one is feeling unsafe, refusing medication, or creating a disturbance such as yelling angrily or talking loudly or inappropriately (eg making sexual overtures to other patients or staff) were all observed to draw nurses' attention.

If a patient's primary nurse (or associate nurse on afternoon shift) was busy, or off the ward, the patient might have to wait for attention. Nurses were not always visible to ask. For instance one winter morning, a patient who had been admitted the night before was observed to ask repeatedly to see her nurse. This patient was sitting in the ward lounge with her coat and boots on. Her primary nurse was involved in an episode of restraint with another acutely disturbed patient. The ward clerk told the patient each time she asked that her nurse was busy, but did not arrange for anybody else to talk to her. This patient AWOLd (left the unit without permission). Going AWOL or "taking off" as patients described it, was not uncommon, as will be discussed in chapter six (pp.141-142).

Another afternoon an elderly outpatient in the patients' lounge called out a greeting to each nurse who went by the lounge door as a way of getting her presence acknowledged. She was waiting for a nurse to take her blood pressure. "Here I am now, and nobody is taking any notice of me. I feel like an outcast. My trouble is I'm not a schizophrenic" she commented. This patient was described by nurses as exhibiting "intrusive" behaviour. However, alternative explanations for such

behaviours, which in the study ward tended to be attributed to illness, include patients' responses to frustration, or ways to get attention, given the limited availability of nurses to the less disturbed patients.

Another patient with a bipolar illness, who had been an inpatient for six weeks, listed ways people got attention in the ward. "Like that" she suggested, indicating an angry altercation just observed between a nurse and a patient who refused to accede to the nurse's request that he stop his loud talking or go to his room. She continued thoughtfully:

> ...leaving the unit without permission. Patients can go and ask to talk to their primary nurse. Some patients seem to find nurses that they get on well with. Gathering in the hall, in the passage way, or making long telephone calls. [pause] You can threaten to harm yourself with razor blades or knives [pause] I did that on earlier admissions. One patient asked for scissors from another patient who gave him some, and he proceeded the other night to cut holes all over a pair of expensive track pants. That got him some attention.

Two other known patients, each of whom had several admissions with depression and suicidal ideation in the period of observation, commented during interviews on the non availability of nurses.

> Its changed a lot over the years as far as things go, and the contact with staff. The staff these days spend a lot of time in the office with the door shut. They never used to do that. They used to be with the patient - they used to be in the lounge - they used to be in other areas with them, ... some of them still do a bit of that, but basically they seem to spend most of their time in the office with the door shut. So if you want to see them, you've got to go and knock on the door. If you're like me you don't do things like that - you wait until they come out. No matter how urgent it might be. A lot of patients just go and bang on the door and walk in there, but I can't do that.
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> I don't know whether because they're short of staff or what, but unless you're constantly observed, or observed say every 15 minutes, you don't get to talk to your nurse, or the other nurses. They are always doing something else. You never get to talk to them.... If you want to talk to somebody - if you are a person like me that doesn't talk very much or say much, or want to say much, its quite hard really to get hold of a nurse to just actually sit down and talk to you. You know, for you to express your feelings. They are always busy, busying around, doing something.

Another patient compared "being in" this time with her first admission 14 years previously.

I got myself referred to the unit much earlier this time. Last time [14 years ago] I was in a real mess. This time it's not so bad. Last time I had medication and was home in a fortnight. I went to groups run by nurses last time too. This time, nurses don't talk to me. My daughter phoned in and asked one of the afternoon nurses if somebody could talk to me because I have things that need to be talked about. The nurses want me to go on leave, but I don't feel ready.

Patients tended to interpret the non availability of nurses as a lack of caring. For example, a young schizophrenic patient who had dropped in to the ward to visit commented:

... you find they don't really care about you any more. They don't ask how you are kind of stuff, you know. I found that even when you're "in" [the ward] they don't really ask how you are very much. The first time I was in there they were good. But this time - oh I shouldn't talk about it - oh it wasn't that bad but ... they are just too busy doing their own jobs eh?

Patient perceptions of caring and non-caring

Patients' perceptions of caring related to nurses availability to listen and talk, and to "work things through", which included the confrontation of painful issues. For patients, good care was equated with caring by nurses. For example, one patient who had been depressed and suicidal reflected on her experience - "So I had really good care in as much as that people were actually trying to help me. I probably was making their life very difficult - but not purposely - I mean I was like that, so that's the way it was with me at the time". Patients valued having "a really good relationship with my primary nurse", and having a nurse who "really knows you" and who could pick up cues when the patient was not feeling safe or needed to talk. "I always had [primary nurse who had left the ward] when she was there. And she could pick up things - like she knew when I was rocking to come and say "Its OK, you can rock, but what's going on - are you safe?"

The nonavailability of nurses to talk, was perceived by patients as non-caring behaviour. For example, one patient described asking to talk with a pm nurse who advised her to go and have a bath and then do some relaxation exercises - "a cure-all it seems, a bath and relaxation." When asked what she would have liked from

the nurse, she replied "I would have liked her to have heard from me that I was actually feeling quite unsafe, I needed to talk, without being told to go and have a bath." Nurses who did not spend much time with their primary patients were also perceived by patients as non-caring. As one patient described her relationship with her primary nurse: "He walks way in front of me [when going to see the psychiatrist]. I don't talk to him, and he doesn't come to [see] me. It's as if he doesn't care." A perceived lack of empathy with patients' feelings was another indicator of non-caring, as a patient with depression and suicidal ideation explained:

> One of the staff nurses I don't say anything to. She's on afternoon, I never tell her anything, because a couple of times when I was feeling really bad - I had just been admitted, or been in for a couple of days and she was on - and she said to me "How was I?" - and I told her how I was feeling...And she said "Oh ___ [Patient] you are always like that anyway, you know you always come out of it!" - Well that really annoys me because its not like that at all. I mean you don't know you are going to come out of it.

The limited availability of nursing staff to inpatients, with the consequent perception by some patients of a lack of caring by nurses, was not recognised by staff outside the ward. For example a psychiatrist commented:

> The nursing staff .... treat patients as people, all the time - in total contrast to the main [general] hospital. And you get very disturbed people who have been anti everybody. A staff nurse will come up who has known them before and say "Well, are you feeling a bit aereated at the moment -what's got under your wig this time" - in a *personal way*[2]. And their ability to defuse things, I think is *very good, very good*. I think they handle the most ill very well. Someone who is clearly psychotic gets treated as a person, and gets treated with care and concern, and what controls are necessary.

This view was consistent with both the researcher's early impression of the ward as a caring environment (p.92), and the view of caring as a moral obligation which was expressed by ward nurses and psychiatrists. Identification of this breakdown[3] in the data required further investigation to reconcile the disparate views of the researcher, staff and patients.

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[2] Emphasis in the original quotation.
[3] Unexplained or unexpected data (Agar, 1986); refer p.56.

Responding to the heterogeneity of patients needs

It became clear that, with the competing demands on their time, nurses operated a "triage" system, responding to those patients most in need of intervention at any point in time. As a patient informant explained "the nurses are too busy with the sick patients, they don't have time for the patients who are getting better", and "the support is only really there if you are unwell".

Limited staffing levels on the evening shift as described in chapter four (p.69), and the heterogeneity of patient needs, contributed to the limited availability of nurses to talk with patients who were less acutely disturbed. Another patient commented "... in the afternoon there just isn't the staff to manage. Really I think they are understaffed in the afternoons." Thus from patients' perspectives between 4 and 8 pm at night was the best time to "take off" (leave the ward without permission).

A nurse who worked evening shifts described the complexity of providing care for the heterogeneity of patients in the ward. "Its partly the nearly well who need entertainment, and the worried who want talking to, alongside the psychotic who need quiet and one-to-one attention ...". The potential for unsafe situations was particularly high around 5 pm, when most of the staff in the unit who worked 8-4.30 pm had left, the unit telephone lines were switched to the ward office, and the evening meal was served in the dining room away from the ward. Another nurse explained:

> If we have only 3 of us on [plus an aide] I think its a dangerous situation. because...you've got an aide around there in the dining room ... any disturbed patients are around in the ward, they will be having their meal there. You will be leaving an aide around in the dining room in charge of you-don't-know-what could happen. If you've got 3 staff you've got to have a very quiet ward to send someone around there to the dining room to be with that aide ...there should be a registered staff round there. Now the moment you do that - you have somebody on the telephone, somebody has AWOLd out of the ward, you are so vulnerable, it is really scary. If you've got 4, at least you've got someone to answer the telephone and two people there to do it.

"Doing it" might mean responding to a new patient arriving for acute assessment or admission, or being with one or more acutely disturbed patients in the ward who needed close or constant observation ("specialling"). An outpatient might arrive to collect daily medication, or to get a depot injection. A decision might be made to commit a patient to a psychiatric hospital, requiring concurrent organisation of paper work, transport arrangements and monitoring of the patient. These were common events to which nurses in this acute ward must respond.

The impact of the after hours service on the ward

Paradoxically, the constant availability and accessibility of the service to outpatients and others in crisis, limited the availability of nurses to inpatients for whom they were employed to provide care. The provision of an after hours phone service by ward nurses impacted on the care of inpatients in the ward. As a patient described it "afternoon nurses are very busy. Although you can ask to talk to them, often it doesn't happen because they are busy". The immediacy of telephone work or a crisis in the community took priority over the needs of all but the acutely disturbed patients in the ward, as illustrated by a nurse who worked evening shifts:

> We have had phone calls that have lasted up to an hour and a half, two hours, which take a hell of a lot out of your evening, but it also puts pressure on the ward as well, because you've one less staff if somebody has a crisis.

> ... I'd like to think that our staff are versatile and that if there is a crisis we can arrange things very quickly as far as getting someone to cover the ward and someone else to go out to a crisis call. Because a lot of the time that is what is asked of us. And sometimes we have to say "No we can't come", because of the staffing situation. But if there is a call that you really think needs your intervention we can cope and leave the ward with an extra staff down. You can go to this call.

Nurses in this situation were unable to plan ahead, or to organise therapeutic work with inpatients. When the ward was busy nurses "respond to the crises and do your best to have a few minutes with the less sick ones." During quieter periods nurses spent time out in the ward, monitoring patient activity and trying to be available for patients who needed them. As one nurse described her work: "Now, I spent quite a lot of time with ____ [a young psychotic patient] on Friday, just

quietly sitting and talking, and she is just starting to get back into an entire person again, and its so fragile".

The impact that the after hours service had on the provision of care for inpatients was largely unrecognised by clinical staff outside of the ward. There was general satisfaction with the service as it functioned, which is not surprising given that it allowed off-duty psychiatrists and nursing staff to go about their everyday lives knowing this backup was available for the people for whom they had clinical responsibility. Psychiatrists commented:

> Yes, I have come to realise they [nurses] do a lot of work like that, especially after hours, quite busy. Its a very important role, I think the night staff play. [It] probably has not been realised that much. Otherwise many of them [patients] would be here during the day time. Some of them may end up being admitted if the demand is not met.... its a worthwhile system providing a service. And its working. I don't think they [nurses] get so many that they can't really handle ... unless we have a really busy ward and we don't have enough staff. It doesn't happen all the time, but once in a while we do have lots of disturbed people [and] the staff are busy all the time ... At night, most of the patients are sleeping. Those that are awake are smoking or they don't take much staff time. So its one way of occupying staff you know, by taking such calls. They enjoy it. So I haven't heard of any objection from any of them.

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> I think the other thing one should say about the inpatient unit is the vast amount that the nursing staff do on nights and weekends about people who call in and talk, the people that they know. And they will say "Oh ____ [patient] rang again, just for a chat" or whatever, or "She rang and we went and picked her up for a meal". There's a whole network of patients that use the nursing staff at nights and at weekends and use the unit, which is quite different from other inpatient units.

Nursing staff on the ward, for the most part, accepted the after hours service as a mandated part of their work. When questioned they commented "...that comes back to being the caring person, its your job to do that.... We are here as an acute psych centre, which includes phone calls"; "Yes, we are here as the ward staff, but the phones after 5 pm - someone has to man them."

The after hours service functioned as a window out into the community for the ward nurses. Knowing in advance which of the known patients in the community

were likely to present in a disturbed state, enabled ward nurses to feel a little more

prepared to respond. Such information was conveyed by outpatient or continuing

care staff about to go off duty, or by nurses working in the community by means

of phone calls, messages in the daily log, or by yellow files (confidential patient

files) left in the in-tray in the ward office; nurses also read the daily log to check

phone calls from known patients. Often an escalating pattern of disturbance in

individual patients was revealed in these calls, preceding an admission.

Thus the provision of the after hours service by the ward nursing staff was

accepted by staff on and off the ward. The situations of risk which arose when

nurses went off the ward on outcalls were not acknowledged. Area Health Board

(AHB) planning documents indicated that a mental health service crisis team was

not available outside the normal working hours, yet the daily log provided

numerous examples such as those below, where a nurse (or an aide) would go off

the ward alone, leaving the ward understaffed to manage any crisis situation which

might develop, or to provide other than custodial care for inpatients. The following

examples of outcalls to known outpatients were logged over a six week period:

> 1955   P/c ____ [patient A] had just "dropped to the floor". Had this x 1 [once] before due to [low] BP. Advised to sit quietly with feet up until staff member comes round to check BP (170/140) - taken to after hours medical clinic.

> 5 days later (Saturday):

> 0730   ____ [patient B] rang requesting Cogentin as experiencing dystonic reaction. Visit by [nurse] at [boarding house].

> 3 days later:

> 2230   ____ [patient C]- phoned to say she had taken overdose - [nurse] will check out the situation and take [patient] to A & E.

> 2 days later

> 1700   P/c from [charge nurse] - [he] and S/N are back at ____ [patient D] 's home with her and are talking with her now in the hope that she will return to the unit. [patient admitted to the ward that day and AWOLd - later transferred to Intensive Care Unit in general hospital]

> 6 days later:

1745 ____ [patient E] 's mother phoned requesting help in managing [him]. [nurse] to house to assess situation and ____ [patient E] brought to unit. ____ [patient E] admitted

the next day:

2045 P/c ____ [patient F]- dystonic reaction [nurse] doing house visit. [phone no.] Pt given IM Cogentin.

2155 Feels better - however requesting time out will come to unit.

20 days later:

1850 ____ [patient G] - phone call from police that a friend of hers had contacted them; ____ [patient G] requesting a staff member (unit) come to her house (Phone no.) - [nurse] sent to assess situation.

1930 Returned from ____ [patient G] 's house - situation appears to have come about by ____ [patient G] drinking alcohol. Husband removed by police for the night. ____ [patient G] initially very loud and verbally abusive - quietened down once hubby left but unwilling to talk reasonably. Told me her plan for the night is to "do nothing and go to bed".

the next day:

1835 ____ [patient E] phoned feeling "awful", requesting to come to unit - H/Aid will collect him.

2015 ____ [patient E] S/B [psychiatrist] [His] mental state remains the same but has been getting breathless lately. Is to come into day care and is for a physical assessment and a referral to a Cardiologist if necessary. N.B.TI/HS.[trainee intern/ house surgeon to action] Taken home 2145 hrs. To be picked up tomorrow please.

3 days later:

0210 P/c re ____ [patient H] from resident at [halfway house]. ____ [patient H] has set fire to a bundle of clothing and is becoming dangerous.[Psychiatrist] contacted - [nurse] will assess and try to get her to the Unit. Police will assist if necessary. Charted p/p [per phone] Chlorpromazine[4] 100 mg prn or Haloperidol [5] 10 mg IMI

____ [patient H] into ward with [nurse] See report in C/C [continuing care] file.

Strategic planning documents did not indicate that there were plans for a separately staffed crisis team, merely that crisis services after hours would continue to be provided by the secondary care service, thus the ward might continue to be the hub of the service. Discussions with staff tended to confirm this scenario. A

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[4] An antipsychotic medication from the Phenothiazine group.
[5] Butyrophenone - an antipsychotic medication

psychiatrist acknowledged that such work "need not be necessarily done by nursing staff or medical staff, it could be done by a social worker or counsellor, but we don't have those people available doing those tasks. So the nursing staff are the only ones on call who are directly available in the ward." He expressed doubt that there was enough work in the phone calls to warrant a social worker being available all the time.

Thus although from the perspective of the researcher as an outside observer, the provision of the after hours service by ward nurses compromised the care available to inpatients, this view was not held by most staff who worked in the mental health service. The after hours service could be seen as more highly valued by staff than care of inpatients, yet the importance of it was under acknowledged in planning documents. Another possible explanation is that nurses experienced more autonomy and more job satisfaction in staffing the communication centre for the mental health service after hours, than in providing care for inpatients. Certainly the way care was structured meant that, for nurses working on all shifts, the lack of involvement in an active therapeutic program appeared to be a necessary condition for their constant availability for acute work both in the ward, and with outpatients. As described in the following section, other conditions were also necessary for such a service to occur without serious mishap on or off the ward.

Balancing the needs of the service

The availability of nursing staff for telephone work and to respond to acute situations which arose unexpectedly on and off the ward was contingent upon maintaining a ward milieu which was comfortable, placed few restrictions on patients, and in which there were mutually low expectations for performance between staff and patients. It was functional therefore in this context, that the majority of inpatients were known to and knew the ward. Known patients knew how the service worked, could orient new patients, and could be expected to take

responsibility for their own care after the first 24 to 48 hours. Such patients often

had short stays and initiated their own discharge.

On the basis of mutual familiarity, nurses relied on being able to intervene quickly

with known patients on and off the ward. However there was reported to have been

a high turnover of nursing staff over a period of two to three years including the

period of this study. As a result patients might be known to the service, but the

mutual familiarity upon which trust and quick and appropriate assessment and

intervention was predicated, did not exist except with a very small core of nurses

who had worked in the ward for many years. Thus several known patients

commented on the turnover of nursing staff, and expressed doubt that new nurses

had enough experience, or knew them well enough, to pick up the cues that they

were feeling unsafe or likely to take off.

> Some of the ones I've known for a long time can [pick up the cues], but see
> there is a lot of new staff who ... probably wouldn't notice ... [Nurse] is gone
> now - she was my nurse for a long time - she knew. When I start doing
> things like sitting and rocking, which I do when I ... [start] to get a bit
> psychotic and my brain's going funny. I mean its just me, I just rock round,
> and that's a really bad sign. When I'm doing things like that you know that
> there's something going through my mind and just watch her now 'cos she'll
> take off. So that's it.
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> It's got to the point now where, I don't know whether [primary nurse] has
> picked it up yet but [nurse] has picked it up, that if I said I was all right in a
> certain way she would know that I wasn't. Sometimes I say I'm all right just
> to get rid of them. If they're sensitive they can pick up that I'm not really all
> right.... I see it in other patients as well. When staff ask them how they are
> and they say they're all right and they're not really. Sometimes the staff will
> pick up on it and sometimes they don't. Whereas at [psychiatric hospital]
> they would pick up on it very quickly. Because they are ... more trained in
> that respect. Unless you get an excellent primary nurse - we've lost quite a
> few of them in the last six months.

Known patients' expectations of care in the ward frequently related to symptom

management and time out, or a rest, from the realities and responsibilities of every

day life outside the unit. Many of these patients had little expectation of nurses in

terms of an active therapeutic program. For example, one patient with depression

and suicidal ideation who had six admissions during the period of the study, was

asked whether she usually had the same primary nurse when she came in. She replied:

> No. I just have who ever is around. Last time I had ___ and she came and told me she was going to be my primary nurse. I said "that's fine". I had no objections to that. And then she said "have you got any expectations of me?" And I said "well no not really". I said "Just be around if I need you ... or to talk to".

The focus for ward nurses and patients was often one of "getting through the day". On the first day of observation a nurse commented that his was "mainly a day to day focus. Today there is a patient in the ward who is being 'specialled' [constantly observed] and has been breaking windows, so there is pressure on staffing". As previously mentioned, patients and OT staff who participated in the 9.15 am OT meeting set a goal for the day. Nurses focussed on responding, receiving, assessing, and intervening with patients who presented for care and treatment on that duty. This day to day focus was in marked contrast to the changes occurring at other levels of the service (as outlined in chapter 1, pp.6-7).

Ways of keeping the workload manageable

The availability of nursing staff for telephone work and to respond to acute situations which arose unexpectedly on and off the ward and were perceived as nondeferrable, was also contingent upon keeping the workload in the ward "manageable". Thus if the proportion of known patients in the ward was markedly reduced, or if the level of acuity in the ward was to rise markedly, the availability of one nurse for "phone work" might not be able to be sustained. Ways of managing the acuity of the ward included calling an extra staff nurse on to "special" a patient; admitting one or more family members, or occasionally a friend of an acutely disturbed patient, as "boarders" to share the responsibility for observing that patient; committal of one or more acutely disturbed patients who were currently inpatients; and committal directly to the psychiatric hospital of patients with a known history of violence. Locking up the ward early was another strategy used by nurses to make the workload more manageable, although this often resulted in

patients feeling trapped and increasing their efforts to break out. As one
nonpsychotic patient described the experience:

> I don't know how long I was on specials, probably a week ... give or take a
> couple of days I don't know, but then it came up to the weekend and they
> didn't have the staff, but they locked the doors all the weekend! Oh, it was
> just awful! Here I was trying to get out the window...

The open environment and the ease with which patients could "take off" from the
ward probably contributed to the low incidence of violence in the ward. When
nurses were asked how they would manage a violent patient when, for example,
there was an all female nursing staff on an afternoon shift, the response was to
"call the police for assistance", and not attempt to contain the patient, rather to
"open the doors and let him go."

The practice of sending inpatients on leave at the weekend also freed up ward
nurses to deal with the increased number of outpatients who dropped in over the
weekend for time out, to visit or to obtain medication. Thus while the bed
occupancy might be 18, there could be as many as 8 -10 patients on overnight or
weekend leave, with others out with family or friends in the day time. Leave was
also used as a way of avoiding the paperwork associated with readmission when
there was uncertainty about how a patient would cope on discharge. A psychiatrist
explained the practice of sending patients on leave, demonstrating both the
psychiatric medical model and the low expectations of patients' coping abilities:

> One of the reasons we do that now is to avoid readmission. If somebody is
> discharged on Friday, we know that they may not do too well and may come
> for readmission next week. So it cuts down the paper work; when you
> readmit you have to go through the whole system of paperwork. That's one
> reason people are sent on leave instead of discharge. Secondly, when we are
> not too sure of the clinical state, because people tend to change once they
> leave this environment, back to their stressful environment. Clearly the
> course of the illness will fluctuate, from day to day, from week to week, so
> sending them out on leave gives them a bit more time to see how they will
> respond.

Continuity and discontinuity in care

One psychiatrist and a psychiatric registrar took clinical responsibility for patients admitted to the ward, and each patient was allocated to an available primary nurse. Thus for known patients who were usually followed up by outpatient or continuing care staff, admission to the ward resulted in structured discontinuity in care. This arrangement eased the workload for nursing staff who previously had to coordinate the care of patients with five psychiatrists, and was generally viewed by psychiatric and ward nursing staff as advantageous for staff and patients. A psychiatrist explained:

> ...the advantage is with people coming to the ward, they come in for special intensive treatment, and its a different quality care than what they receive as an outpatient. So ... they come for some intensive treatment, they get better and go back to their usual doctor, the continuity is maintained. So I think in a way we are achieving more that way, than having the same doctor. But sometimes you need a break as well.... different ideas. Sometimes, you know, a break for the patient. The patient needs variety. Its an advantage for the patient I think. And on the other hand advantage for the doctor as well, because I had been seeing that patient all the time, and so if somebody else sees them for a while then I take it back, then I'll maintain that vigour I used to have in maintaining that patient. So that's the advantage part of it. I think the disadvantages are very little compared to the advantages of having that discontinuity.

Similarly, a primary nurse supported the discontinuity in the allocation of "primary" nurses for patients who were readmitted:

> I don't think that clients should particularly have the same primary nurse every admission. I don't think that's good for the nurse. Its probably not good for the client either. [pause] I don't [pause] - for example like ____ [current inpatient] - she was my primary patient last time, and we still have a bit of rapport, even though she is somebody else's primary patient now. Somebody else sees things from a different point of view, and if you are always the primary nurse for that particular person, you don't get that same input or diversity of suggestions - well that's what I think - so I don't see that as a bad thing, as long as there's communication.

Patients were generally not happy with the discontinuity in their care that resulted from an admission to the ward. One commented "I hate it. I send messages through my primary nurse. I only see [ward psychiatrist] once a week. [Outpatient psychiatrist] keeps in touch." Another patient who had frequent admissions (six during the period of the study) explained:

> I don't like it because their ways are different and they change the drugs around, and also you have to explain things all over again to people which I don't like doing. I'm lucky in a sense that [outpatient psychiatrist] comes to see me every day anyway that she's around, she will always come and see me which is good - because I mean she still keeps that contact. But when you've got to sit down and explain to somebody why you're here and how long you've been coming here, and why you have to come here and all this. You get so sick of telling the same story to somebody [sighs] and I just don't feel comfortable doing it. So I'm not comfortable at all. Some of the patients don't seem to mind too much, but a lot of the patients do mind, I'm not the only one who minds about it.

Some nurses did try to take responsibility for planning and providing care for primary patients on subsequent admissions, however three primary patients were considered a full workload for nurses on the morning shift, and a returning patient might thus be assigned to another nurse. The high turnover of nursing staff compounded this discontinuity for patients. When it was suggested that some of the patients seemed to find it quite difficult having to change their psychiatrist when they came on the ward, a nurse replied "Yes, they do. [pause] But then the old ones know that changes are going to take place also."

As previously stated, the ward operated as the hub of the service. When known patients were admitted or presented for assessment after hours, decisions about medication and directions for care made by ward nurses or on-call staff were not always consistent with the directions for on-going care provision planned by outpatient or continuing care staff and vice versa. As one continuing care nurse commented "we don't seem to be able to provide effective guidelines for people to deal with these [patients] ... and for some reason people don't really use [the guidelines] anyway."

Some patients learned to use the discontinuity between the parts of service to achieve a change in medication or an admission, by presenting after normal working hours. The entries about one patient in the daily log included in chapter four (pp. 98-100), provide one example of this process. The reasons why people presented after hours were explained by staff as being related to "fluctuations in

the illness". Staff explained that distressed feelings and other symptoms tended to escalate at night when patients felt confined in the darkness, hence the calls after dark. Consistent with an illness model, the focus of care was on symptom management and patienthood, both within the inpatient service and the after hours service. Asked about the possibility of creating dependence with the prescription of phone in and time out facilities to outpatients, and to inpatients going on leave or on discharge, a psychiatrist replied:

> Some patients like ___ [current inpatient, diagnosis of personality disorder], we know its an ongoing life long kind of distress this lady will be in. Therefore it's appropriate that we know that she will get into difficulties and she can always call back to the ward to ... get this kind of support.

Thus patients' dependence on the unit was attributed by staff to their illnesses rather than being perceived as related to the organisation of care. A patient described the impact of the constant availability of the ward, coupled with the low expectations of getting well:

> They make it acceptable to be "grotty", to be unwell. They [nurses] are kind and caring and take over responsibilities. Once you get into a system that you know, it is too easy to give in to it. When you are out in real life you have got to keep going. Whereas they make it acceptable to be "grotty", to be unwell.

Both the dominant belief system operating in the ward and the organisation of care described in earlier sections of this chapter, contributed to a ward milieu in which stability rather than change was the predominant focus of care. Indeed the ward could be described as a holding environment which provided time out from the outside world.

The ward as a waiting room

The public spaces in the ward were like the platform of a railway station - busy and anonymous at some times of the day as people came and went, particularly when there were student nurses and tutors as well as other nurses in the ward; and at other times deserted. However for inpatients the ward was like the waiting room at the railway station, where they sat and waited to feel better, for medication to

work, to feel more in control, or for external events to change, or external problems to be resolved.

One patient, when asked what had happened since she came in 3 days ago, replied "Nothing, they've been watching me all the time. They've changed the antidepressant I'm on." Another commented "I was glad to find the day when I got home [last time]. I waited and waited." The father of a young patient expressed concern over the uncertainty of his son's illness and the passing of time.

> My biggest thing is the time factor. Whereas time means nothing as far as the doctor is concerned - whether he gets right in 2 months or 12 months, it doesn't really make any difference to them - I would like to - you know - time is in the way. For his sake, not for mine.

Patients for whom this was their first admission, picked up the low expectations of change held by staff and fellow patients by watching and talking with known patients who had had many admissions over the years. Patients without a major mental disorder who expected active therapy, and expected that an admission would result in change either in themselves, or in situations external to them, described waiting for something to happen, feeling stuck and losing hope. "Am I really this bad?" One patient described what happened to these inpatients:

> What I have noticed in other people is that, it is almost like they die. Something about them gets lost here ... and their ability to function outside becomes less and less after a while. Its almost as if there should be a limit put on how long a person is here. I've noticed a couple, the first couple of weeks has been really helpful, they've really improved, then its just been a downward [pause] ... I think that the staff here in [the ward] have got to find a way through. Of people getting caught up and lost.

This process of "getting lost" in the ward while waiting to get better, is further illustrated in the following description by a nurse of a patient experiencing his first admission. This patient, although depressed, did not have a major mental disorder.

> Well when he was admitted, he presented very depressed, very distraught, down, crying, stayed in his room. You know, "broken down" really, that he has come to this point - not wanting to be here, hating to be here because of the stigma. Scared of ECT, not wanting that, not wanting to be in this place, because there's weirdos about. Now he's at a point where he's not wanting to

leave almost. His presentation was, he was wanting ECT! [laughs] Almost like he should have been discharged somewhere in between that changeover somewhere!

The focus on getting through day by day, the absence of an active therapeutic program in the ward, and the perceived non availability of nurses to talk with patients who had been "in" for a while, or who were not acutely disturbed, resulted in patient energy available for change being invested in relationships with other patients or dissipated in acting-out behaviour.

Patient friendships on the ward

Some patients tried to keep to themselves while on the ward, "unless there's somebody who's in dire straits, then I'll help out. If somebody has an extremely similar circumstance to myself then I'll say something then [like] 'I know what you're talking about. I know how it feels'." Other patients formed relationships with fellow patients who provided company to help fill in the time, as described in chapter four (pp.83-84), and were sources of information and support.

One elderly continuing care patient played a "mothering" role in the ward (described as intrusive behaviour by nurses) as she came to the unit for meals. At mealtimes she called people by name, encouraging them to come and sit down and eat. She would organise patients to sit in certain places or to get cups of tea for other patients. Part way through the study she chose to move into residential care for the elderly, and her role was not picked up by another patient.

Patients talked about being in the ward, compared symptoms and the medication they were on, offered support and encouragement when a fellow patient was feeling down, shared inside information, and intervened when another patient was out of control or was perceived to be at risk. As one patient explained, "patients are thick." - in other words, they stick together. Known patients (inpatients and those who dropped in to visit), sought out other newly admitted patients, with whom they

might have age or gender or illness in common. For example one young patient asked another what was wrong with him. "You have the same as me, right". In talking with the new patient about the drugs he was on, the former patient assumed because they each took 3 tablets at night, that it was the same medication. Patients might also attempt to counsel others. One patient with a bipolar disorder recounted talking to another young patient with schizophrenia who kept feeling guilty and wanting to apologise for things but feeling afraid to do so.

> I suggested that the day was like a big white sheet of paper, and that she had done a lovely drawing on the paper but she went over the edge of the paper and she could just ignore this or turn it into a ladybird or a flower or something, but to go back and try and have a go at rubbing it out would probably make it more noticeable than if she didn't attend to it.

On another occasion three patients and the researcher were talking in the corridor when a nurse came and requested that they "move along" and not congregate in the hallway in proximity of the clinic, phone and ward office. The group left the ward and joined three other patients in the OT day room. The discussion moved from sharing feelings of frustration and depression to talk of suicide and ways to do it. Another inpatient had taken an overdose that day, and had been transferred to the intensive care unit in the general hospital for monitoring. One patient who was feeling depressed got up and left the day room and went to play pool. The researcher sat with the group a while longer then went out to talk to that patient. He explained "I had to leave to distract myself. I don't want to think about suicide - I won't do it, I'm a Christian." Other patients also tried to avoid discussions of suicide "I've never really talked to people about it ... a lot of patients will ... talk about it amongst themselves, they'll say - 'do you get suicidal' or something like that, and I'll say 'Oh yes, I do'. But I never actually discuss ways and means of doing it. [laughs] - Oh I know some of them do."

There was informal teaching about behaviours such as cutting, burning, and taking off, as well as ways to suicide amongst patients on the ward, such that new patients

might adopt these behaviours on this and subsequent admissions. A patient informant explained:

> I know that ___ and ___ [patient friends] did it [cutting] after me, on a regular basis. And I've always felt a bit guilty because they picked it up off me. But I didn't actually pick it up. But yeah ... you do [learn] from the others, like what to overdose on and what not to overdose on.... Sometimes its ... someone saying to you "if you want to do the job properly take this", or its just talking to others and knowing what they've taken and knowing that that didn't work. You know there is [sic] two ways of doing it. And also there is [sic] the different things like learning to cut your wrists one way and not the other way.
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> Patients also I think tend to tell each other a lot. Other patients know, for example, that someone has got razor blades or something... Patients know a lot more about each other than what the staff know. Sometimes they tell and sometimes they don't. Though I think most patients if they really felt that someone is really at risk - like they cut themselves with their razor blades and they were really going to do enough damage to kill themselves, then a patient would probably tell the staff. I know the time that I was really worried that someone might really damage themselves, I told the staff.

The same patient explained about cutting and overdosing. "There are two quite different parts to it, right ... [taking overdoses] is actually quite separate from the things like breaking glass, breaking bottles and things like that to cut yourself."

> The overdoses [I took] were definite attempts at suicide - they were "I want out." I think for me part of the other was ... if you cut yourself or hurt yourself, it tends to, for a while anyway, it makes you think of the physical pain not the emotional pain kind of thing. So I think that is part of it, because I know most of the time when I did it, I made very sure that there was nobody around to know that I was doing it. But there was other occasions, just one that I can think of, when I was really slacked off with the nurse. I was really sure that she knew that I was. I can't remember what I used, a bit of broken glass I think, kind of as a "I'll show you that you can't do that to me". But, I know with other people, like I know with ___ [patient] that she finds that she can get more attention by cutting herself. And she finds that attention really reinforcing. But I don't think, most of the time, I don't think I actually did it for attention.

Patients not only provided information and support for each other, but also intervened in out of control behaviour. For example, on one occasion a patient came to the office and alerted nurses that another patient had broken a milk bottle and had taken off outside the building with it. On another occasion loud screams were heard and a young male patient was found screaming in the Recreation room. Two other young male patients were already with the patient attempting to calm him. They left as nurses arrived. Again, one morning there was a very angry and

noisy interchange between a male patient who was in his room and a young female cleaner who attempted to enter his room to clean it. The patient verbally abused her and she responded angrily telling him he belonged at the psychiatric hospital. The staff in the office including the ward psychiatrist looked surprised and bemused at the cleaner's response, which they said was totally out of character. Other patients moved in to defuse the situation and talked to the aggressive patient. Another evening a patient who had been specialled for several days and was now on 15 minute observations, intervened to stop a 16 year old acutely disturbed patient from reentering the ward office when there were no nursing staff around. She had earlier entered the office and drawn on the whiteboard with a marker.

At other times patients met their own needs for entertainment by encouraging disinhibited behaviour of nonvolitional patients. An inpatient was observed in the smoker's lounge in the ward with the elderly continuing care patient (described on p.109), who spent a lot of time on the ward. The latter was disinhibited, what she said did not make sense. She was less coordinated in her clothes than usual, funny and happy. After she left the other patient acknowledged enjoying her. "I like her better like that than she was yesterday" (when she was intact mentally and appropriate in her behaviour). "I get a lift from her, used to also from ____ " (a patient with schizophrenia who was disorganised and floridly psychotic, and was committed to the psychiatric hospital a few days prior to this conversation). The same patient encouraged an intellectually handicapped inpatient to write a petition about lack of food (he had been discouraged by staff from having a second helping of dessert because he was overweight); and encouraged other patients to be an audience for a large grandiose nonvolitional patient who was pounding on the piano and chanting gibberish. Other patients also were entertained by the grandiose ideation of this long term patient who spent several days a week in the day program, and had multiple admissions during the period of this study.

Thus sometimes in this milieu of chronicity, inpatients formed a close knit patient group and supported each other when nothing else seemed to be changing for them. Occasionally in this environment the acting-out behaviours of particular patients escalated rather than decreasing, as if by trying out and practising the behaviours these patients were becoming better at being a psychiatric patient, rather than getting well. Patient friendships increased people's dependency on the ward rather than on outside sources of support. As one inpatient described it "One of the other female patients is going [home] today, and I think 'Oh, no! Oh, no'."

Summary

This chapter described the underlying belief system operating in the ward, acknowledging the dominance of the psychiatric medical model which was used by nurses and psychiatrists in this setting as a basis for interpreting the meaning of patient behaviours and for expectations of patient outcome. Thus an expectation of ongoing mental illness, of chronicity over the life time for the majority of patients admitted to the ward, and the attribution of the rate of readmissions to fluctuations in the illness process, were corollaries of this model. It is suggested that this dominant belief system shaped the way care was organised, both in the ward and the after hours service, and that this organisation of care impacted on nurses' work with patients.

Caring was viewed as a moral imperative by the majority of nurses and psychiatrists in this setting. This perspective of caring was reflected in the way patients, particularly those who were acutely ill, were responded to as people, and accepted as individuals, and it underpinned staff decisions about the provision of care, as did the dominant belief system described above. Thus the distinction between caring and the provision of care as it has been articulated in this thesis, was not always recognised by staff. Rather the perception of caring as a moral obligation was in some situations interpreted by staff as a moral obligation to

provide care, particularly for patients viewed as chronically psychiatrically disabled. The availability and accessibility of the ward to these *known* patients, through frequent inpatient admissions and the provision of the after hours service by ward nurses, was predicated on a moral imperative to care by providing a safe haven from the outside world. The limited availability of nurses to inpatients who were less acutely disturbed, although perceived by such patients as a lack of caring on the part of some nursing staff, could be attributed both to work strategies adopted by nurses in order to keep their workload and the ward manageable, and to the blurring of the distinction between caring and the provision of care (safe haven) identified above.

While the issue of *control* in relation to nurse patient interaction has not been directly addressed to this point, the recurring theme identified in the data of a lack of "boundaries" suggests that control, or lack of control, is a central issue in the overall functioning of the service. Thus this chapter outlined difficulties in establishing boundaries on the service and between parts of the service, and the limited opportunity for ward nurses to control their workload.

The next chapter will explore nurses' abilities to place limits on patient behaviours and to assist patients to regain self control in the open environment of the ward. The relationship of caring and controlling acts to the dominant belief system and the social organisation of care is further explored in chapter seven.

VI

CONTROL IN AN OPEN WARD ENVIRONMENT

Introduction

Admissions to the ward occurred because individuals, or the situations in which they lived, were "out of control", thus control is integral to the provision of care in an inpatient psychiatric setting. Yet, as will be illustrated in this chapter, nurses in this setting seemed to have little ability to contain patients in the ward, to set limits on their behaviour, or to provide external controls when necessary, except by medicating, by invoking the assistance of the police, or ultimately by raising the possibility of, or initiating, committal procedures. Thus the impression gained by the researcher was that of an environment with an ethos of caring as described in chapter five, and limited mechanisms for control.

In exploring the reasons why it was difficult for nurses to provide therapeutic control[1] in this setting, recurring themes of safety and responsibility were identified in the data. Thus in this chapter factors which influenced the provision of safe care in this setting, including the open ward environment, the heterogeneity of the patient population, an individualistic approach to the provision of care, the perceived rights and responsibilities of patients and nurses, and strategies for control and for risk management and their outcomes with differing patient populations, are examined. The process of committal is described. The chapter finishes with a brief discussion of the involvement of families in the provision of care and control, and control in the context of "continuing care".

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[1] Interventions which both ensure the safety of patients and others in the environment, and which facilitate the maintenance of, or return to self control by patients.

Setting limits on patients' behaviours

Given the apparent inability of psychiatric staff to set boundaries on the mental illness service, and nurses' inability to set boundaries on their own work, outlined in chapter five (pp.108-111), it is not surprising that problems existed in providing boundaries for patient behaviours, or setting limits on out of control behaviour. Conversely, the ward staff's perception of caring as a moral obligation, which in some situations was interpreted as a moral obligation to provide care, coupled with nurses' beliefs about the rights of individuals as voluntary patients, restricted the range of options for limit setting which nursing staff perceived as possible or appropriate. This restricted range of options for limit setting was particularly evident in relation to ensuring patient safety, as will be illustrated later in this chapter. Patients most in need of effective behavioural limit setting learned to escalate behaviour to gain admission, or to gain attention.

Patients frequently left the ward without permission (went "AWOL" as staff described it), and "acting-out" behaviour in the ward around "safety issues" such as patients cutting themselves with razor blades, broken glass, or other sharp objects; taking an overdose of medication, or accumulating and secreting a "stash" of pills to have a means of self harm; or burning themselves or bedding was relatively common. For example, during the one year period of this study six inpatients took an overdose which necessitated a transfer to A&E for gastric lavage, and admission to the general hospital for monitoring and observation. This acting-out behaviour occurred more commonly with nonpsychotic patients.

When frustrated by patients who took an overdose while on the ward, or who went AWOL when acutely suicidal, but did not attempt suicide despite having the means, nursing staff speculated about the meaning of the behaviour: "a bit obvious, taking them [pills] on the ward", or "if she wanted to do the job she wouldn't be sitting around with all those pill bottles in sight"; and the question "did she go for

a walk, or did she go to jump?" While nurses distinguished in their own minds between patients whom they saw as having a psychiatric illness and those whom they saw as "behavioural", effective behavioural interventions were not observed to be implemented in the study ward. On the whole patients were treated as not volitional, consistent with the medical model of psychiatric illness. One psychiatrist commented:

> And so there's this constant debate about the people, "do they know what they were doing?", in which case one ought to respond to them like a person, or "are they ill in a psychotic way?" It is as though there is a kind of division, and there really isn't. I mean, quite psychotically ill people can still be aware of what is going on around them. Some of them can't - and they can both appear equally ill. And someone who is terrified and depressed can lash out because they think that you are trying to poison them when you go to give them a cup of tea, so you get an acute outburst. And its really hard to sort out whether they know it or not.

The attribution of acting-out behaviour to "illness", and the perception of the ward as a safe haven where patients could "let it all out" or be crazy (as defined on p.79), contributed to tolerance of, rather than limit setting on acting-out behaviour. Nurses explained:

> I think we are very good at ... absorbing acting-out behaviours, psychotic behaviour - not being judgemental, yes - absorbing the whole drama of that ... in this very liberal atmosphere ...
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> ... first admissions are often quite difficult as far as people learning to trust you and to know that you are not going to go out and blab to the community; and to find out what they can actually do in the unit. To know that they can go into their room and scream and punch a pillow if they need to, and they are not going to be told off for it. To know that they can yell at us if they need to and they are not going to be told off for it. All those sorts of things that make people quite reserved about doing things. It takes them a little while out to find out that they can actually do it and not be told off. As long as the person that you are doing it to is accepting of it, and its not that someone that is being abused for no reason.

As a patient informant described the situation "I am a psychiatric patient, so it doesn't matter here. I can do what ever I like." This belief contrasted with societal beliefs as expressed by the father of a patient:

> ...we can all become dithering idiots if we want to. We've got to consciously lift ourselves up to keep on top of things. Many's the time you'd like to cry or scream or yell at somebody, but you've got to act out this level of [pause] normal behaviour.

Being "in control" and "out of control"

When asked what happened that they needed to come in, patients' responses reflected a loss of self control: "I held a knife to my wrist"; "I overdosed"; "I was depressed, feeling suicidal and the social worker recommended that I come in"; "I really needed to be kept safe, I was very depressed ... I was really dangerous to myself"; "I went high, I lost it"; and "Oh, I climbed over the fence out there, and I was standing on the white line on the road curtsying to the cars ... it seemed like a good idea at the time, although it doesn't seem like it now".

Patients presented themselves for admission when they were fearful of losing control. One patient explained what happened when her thoughts got out of control and she became psychotic. "I just lose touch with reality - nothing is real any more. The [wish to] suicide is really really intense.... death becomes a certainty rather than life a certainty. I start acting-out. It doesn't happen now as much as it used to, but it still could happen." Such patients reported feeling "really driven" to harm themselves, or others, however they were able to recognise their need for help, and requested admission.

Other patients lost control, but did not recognise that at the time. "When I got high nothing could stop me.... its really exciting when you've lost your way of doing things. Its the Tegretol[2] that brings you down." Such patients were brought for admission by family and friends, police or other community agencies.

Being "in control" of thoughts, feelings, and behaviour was positively valued by nurses and by patients. For example, one patient reported he had been to the gym and managed without getting high. "I stayed in control, I'm pleased with myself,

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[2] Carbamazepine - anticonvulsive medication which has been found to be effective in treating elevated mood in mania or bipolar disorder.

I'm getting to be normal." If a person was perceived as in control, they were usually seen as volitional and responsible for their own decisions and actions.

Out of control behaviours on the ward

Out of control behaviours observed on the ward included *disorganised or disinhibited behaviours* such as disrobing, or being inappropriately dressed (eg wearing multiple layers of outer clothing); entering other patients' rooms, sleeping in other patients' beds or taking other patients clothing or personal belongings; singing, swearing, yelling or making multiple distressed or abusive phone calls; breaking windows and setting off the fire alarms. The majority of these disinhibited behaviours were tolerated or "absorbed" by ward staff and by fellow patients. However complete disrobing and setting off fire alarms usually resulted in committal.

Other patients exhibited *withdrawal,* reflected in behaviours such as refusing to eat, or to talk, incontinence, inability to care for themselves with respect to personal hygiene; responding to voices or hallucinations, rather than to the external environment; "pacing" or isolating themselves in their rooms. These patients at times required considerable physical care and assistance with basic activities of daily living such as doing personal laundry. For the most part withdrawn patients were managed on the ward provided that they were willing to stay, and to take medication.

Out of control behaviours which posed a *danger* to the patients themselves, or to others (staff and patients) tended to result in committal or the threat of committal. Such behaviours included running into the road and directing the traffic, setting fires, attacking another patient or a staff member, and taking off with the intent to self harm. These were the behaviours which evoked intervention by both fellow patients and staff.

There was a low tolerance for *violence* on the ward, and patients with a history of violence were likely either to be committed directly to the psychiatric hospital without admission to the ward; or if admitted to the ward to be committed prior to any violence occurring, when nurses expressed concern that such patients were "going to blow". Such committals resulted in a more manageable ward for nurses, but often evoked anger on the part of fellow patients. "She didn't need to be committed, she hadn't done anything wrong; —— [another psychotic patient] should have gone before she did" and so on.

Self-harm behaviours such as cutting and taking an overdose while on the ward, drew mixed responses from patients and staff. Cutting and taking small overdoses were viewed by patients as ways of distracting from, or blotting out, emotional pain, or of getting attention or getting back at unpopular staff. Several patients reported it was not possible to commit suicide on the ward; this may be because other patients would intervene if they felt a fellow patient was seriously at risk (as illustrated on pp.131-132).

Ways patients stayed in control

Being admitted to the ward involved loss of power and personal control, and the assumption of the sick role of a psychiatric patient. No matter how much patients wanted to relinquish responsibility for themselves to someone else, many expressed discomfort about the discontinuities in their care which an admission brought about, and the loss of personal control over a wide range of issues. These included whether one could lie in bed or had to get up - "I felt like just staying in bed for a while - doing what I feel like [because] I'm not used to being told what to do"; the lack of control over decisionmaking about the amount of, or changes in medication; custody of children; readiness for discharge, living arrangements after discharge, and rights to discharge themselves against advice (without fear of committal). As one patient described her experience:

> They take control by filling you up with medications, without recognising what the implications are. For example, I have been dished out medication, and I have asked to have information about what the side effects are. And I am still waiting for it.... I get really pissed off when the psychiatrist changes my medication without my knowledge. Like the other day, I saw him, in and out in five minutes, and come back up here, and the primary nurse comes in and the doctor says we are increasing your medication to this that and the other. Gee I was angry! -what can I do about it? I am just another patient!

Not surprisingly, many of the ways patients exerted control in this environment were forms of negative control. Patients might refuse admission, or refuse to stay once admitted. They might refuse treatment such as ECT or medication, or refuse either to participate in the OT program or to comply with nurses' requests for change in behaviour. Patients would choose which staff to talk to, which shift to act out, and whether or not to reveal how they were feeling - "being honest" or "saying I'm all right when I'm not"; or whether or not they had a "stash" of pills or blades. As one patient described it, "they used to ask me 'What have you got?' and sometimes I would give them to them and sometimes I wouldn't."

Patients might request a change of doctor, or request a particular primary nurse, or an increase or decrease in prn medications, however the outcome of these requests was not within their control. *Taking off*, as described in the next section, could be construed as one way of taking control, although it was usually construed by staff as losing control, giving in to impulsive thoughts.

Taking off

The majority of times patients "took off" or "broke out" of the ward (went AWOL), the outcome was not one of self harm. Mostly such patients arrived at their own home, or that of friends or parents, and were brought back to the ward by family or friends; alternatively the patient might remain at home with family or friends "taking responsibility for them". Such patients were placed "on leave". Discharge was rarely an outcome of going AWOL. Occasionally the help of the police was sought in locating patients who staff felt might intend to "self harm", or

in returning patients to the ward. Some patients who took off returned to the ward of their own volition, as illustrated in the following quote.

> ...it is very easy [to take off]. I mean, the day that I took off ... I just walked down the corridor - I passed three people who said "hi" to me. I passed another staff member as I was going down the main corridor of the main hospital, and they just said "hi", and I just carried on out. I was gone for two and a half hours. I came [back] and slept - the only way they knew I'd been out was because I was so wet when I came in because it was pouring with rain - and they never missed me either [laughs] - gosh!

Nursing staff accepted the inevitability that some patients would take off:

> ... there are [patients] that have been here for a while and have got frustrated with the place and know the place so well that they've actually put planter boxes outside the windows so they can get back in when they've finished their walk after the doors are locked! But ... the ones that have done that, we haven't any worries about going out for walks. They are just totally frustrated about being here and waiting for someone ... usually family or community services, to make a decision of where they go from here. They just want to go out for a walk, get some fresh air, and let off a bit of steam.

However nursing staff had to assess or make judgements about the possible intent of the person going AWOL, and the risk of self harm. Patients sought places from which to jump: one patient had to be rescued from a high tower in the railway yards, another walked to an overbridge over the railway lines on more than one occasion, while another located an unused stairwell in the general hospital. The busy roads around the unit provided opportunities to walk in front of oncoming traffic. Nurses' time and energy was used in chasing or searching for missing patients believed to be at risk. When asked about keeping people safe in the ward one nurse replied:

> I think that we step over the boundaries sometimes. Well its not a very safe environment to start with - structurally [with] all the glass, and where the building is in terms of main roads, and bridges and God knows what else. But I think that physically we do the best that we can with what we've got ... like "specialling" them and stuff like that. But I do think that sometimes we are really stretched in doing that. And chasing people, you know, up the street and climbing towers and things like that. We shouldn't have to do that. I don't think that ... should have to take place. People should be able to feel safer.

Safety, responsibility and risk

The open ward environment

The provision of immediate safety was often the objective of an admission, yet paradoxically the safety of patients was difficult to ensure in the open environment of the ward. Nurses cited the "geography of the place", which included the physical layout of the building, and its proximity to dangerous situations such as busy roads, towers, bridges, stairwells; inadequate staffing; and the rights of voluntary patients, as reasons why it was difficult to provide safe care.

The ward was not structurally modified for the safe care of patients who might harm themselves or others; neither were routines and rituals in place which are commonly used in other acute psychiatric settings to protect such patients. Routines such as searching belongings, removal of any items with which a patient could harm themselves, or keeping suicidal patients in their nightwear as a deterrent to taking off, were considered either an infringement of the individual rights of voluntary patients, or inappropriate in an open ward milieu.

The rights of voluntary patients

Nurses perceived the rights of voluntary patients in this ward as barriers to taking safety precautions on a routine basis. Patients were permitted to bring into the ward, and to keep in their possession, any personal belongings including those which might be used for self harm by themselves or others. Valuables were locked away and patients were asked to hand over to nurses any medication they might have brought with them. However, nurses' concerns about maintaining a "normal" open ward environment, and not infringing the individual rights of patients, precluded otherwise restricting what patients may have in their possession, or searching patients' belongings without their permission. A nurse explained the situation as she saw it, illustrating the confusion over rights and responsibilities which existed in the study ward:

We ask everyone that comes into the ward to hand in any medication and things they've got. If they don't hand them in, then legally it's their responsibility because they are a voluntary patient, but we also have the responsibility for these patients, but because they are voluntary we can't search their bags and things without their permission and with them present. And a lot of the time it doesn't make a nice atmosphere between the patient and yourself if you say to them "Look I need to check your bags because you might have these sorts of things". They immediately think "Oh they don't trust me I'm in jail" - things like that.

... The razor blades is [sic] an issue that's going to go on for ever and ever, because no matter how many packets we take off them they just go to the shop and buy some more. And it's taking away their rights to buy what they want to buy. Really we have to give them that responsibility... of saying "I'm feeling grotty, I want to cut myself", [and to] find different ways of dealing with it rather than go out and buy razor blades. As much as we take them off [them], they just go off and get another packet - it happens. So you are just taking blades off them the whole time. But the majority of ones with blades or glass and things will tell you, will give you some sign that they have got them, or some hint, and then it's just waiting until they will hand them in to you. More often than not they won't do any damage with them while they've got them, or they do a little bit of cutting - but not [deep] - "cat scratches".

For many nurses, the view that patients had rights to bring razor blades into the ward was confused with empowerment. Thus, in discussing the problems with razor blades, another nurse commented "the other thing about that is [pause] over the years these things have changed in allowing people to make more decisions for themselves, and empowering them. So I guess that there are different views come into that."

Other factors also contributed to the difficulties ward nurses described and were observed to experience in setting limits on patient behaviours, and in providing safe care for patients who were out of control. One factor was the lack of any clear ward policies or unit rules to provide boundaries for patient behaviours. The focus was on monitoring, responding to, and absorbing individual acting-out or psychotic behaviours which occurred. Another factor was the individualistic approach to care adopted by the majority of nurses.

An individualistic approach to care

As previously stated, there was a low tolerance for violence in the ward. Aggressive behaviour was dealt with by warning of, or initiating either discharge or committal. However most situations were responded to on an individual patient basis, and staff used idiosyncratic strategies rather than shared or common strategies in determining their responses to patients. As one nurse explained:

> We just deal with such a wide variety of people. Its hard to say no, we can't do that.... So each case has to be taken separately - its such a wide area to get anywhere, you know, to make any definite rules. We have guidelines but we can't have set rules because everyone is so different.

On the morning shift nurses tended to work as individuals going about their work with their primary patients. Nurses often left the ward for meetings, or left the building while organising patient care. Frequently the number of nurses remaining in the ward was low; also no one nurse within the ward had a clinical overview or coordinating function. The charge nurse's office was outside the ward and his responsibilities were administrative, rather than clinical. The incumbent of this position changed during the period of the study. Asked about the individualistic approach to care, nurses responded:

> Yes, it's a funny place to work in terms of that. Although you are part of a team, and although you work within a ward, you actually do a lot on your own.... I might come to work and I might not have a lot to do with anyone else all day.
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> Even if there is a meeting, staff should document more when they leave the ward, put it on the board for instance... I mean I should do it myself. I shoot off ... and come in again without saying I am shooting out. I usually tell someone, but I usually assume there is always someone else there I suppose.

Nurses expressed conflicting opinions within and between shifts about appropriate courses of action to be taken with particular patients, and when one nurse's workload was heavy, or teamwork was required, for example with constant observation (described on p.148), nurses at times expressed feeling unsupported by their colleagues. "Its where you have to rely on your colleagues to help out as far as observations are concerned, constant observations. I think its important it

involves team work, and if your colleagues aren't pulling together to do that, then its difficult"; and "The team doesn't do well in jointly watching who should be watched."

The individualistic approach to care was noticed by patients also. For example, a continuing care patient (a young woman with a diagnosis of schizophrenia), when talking about the diversity of patients in the ward, commented "I was thinking of the staff as well, everyone is different - they don't seem to - sometimes they don't sort of fit in together do they? Because everyone has got their own job and they don't sort of work together do they - do you know what I mean?"

Safe haven, but not a safe care ward

Thus while the ward might function as a safe haven from the outside world, it was not possible in this setting, as care was structured, to ensure safety for persons who might be a risk to themselves or others. Nevertheless such patients were admitted to the ward, and nurses felt responsible for attempting to ensure their safety. Both patients and nurses recognised the ambiguities in such a position which was engendered in large part by the need to provide care for a heterogeneous group of patients in an open ward.

As one nurse commented "well there's the openness of the whole thing that it is too easy. So whereas the responsibility is thrown at the patient, you are a voluntary patient, this is an open ward - you can't do that in an acute ward. So you are giving a mixed message." Another nurse recounted talking with a suicidal patient "Now to me, she's come in for help, and this is what I was able to say to her. 'Look you realise your situation, you realise how dangerous it is, you have come to us for help, now its up to us to keep you safe.' Now, we can't keep her safe under these circumstances, we can't!" A patient who had been admitted on several occasions with suicidal ideation commented:

...the fact is that if someone is in a psych ward I guess, the staff have to be responsible to some degree for their safety. If someone comes in suicidal, the staff can't say "well you can be responsible for yourself" can they? I can see the dilemma [pause] - and yet I've actually found that [pause] yeah - I must say I've found it much easier to take overdoses actually in the unit than out of the unit.

A possible explanation for the latter remark is outlined in quotation from the same patient in a later section (p.151). Patients who were admitted with suicidal or homicidal ideation, and felt out of control expressed concerns that "this ward cannot keep me safe"; "I need to be in control of myself to be here"; "I am too far gone for this place, I need to be locked up in a room.... [where] I could sleep it off. I have to keep my shit under control here"; and "I was scared of that. As much as I wanted to do something, I was still scared that I wasn't safe." For some patients the function of the ward as a safe haven provided enough security, however even these patients were aware that the ward could not really keep them safe.

The place is security when I need it. Because when I need to be there, it is a place of security and all that. Although its not all that secure sometimes! [laughs] You can still bugger off if you really get [pause]. But I guess that's one way I see it. The ward feels secure, but then it depends on you anyway a lot - how honest you are with the staff.

Ways of keeping patients safe

Ways of keeping patients safe in this setting included restricting access or leave; the patient might not be allowed out of the bedroom, ward or building unless accompanied by a staff member, or a family member. Infrequently, the use of day wear or shoes might be restricted. Constant observations, or observation every 10 or 15 minutes might be instigated; or the building might be locked up early on the pm shift to "limit the area to be covered". One or more family members might stay with the patient to "share the responsibility" with staff for observing the patient's whereabouts. Extra medication might be given to reduce the patient's anxiety and impulsivity.

Nursing staff challenged patients whom they suspected to have a "stash" of pills or "sharps" such as razor blades, and requested that they hand them to the nurse.

Patients might also be challenged to take more responsibility for themselves, either by contracting not to harm themselves, or by a threat of committal to a psychiatric hospital if they took off or otherwise harmed themselves.

Constant observation

Constant observation in this setting differed from that carried out in secure psychiatric settings. One nurse contrasted her previous experience of constant observation (or "specialling" as it was termed in the study ward) with what happened in this ward:

> ... if you were specialling someone then you were no further away from them than arm's length. There were no obstructions between you and them. And within their environment, it was safe, no cords, no sharp objects. When they had meals, they had finger foods, so that they didn't have utensils.... that would be "A obs", and "B obs" was that you could have something between you and the person, and they were given back some things into their environment. And then you can take it back one step further and go on to "15 minute obs" and so on. I couldn't believe that [in this unit] you could special somebody through a door, and they could have shaving equipment, and they would have their tray with knives and forks on it. That didn't make sense to me, it still doesn't a lot of the time.

Specialling in this ward could mean constantly observing the whereabouts of a mobile patient dressed in street clothes in an unmodified environment. Constant observation provided discontinuous, rather than constant care. Nurses were not assigned to special a patient for an eight hour shift, rather they took turns to be with the patient, with a change of nurse every 15-30 minutes. Thus patients experienced being "watched" or controlled, but not necessarily cared for. Opportunities for therapeutic work afforded by high staff contact were negated by the continual turnover of nurses. As one nurse described it:

> Specialling somebody on a mobile basis in this ward, is really hard work.... we can [do it], but the problem is how long we can maintain that. We have specialled for ... about three and a half days, I recall. [That is] constant specialling, getting extra nursing staff in to special over a total period that included nights.

Control of acutely psychotic (nonvolitional) patients

Psychotic patients who were brought to the ward for admission in an acutely disturbed state, were restrained from leaving the ward, or brought back if they took off, and intramuscular medication necessary to control the acute disturbance was given. Such treatment was observed to be given in a caring manner, and nurses expressed concern that the self respect, dignity and privacy of the individual be protected, although this was very difficult within the limitations of the ward environment, as described in chapter four. Thus for these patients (who would be certifiable as mentally disordered in terms of the Mental Health Act), *the right to treatment* in this state was the over-riding consideration. The committal process might not be initiated for such patients if they settled quickly (within 24 to 48 hours), given that other conditions in the ward were such that the ward remained manageable for nursing staff (as discussed in a later section, pp.161-162). However if restraint and involuntary medication were required on an ongoing basis, beyond the immediate use to ensure control and safety on admission, such patients were committed and were sent to a psychiatric hospital.

As previously stated, taking control, when a patient is "out of control" is integral to the provision of care in an inpatient psychiatric setting. Nurses' actions in taking control of acutely psychotic patients by providing constant observation, medication, support and reassurance, enabled these patients to feel safe and to relinquish control. With the resolution of the acute psychotic state, such patients began to take responsibility for themselves.

Nurses usually showed patience, used reassurance, and gentle persuasion with psychotic patients. For example, one evening an elderly psychotic man who spent a lot of time in the ward either as a day patient or an inpatient repeatedly attempted to leave the ward. He was reported to be responding to voices telling him to go outside. A nurse attempted to dissuade him from going outside after the evening

meal as there was a very cold wind. He insisted and opened the outside door in the lounge. The nurse followed and brought him back. When he couldn't settle she accompanied him around the outside of the building twice and then locked the outside doors, except the main front door. The patient was again seen outside. The nurse unlocked the lounge door, brought him in and another nurse encouraged him to go to bed early.

Another evening, a nurse was observed to reassure a psychotic patient who wanted to go home that "this is your time for a rest. Your children know you are here and want you to have a rest. They will come and see you when they can. They won't abandon you." This patient had been distressed all day, wanting to go home, wandering the corridor, asking nurses, going into the ward office. On the morning shift she often got an offhand response and did not always get referred to her primary nurse.

However psychotic patients who were well known to the service, and who presented in a less disturbed state, might be treated as if they were volitional when they were not. For example a patient with paranoid ideation and high blood pressure was allowed to refuse medication and was discharged home within a week, rather than being committed to ensure her right to treatment. As the patient described it:

> They gave me 2 tablets. I said "I'll take half of one tablet, because I only take a quarter of any prescription". So I took half a tablet. And the next time they came around, they had two tablets, and they said "Will you take the medication?". And I said "I'll take half of one tablet", and I did. Next time they came round, they brought one tablet. They said "Will you take the medication?" I said "I take half of one tablet". And the next time they came around, I said "I don't want any more. I don't like it, it agitates me."

This patient was committed to the nearest psychiatric hospital for treatment shortly after her discharge from the ward. It appeared that such patients were often discharged from the study ward without adequate symptom management, raising the question as to whether a longer admission with more active treatment rather

than time out, might enable better functioning in the community and a longer interval between admissions. Failure to take control with these psychotic patients who were less floridly disturbed, but whose level of disturbance rendered them dysfunctional in the community resulted in such patients remaining disturbed. They often made frequent use of the phone-in, and time out services after hours, but achieved little change unless a committal was instigated.

Control of nonpsychotic patients

For nonpsychotic patients who reported feeling "unsafe" and needing someone to take responsibility for them, the use of traditional measures such as constant observation and medication did not appear to produce the same outcomes as for psychotic patients. Such patients might initially appear to relinquish control, however not infrequently impulsive behaviour such as taking off, cutting and burning escalated rather than diminished. Paradoxically, taking over responsibility for the safety of nonpsychotic patients by constant observation in this manner could increase patients' feelings of being out of control, and thus increase rather than decrease acting-out behaviour. Patients commented "It makes me feel less safe", and " I was more determined to do it; I put all my energy into it". Another patient who had been suicidal reflected on her experience:

> ...it actually made me worse ... some of the time it made me feel really trapped. Like ... I couldn't do anything, I wasn't my own person. Like they had control of my life and I didn't have control of my life. But then in some ways, I don't know, I quite liked that, feeling that I wasn't responsible. Like they were responsible for keeping me safe and I wasn't responsible for keeping me safe.... Also, if you don't have to [pause] if you don't feel like its your responsibility to keep yourself safe, then basically you can do what you like and its your job to get out there and do what you like, because its not your responsibility to look after yourself.

On some occasions with such nonpsychotic patients, the periods of constant observation were brief. For example, one depressed patient was specialled over a weekend, but was permitted a brief period of unaccompanied leave on the Tuesday evening. However with other patients these situations did not resolve quickly. Lengthy admissions resulted, with the patient feeling disempowered and hopeless,

and the staff split as to the meaning of the behaviours and appropriate courses of action. The problem was usually attributed to the patient, who might be described as having a personality disorder, and viewed as unlikely to change. The focus then moved to achieving a discharge.

Taking responsibility for patients

The practice of nurses taking responsibility for patients was accepted by nurses and patients. When patients came in, often they reported "feeling unsafe", and wanting "somebody to take responsibility for me"; or friends and relatives or community agencies might request the admission because they could no longer cope with, or take responsibility for the patient. A nurse described the situation on admission:

> Our responsibility to them during the first 24 to 48 hours is basically to take responsibility from them because ... they are usually so distressed that things aren't going so well that they just want to close in and let everything go and then they'll take responsibility from there.

Known patients for whom the ward provided a temporary safe haven from outside pressures often did take responsibility for themselves within a few days, however a significant number of patients, both first time admissions and readmissions, continued to view nurses as responsible for them while they were inpatients.

It could be argued that for nurses to take responsibility for nonpsychotic patients beyond the first 24 to 48 hours was to invite irresponsibility, to give permission to be "crazy". However when a person states they feel suicidal or engages in self injurious behaviours such as cutting with razor blades or burning with cigarettes or lighters, most people who are in contact with that person feel responsible for initiating some preventive action. It was often because clinicians outside the ward were uncomfortable with that responsibility on an outpatient basis, that such patients were admitted. Nurses then took on that mantle of responsibility for the day to day care and safety of those patients in the ward. Thus the potential was

there at the outset for that pattern of acting-out to occur, where patients put their energies into defeating the efforts of nurses to keep them safe.

Establishing patient self responsibility

When the status level of a patient presenting with suicidal ideation was reduced from constant observation to 10 or 15 minute checks on the patient's whereabouts, the issue of who was responsible was clouded. From a nursing perspective, patients had to take some responsibility for staying in the ward, yet this was not always a shared understanding. Patients' energies were readily diverted into outwitting nurses if they felt that nurses, rather than themselves were responsible. As one patient commented "unless you're really psychotic maybe you won't work it out, but it doesn't take much to realise that they've looked at you and you've got 15 minutes to do something, because you know they are not going to be back for 15 minutes." A nurse outlined the ambiguities this situation this created for patients and nurses:

> I think [pause] that a lot of them take that responsibility themselves - the patients. They are aware that we are watching them, but they are ultimately responsible for staying. Does that make sense? ... [with] specialling you are there all the time, but if you are not there all the time and you are doing ten minute checks or 15 minute checks, unless everybody else on the unit, all the staff ... [are] aware that that person is being watched ...Yeah [pause] But that is sometimes very difficult...

> ⎯ [nonpsychotic patient] actually said to me "If I really wanted to leave, I could do it you know". I was doing 15 minute checks on her, and she said to me "Look I know when you are checking, and I can just slip out immediately after you've checked and I know that you wouldn't be looking for me for another 10 minutes - quarter of an hour; by that time I could be down at [local shopping centre]" And I said "Yeah, you could be, but you are not going to be".... But she's right, she could be! I responded to that by saying "Yes, but everybody knows - all the other staff know too that you are to stay here, its not just me, I'm not taking full responsibility for that. All the staff members know". And that, because people don't exactly know the extent of the staff, may be kind of a threat to stay.

Also reflected in the above quotes is concern about the level and consistency of support by nurse colleagues, stemming from the individualistic approach to work described earlier in this chapter (pp.145-146).

There was a lack of clarity about how nurses gave, or patients took back, responsibility. Nurses variously stated "Patients have to be told its time they took responsibility for themselves."; "...some staff members like to take responsibility for patients until they are sure things are going to run smoothly and other staff like to give the patient responsibility as soon as they look like they are going to be able to cope with a little bit of responsibility."; "The status can change quite rapidly and sometimes it is a bit confusing. But that's trying to respond to degrees of improvement.... and affording someone that responsibility for themselves, and sharing it a bit."; "The fine line of who takes what responsibility - I don't know if I can answer that totally. Its an ever changing picture at times."

Patients experienced this changing picture. An inpatient explained "...that's why I am here, because I am unsafe and can't take control - I need them to do that for me for a while- but there is a limit to that." Asked how she negotiated the relinquishment and taking back of control, the patient stated "Well when you take it back, it is just going to happen, there is no - like I know my own patient status is down to 4 or 5 or something - 5, and some days I look at the board and - oh I have gone up. And there is no, sit down, okay what can we do to improve, or whatever. " A discharged patient looked back on her experience of being in that situation of perceived powerlessness and commented:

> Well [long pause] I think you have to get to a point where you realise that its not really their responsibility to keep you safe, its your own responsibility to keep yourself safe. [pause] Like, when you realise that they can't possibly keep you safe, like when I actually realised that being in [the ward] was not a safe place to be, then I realised that I had to take control for myself. And while that was really hard, [pause] and I didn't do a particularly good job of it [pause] yeah, there was something about that, once I had realised that they couldn't keep me safe, I lost a lot of the respect kind of that I had for them.

Ways nurses managed risk

With nurses the issue of managing risk, protecting oneself, often surfaced. As one nurse explained "Its all kind of a risk, that's what it basically comes down to. Its -

can you let this person take the risk? And sometimes you don't feel very comfortable about that." Asked for examples, the nurse responded:.

> Someone might say to you that they are not feeling very safe, and then in the next breath they'll ask you if they can go on leave.... that puts you on the spot. Because they've told you that they want to kill themselves, but yet they want to go out. So I just hand that back to them and I say "What do you expect me to do with this now that you have given it to me? Do you expect me not to act on it and to allow you to go out and hurt yourself - to give you permission to do that? I am not prepared to do that; that has to be your decision." So I make them take responsibility for that. Sometimes they will say "Oh, yes, leave is not such a good idea", and sometimes they will compromise and decide to go with somebody.

One weekend, a nurse was observed to respond to a phone call from an outpatient (a person not known to the ward) complaining of depression and arranged for him to see the on-call registrar. Asked whether she had considered asking him to wait and call the next day (Monday) for an appointment with his psychiatrist, she responded "The thought went through my mind, but when somebody talks in that tone of voice, sounds depressed and says he's not coping, I have to consider, I have to protect myself. I don't think I could live with myself if I turned him away and he harmed himself." Similarly, in talking about an inpatient who had been acutely suicidal and had very recently come off constant observation and 15 minute observations, another nurse commented:

> I think she's coping quite well latterly about that. The caution is [sigh] that it could be a dead lady. You get the control thing again. At some stage, you have to relinquish some control and get her back to her own persona and some self esteem.

As will be described in the sections which follow, therapeutic confrontation, behavioural contracts, and the threat of committal, were strategies used by nurses both to manage risk, and to assist patients to take responsibility for their own behaviours.

Therapeutic confrontation

Therapeutic confrontation or challenge was one way nurses might encourage patients to take responsibility for their actions. When talking about the informal

learning about cutting and other behaviours which occurred on the ward, one nurse commented "what I do is I confront them with that, and say 'Look when you came, these were the issues - why now are there ... these things as well, where do they come from?' And sometimes people actually aren't aware that they are doing that."

Another nurse recounted confronting a suicidal patient who left a note and took off requiring police involvement to locate her. "I just told her straight forwardly 'I'm not putting up with that any more, I don't want any more of that sort of carry on from you. You know, that's very unfair,' and so on. And she responded very well to that. She's been very good with her program."

However what was observed on the ward was more often accepting behaviours, rather than therapeutic confrontation. Failure to confront in this manner might be a "safe option", a way of avoiding risk. A nurse explained how this might happen:

> Yes, sometimes that [confrontation] doesn't happen and I think that is because some people are afraid of confrontation ... you have to establish some kind of rapport with the people - your clients - but that doesn't mean to say that you always have to be the nice good person. It means that sometimes you have to be someone that they don't like. And sometimes as a person, you may not like that role. And so therefore the challenge goes away and you don't have to confront - so those people - it's not good for your client, because that's enabling them to stay unwell and to keep on with what they are doing. Because you might not like to be seen as a bad ogre, or whatever.

Behavioural contracts

Behavioural contracts were sometimes used as a way of giving back responsibility to patients, however their primary function appeared to be as a way staff managed risk. For a behavioural contract to be effective both parties must adhere to the agreement. If a patient continued to see nurses as responsible for their safety then the contract might not be seen as binding. As a patient explained "Like they would talk me into signing a contract, I'd sign the contract, or I'd make a verbal contract or whatever. But I was only doing it to keep them happy.... It didn't worry me whether I kept it or broke it." A nurse commented:

...it comes down to their own decision, their own choices in the end, whether they are going to stay in the unit or not, and whether or not they are going to stop behaviours or not. I mean I can set limits on them [pause] sanctions, whatever - it all comes down to the crunch of whether they are willing to comply or not.

Conversely, compliance with a behavioural contract could have unanticipated outcomes for a patient. One patient, after an extended period of time when nurses had taken responsibility for her safety, was sent on leave with a behavioural contract, one clause of which required her to phone the ward or come up for time out if she was feeling unsafe. She did contact the ward saying she was not coping and was immediately brought back from leave and tight controls applied. As she described it "...woosh - panics yesterday in all of them [sighs] I lose everything again, I lose everything." As she saw the situation, the act of asking for help as she had contracted to do "landed me in the shit! "

Contracts in this setting tended to clearly specify behavioural requirements of patients, but did not indicate what staff (nurses and the ward psychiatrist) contracted to do in return for patient compliance. Staff retained the right to act as they saw fit at the time, hence there was a one way, rather than a two way contract. The responsibility and control offered to the patient might be illusory rather than real. A nurse described the process of contracting with another suicidal patient:

> ...now I'll give her that responsibility back, and the way I'm doing that is I've drawn up a contract with her ... and informed her that I am unable to take full responsibility for her - you know she's primarily responsible for her actions, and contracted with her in a formal written contract that has been discussed with the consultant and other team members who are involved with her and herself ... saying that if she wants to leave the ward that she's to inform the staff where she's going and when she's back again, and if possible go with somebody else. And she's also got to promise that she won't harm herself while she's gone. And the contract also involves the clause where if she fails to comply with the contract, or insists on going regardless of the contract, that she has to sign a self-discharge form. Of course, if she doesn't do that, she's unsafe, and I'll commit her, but she's been given the responsibility back in that way, and now presently she's been given responsibility to be able to go out on small outings by herself.

Consistent with the individualistic approach to work and decision making described earlier in the chapter (pp.145-146), attempts at behavioural programs to

control patients' acting-out behaviours were not supported by all staff. For example, one adolescent patient was started on a token economy program where credit was earned for attendance at occupational therapy, and for remaining in the ward rather than repeatedly taking off. The reward was to be a supervised fun outing with a parent or adult friend in the city, but the outing was not to be to her home. The patient complied with the program and requested to go to an aerobics class at a gymnasium in the city. A nurse allowed her to go unaccompanied and she later phoned to be collected, stating that she couldn't cope. Later that afternoon her mother came to visit, asked to see the ward psychiatrist, and was allowed to take the patient home on leave overnight. The patient did not return to the ward after this leave, having contracted to do so, and was later discharged. Ironically, the ward staff's failure to be consistent and adhere to decisions made about the patients' program mirrored the patient's home situation where the parents could not agree over their daughter's care. Many nurses had little faith in behavioural programs, citing examples where the outcome was that patients controlled the staff.

Community expectations of control

People outside the unit, family members and others in the community, often expected the ward, and nurses as agents of the ward, to take more responsibility for, and to exert more control over, patients than was appropriate given their informal status. For example, the nursing notes recorded "____ [Adult patient's] mother phoned, angry patient not in ward, told she is voluntary patient here. Overall patient's mother wanting limits placed on patient. We explained this was not possible in her voluntary status in the ward."

On another occasion a woman from a voluntary agency came into the unit to express concern that a young chronically psychiatrically disabled female patient "should be on leave with a male who is so needy himself". A psychiatrist attempted to explain that "on leave" meant a bed was held for that patient and that

the unit did not have that amount of control over where she went while on leave. Thus community members expected nurses to exert more control over the lives of patients than they were legally able to do. As one nurse exclaimed after answering a phone call "Why is it that people think we are responsible for everything that happens!"

Committal

As voluntary admissions, informal patients could not be forced to stay in this ward, nor to receive treatment such as oral or intramuscular medication or ECT. If patients left the ward without permission they could not be forced to return to the ward. However as outlined earlier in this chapter (p.149) consideration of an acutely psychotic patient's right to treatment meant that such patients on admission may be restrained from leaving the ward, or brought back if they took off, and intramuscular medication necessary to initially control the acute disturbance would be given.

The status of a patient who was admitted informally could be reviewed at any point during an admission, and if deemed necessary by psychiatric staff, the process of committal initiated, or the possibility of committal discussed with the patient. Patients were unhappy about this ambiguity in their status. As one informal patient, with whom the possibility of committal had been discussed, commented: "it isn't right that while you are an informal patient you can be committed so you can't really discharge yourself against advice".

The threat of committal

The threat of committal was often the only effective control mechanism that nurses and psychiatrists perceived they had to manage risk. As another patient described it "my level of self responsibility has increased now, but before that I was threatened with committal. [pause] If I did anything it was high ho, off to

[psychiatric hospital] you go." This experience was described by other patients also. This threat might be used as a behavioural control even to the extent of writing one set of committal papers, though it was unlikely that the threat would be actioned. Thus a psychiatrist commented in relation to the latter patient:

> ...we have said "Right if you do that again, we'll commit you". But we tend to defer that because we know after a fortnight we would be back to where we started [the patient would be referred again to the ward from the psychiatric hospital]. So I think that what we are trying to promote is more [that] she is able to take responsibility for herself, and in times where she feels she can't, we are here to provide her with that kind of care.

Patients were unhappy that the threat of committal was used to control their behaviour. The threat of committal was experienced as very disempowering, and was often perceived by patients as control without caring. The patient referred to above, and cited previously in this section elaborated on her experience:.

> I really hated it [the threat of committal]. It was really scary because I know that at any time I could blow it anyway, and I would go off. It made for a very tense time for me. I think it is really unfair that that's the option that they use all the time to keep a person safe. I think it really comes back to the whole thing that they don't understand ... how a person works psychologically, ... and the personal pain and all that sort of thing.... I think if they actually sat down and spent an hour or two hours just trying to understand what I was on about, that maybe they could have found a way through to provide something else rather than the threat of committal.

Patients suggested that alternative ways of keeping them safe lay in "having a good relationship", and "talking things through", both of which would require that nurses were available to talk; and in shared decision making -"he sort of made me feel I had some control over what was happening."

Patients' perceptions of committal

Being committed to the psychiatric hospital was feared by many patients. Patients told stories about it, it was unknown and scary. They feared being locked up - "its like a prison out there", "I felt like an animal in a cage", hence the effectiveness of the threat. Ironically other patients asked to go to the psychiatric hospital. For some who had been there, it was seen as secure and safe. "They look after you and that, and they always make sure you eat properly and all that kind of stuff. I

suppose you know that nothing can happen to you." When the psychiatric hospital was visited, a patient approached the researcher and said "I'll tell you something about this place - there are people who want to get in who can't, and people who want to get out who can't".

Reasons for committal

Legal grounds for committal required that the patient be mentally disordered, which according to the 1969 Act means suffering from a psychiatric or other disorder whether continuous or episodic, that substantially impairs mental health and requires care and treatment. The Mental Health (Compulsory Assessment and Treatment) Act which becomes law in November 1992 tightens the definition of mental disorder to mean an abnormal state of mind, whether of a continuous or an intermittent nature, which is characterised by delusions, or by disorders of mood, volition, cognition, or perception. That abnormal state of mind must be of such a degree that it: a) poses a serious danger to the health or safety of the person or of others; or b) seriously diminishes the capacity of the person to take care of himself or herself. This Bill has been before parliamentary select committees for several years and it is these criteria which psychiatrists explained to the researcher as grounds for committal.

While an inpatient in the study ward might be mentally disordered, as defined above, the process of committal did not always take place. If possible, patients who legally would be committable were cared for in the open environment of the study ward. Reasons cited by staff for actioning the committal process included patients' history of aggression toward another patient or staff member, refusal to take medication, being a danger to themselves (such as running in front of cars), staffing levels on a particular shift being too low to implement constant observations, too many acutely disturbed inpatients for the ward to be manageable, or the patient remained disturbed over too long a period for nurses to be able to

sustain the level of care required. So for the patient there was an element of chance.

On some occasions one or more of these informal criteria for actioning a committal were present, yet the committal process did not take place. Such exceptions were observed to occur when a patient had special status (for example a health professional referred from another Area Health Board), or a concurrent serious medical condition for which proximity to the general hospital was advantageous, or when family members were available to be with the patient, and to take responsibility for getting the patient to take medication.

It was usually nursing staff who were observed to initiate the committal process. They decided when they were unable to manage a particular patient and contacted psychiatric staff with a request for committal. Psychiatric staff did not always agree with nurses' requests for committal, however while psychiatrists held the power of the final decision, it was nurses who had the responsibility for day to day care. As described in chapter five (p.123), it was in the interests of both nurses and psychiatrists that the ward be manageable. To this end, one of the two required sets of committal papers might be written on a Friday, for an inpatient for whom committal over the weekend was a possibility. This action avoided a lengthy delay once a decision to commit a patient was made, as there would be only one doctor on call. When a lengthy delay occurred, tension in the ward mounted and most nursing resources went into controlling that situation. A nurse explained:

> We don't notify the doctors idly until we really feel that [the patient] needs to be quickly assessed because the situation has got to the stage, we can't cope any longer. But the process and the advocacy that goes with committing a person, you've got to recognise that, and it can be an awful long time, and realistically the patient has lost control. And we've lost a degree of control over the situation too.

Nurses also anticipated the possibility of a committal when the name of a known patient who had previously been committed appeared in the daily log frequently, or

was put on the board possibly for admission, or when there were queries about that patient. A nurse would phone the psychiatric hospital to find out whether or not that person was still on "trial leave".

The involvement of families in the provision of care and control

When committal occurred, the family as well as the patient lost rights and control. Some families were relieved to have their out-of-control member taken care of. Others stayed to help provide care for and supervise their family member in the ward, and might refuse to consent to his or her committal. One psychotic adolescent was discharged "to the care of" his parents after they refused to consent to his committal following an episode of restraint and involuntary medication in the ward. This episode occurred when the young man was unwilling to stay voluntarily, and was physically restrained by nurses to prevent him leaving. The nurses expressed concern that he needed to be committed, to be in a controlled environment where he could relax and deal with some of what was going on for him, without continual attempts to leave. They were pessimistic about his future. The father explained why he refused to consent to committal:

> It's here as I understand it, I can come and visit, perhaps stay here with him. We can visit when *we*[3] like it. We can discuss the medication and what's happening, give our input into the system. Whereas at [psychiatric hospital] you have no visiting rights. The doctors decide what medication and how they'll give it, and if they decide that they'll withhold treatment, they can ... Whereas here they don't have the same right. We can withdraw him and he stays with family life, whereas once he's committed, he is a committed mental patient.

Working with families in this way was difficult. As a nurse commented it required "divvying up, giving away, power and control", particularly where the views of family and ward staff were disparate; both had the "best interests" of the patient as a focus of their decision making. Each party believed the other was mistaken, or did not really understand.

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[3] Emphasis in original quotation.

In this ward, families were involved as coworkers, as carers and controllers of patients, but a family focussed approach to the etiology and treatment of problems was absent. Even when nurses were aware of family conflict, the underlying illness, rather than relationship problems, was the focus of care. This finding is consistent with the dominance of the medical model of psychiatric illness as outlined in chapter five.

Continuing care and control

For patients who were followed up after discharge from the ward by the continuing care service, particularly those who used rehabilitation or halfway house facilities, control could extend beyond symptom management to influence housing, finance, and custody of, or access to, children. However the focus remained that of symptom management. A nurse explained that "the key issue of care and control in continuing care, is knowing when to take that control off the patient and to start to take control." Asked ways she could do that, she responded:

> By knowing your client ... you know the signs that they are not in control of themselves, then you are able to take that control. It's like ___ [chronically psychiatrically disabled patient], knowing when ... I need to take control and say "Right ___ you are going to be admitted to the ward". Or, "___ , you are to have your injection". And at the moment she is actually having her injection every week, because I feel that she is not quite as in control of herself as she used to be. But when I can see the signs of her becoming more in control and her decision making is much better, then I will say to her, "well you can have your injection - do you want it this week?" And she will say, "No, I'll have meds next week" - then she can start taking control of that again.

Continuing care nurses saw themselves as having less control over patients than ward nurses, however the control was experienced as more pervasive by patients themselves. Patients said they felt less cared about after discharge - "once you leave they don't care about you - they won't worry about what you do." Producing symptoms such as restlessness, muscle stiffness or feeling suicidal, became a way to get attention and concerned caring from nurses, often via the afterhours service. Thus for people whose identity was focussed on being a psychiatric patient,

symptoms were the passport to care. Toward the end of the period of observation, when restructuring was occurring in community and continuing care services, continuing care nurses were attempting to discourage such outpatients from dropping in to the ward on a regular basis. " There's a big wide world out there".

Summary

Patients were admitted to the ward because they or their life situations were "out of control"; being "in control" of thoughts, feelings, and behaviour was positively valued by nurses and by patients. Different kinds of out of control behaviours drew differing responses from nurses. Thus disorganised, disinhibited patient behaviours were largely "absorbed" and tolerated by nurses, while withdrawn behaviours resulted in nurses providing physical care and assistance. These interactions reflected nurses' acceptance and concern for patients and produced little overt conflict. Difficulties were most evident when the mandate for care was to "keep patients safe" in the open environment of the ward.

The distinction between the provision of a "safe haven" from the outside world, and the provision of "safe care" was not always clear for staff or patients. Nurses often felt responsible for patients in a open ward environment where they could not provide safe care. Thus issues of safety and responsibility were recurring themes which arose from the data, around which the discussion of control in this chapter has been structured.

In the discussion chapter which follows, the findings which have been outlined in chapters four to six will be examined for their fit with the existing literature on caring and control, and the implications of these findings for nursing practice and service development will be discussed.

VII

DISCUSSION

Introduction

In chapters four to six the findings of this study have been presented in terms of what went on in the study ward; what drove and constrained the way care was organised in this setting; and the differing patterns of caring and controlling interactions between patients and staff which eventuated as nurses attempted to meet the needs of a heterogeneous patient population within the open environment of the study ward. In this chapter these findings will be examined for their fit with the existing literature on caring and control, and the literature on general hospital based psychiatric units. Models of caring and control which take account of context are developed, then alternative ways of framing the findings are explored and evaluated both for fit, and for their implications for nursing practice and service development.

A critique of methods used in the study is undertaken, the delimitations of the study are outlined, and questions for further study are identified. A detailed summary of the study is provided in chapter eight.

Caring and control in context

In this study, care (the provision of), caring and control were examined within the cultural context of a general hospital based psychiatric ward located within a freestanding unit which was the focus for outpatient mental health and illness services for the local region. The processes and outcomes of caring and controlling interactions between patients and nurses, and between patients themselves, which have been described in the preceding chapters (4-6), arose from, and are embedded in, the shared knowledge and belief systems of the participants, and the organisation of care in that setting.

The dominant belief system and its impact on patient care

The medical model of psychiatric illness underpins the dominant belief system in the study setting. As Mishler et al (1981) commented:

> The dominance of this model in medical theory and practice is universally recognised. Its assumptions are so deeply interwoven with ways of thinking and working in medicine that health professionals tend to forget that it is a conceptual model, a way of thinking about the world. That is, the biomedical model is treated as *the* representation or picture of reality rather than understood as *a* representation (p.1).

The dominance of the medical model of psychiatric illness contributed to a view of mental illness as a life long event for the majority of patients admitted to the study ward (pp.104-105). This view, coupled with beliefs about a tough world outside the unit, contributed to staff feelings of powerlessness to alter situations for, or with patients, with consequent diminished staff expectations of patient outcomes in terms of cure, or ability to move back into the mainstream of life without ongoing dependence on the unit (pp.107-108). These beliefs and expectations, coupled with the acceptance of caring as a moral obligation by psychiatrists and nursing staff (pp.109-110; 133-134), contributed to the function of the unit as a first resort for some patients (p.92), and as a last resort for the community - "if we don't [care, do something, provide support] who will?".

The treatment goals of palliative care, including symptom management using psychotropic medication, and the provision of a safe haven, rather than active treatment (pp.84-85), and the acceptance of the "revolving door" pattern of readmissions as an inevitable outcome of fluctuations in the ongoing mental illness (p.105), were other corollaries of the dominance of the biomedical illness model in this setting. A metaphor used to describe psychiatric care by nurse respondents both in this study and that reported by Kavanagh (1988), was that of "putting Band-Aids on the Ills [Cancer] of society".

The attribution of presenting problems to an underlying illness, rather than to factors in the social environment which might be addressed, such as cultural issues, conflictual relationships, housing or finances, contributed also to "social admissions" (pp.77-78), and to the individualisation of problems (p.164). By locating the problems within the individual, family and social situations outside the unit were stabilised. As Waitzkin (1984) suggested "one of medicine's effects may be the defusing of socially caused distress" (p.344). Indeed stability rather than change was the goal of many interventions, as illustrated by the primary function of the ward of maintaining chronically psychiatrically disabled patients in the community.

The construction of an identity as a psychiatric patient

For many of the patients in the study setting, the process of construction of an identity as a psychiatric patient began with an admission and associated diagnostic labelling. A process of self labelling also occurred as patients struggled to come to terms with the meaning of their illness, diagnosis, and admission, and their hopes for the future (as illustrated on pp.105-107). This process was facilitated by watching and talking with other patients who had repeated admissions (p.128), and by picking up the low expectations held by staff about patients' ability to move back into society without ongoing dependence on the unit. To internalise these staff expectations was to accept the identity and career of a psychiatric patient. Patients' acceptance of their illness, compliance with medication, and acceptance of ongoing need for support, factors consistent with patienthood, were valued and reinforced by staff.

The lack of an active therapeutic groupwork program for nonpsychotic patients, and the perceived nonavailability of nurses to talk with patients who had been "in" for a while, or who were not acutely disturbed, resulted in energy available for change being invested in patient friendships (pp.129-133), or dissipated in acting

out behaviour. Indeed it could be suggested that some patients, by trying out and practising such acting out behaviours in the "liberal" ward environment, were becoming better at becoming psychiatric patients, rather than getting well.

The individualisation and medicalisation of life problems, coupled with the function of the ward to maintain order in society in cooperation with family members, other community agencies, and the police (p.98), resulted in ongoing reinforcement of an identity as a psychiatric patient on subsequent admissions. In this way, processes intended to relieve suffering might, as Estroff (1981) suggested "perversely be stabilising, maintaining and perpetuating them" (p.39).

Patients were not merely passive recipients in this process. Those who had adopted the identity of psychiatric patient were active players in the maintenance of that identity (as illustrated on pp.98-100). Some patients strongly resisted staff attempts to redirect them away from their dependence on the unit; indeed for some of the younger chronically disabled patient group (described on pp.88-89), the identity as a chronic psychiatric patient, may have been the first clearly established identity after leaving school. Estroff (1981) explored the social construction of a "crazy reality" for chronic psychiatric patients in treatment in a community setting. She portrayed such chronicity as a "self-other constructed trap". Thus she commented:

> Being a longterm psychiatric patient does not seem so awful any more. Yet it also appears to be a self-other constructed trap. Clients have taught me and have demonstrated the benefits and rewards of this pathway. But they are also not unaware of the costs, negative consequences and trade-offs to be made. (p.19)

In the study setting, patients whom staff would categorise as social admissions, and who did not have a major mental disorder, could also slip into this trap (as illustrated on p.128). Such patients became"caught up and lost" in the comfort and security of the ward. Having accepted the individualisation and medicalisation of life problems, they waited to get better. For some of these patients a prolonged

admission with nurturance and protection resulted in little change, or even a deterioration. Belated challenge would then occur, with blame attributed to the patient for failure to progress. The treatment goal would then change to achieving a discharge.

The impact of staff expectations on patient outcomes

Bachrach (1985b) explored the issue of the impact of staff expectations on outcomes in relation to differential expectations for performance of men and women in rehabilitation programs. This issue has also been extensively addressed in the educational psychology literature since Rosenthal and Jacobson (1968) presented data suggesting the existence of a *self-fulfilling prophecy* in the classroom, in which teachers' incorrect beliefs about students' abilities or behaviours in some way brought about the behaviours the teachers expected. Woolfolk (1987) further reported a *sustaining expectation effect* which occurs when students show some improvement but teachers do not alter their expectation to take account of the improvement. Thus the teacher's unchanging expectation sustains the student's achievement at the expected level.

Both of these kinds of expectation effects occurred in the study ward. The self-fulfilling prophecy was illustrated by the tendency for staff expectations of dependence and chronicity, which were derived from the small group of patients who have the worst prognosis, to flow on to the larger inpatient population (as described on pp.104-105); with the result that nonpsychotic, volitional patients could pick up these expectations and follow a chronic trajectory (as illustrated on pp.127-129). The sustaining expectation effect was illustrated by the patient's comments that "they make it acceptable to be 'grotty', to be unwell", and "you are not expected to cope".

The influence of the dominant belief system on caring acts

The nature of the caring acts which took place in this setting was shaped by the dominant belief system. As previously stated (pp.133-134) the distinction between caring and the provision of care as it has been articulated in this thesis, was not always recognised by staff. Rather the perception of caring as a moral obligation was in some situations interpreted by staff as a moral obligation to provide a safe haven, particularly for patients viewed as chronically psychiatrically disabled. Thus what was observed was most often nurturance and acceptance of patients by nurses, consistent with the staff's limited expectations for change.

Two routine nursing practices which were predicated on caring expressed as nurturance and acceptance, were clearly identified by the researcher as contributing to patient dependency. The first of these practices was the routine advice given to inpatients by nurses when the former went on leave (p.124) to "phone in or come back early" if they encountered any difficulties. This advice conveyed an implicit message to patients about the nursing staff's lack of confidence in their abilities to cope outside the unit. Illich (1989) described such routine practices as rituals:

> forms of behaviour which make those who participate in them blind to a discrepancy which exists between the purpose for which you perform the ritual [an expression of caring] and the actual social consequences the ritual has. (p.5)

Thus behaviours intended to ensure the provision of support, contributed to dependence on the unit. Alternative strategies such as preparing patients for coping with difficulties likely to be encountered after discharge by anticipation and rehearsal of coping strategies, and prediction that they could cope; or by the use of a discharge issues group (Armstrong, 1990), were not observed.

The second practice which contributed to patient dependency was the practice of encouraging outpatients to come to the unit for "time-out" (pp.73-74). It has been suggested that outpatient treatment programs which operate from a hospital base

may "unwittingly promote dependency needs and a state of readiness to seek rehospitalisation when crises occur" (Schanding et al, 1984, p.171). The operation of the after hours service from the inpatient ward had this effect, since staff had little option but to encourage patients to come to the unit; their dual role as crisis service and providers of inpatient care did not allow for intervention and resolution of problems in the community setting.

As earlier noted (p.115), there were disparate views between the researcher, staff and patients as to the extent and outcomes of caring acts by nurses in the study setting. In part these differences related to divergent views of treatment held by staff and patients (Sullivan & Yudelowitz, 1991). There were disparities between what nurses intended to do and what patients perceived was happening to them.

Patients in this study valued and expected from nurses behaviours which they saw as caring, and were unhappy when they experienced a lack of such caring (pp.114-115). The characteristics of caring and non-caring these patients described can be understood with reference to the processes of caring identified by Swanson (1991), as outlined in chapter two (p.40) and illustrated in Table 7.1.

Characteristics of caring and non-caring

In this study *knowing* was reflected in patients statements about nurses as "really knowing you" and being sensitive to cues that the patient was all right - "she could really pick things up". There was a clear distinction between this kind of *knowing* and knowing about a particular patient as reflected in staff categorisations of patients as "known" or "not known" (p.77). The absence of knowing, reflected in patient's descriptions of some nurses as having a lack of empathy, understanding, knowledge or skills, - "they don't understand how a person works psychologically...", was perceived by patients as non-caring.

Table 7.1 Characteristics of Caring and Non-caring as perceived by patients

Caring Processes (Swanson, 1991)	Caring	Non-caring
Knowing	Being sensitive to cues that the patient is "not all right" "She could really pick things up" "Really knowing you", versus being a *known* patient	"A lack of understanding, knowledge and skills" "They don't understand how a person works psychologically" "Lack of empathy and understanding of one's plight"
Being With	"Having a really good relationship with my primary nurse" "Expressing concern about my wellbeing" "You need someone who will sit and listen and give you a small amount of advice"	"The nurses are not available to talk" "Pet answers - have a spa bath and relax" "Some of them can be quite abrupt" "He walks way in front of me, he doesn't come to see me"
Doing for	"I need somebody to keep me safe for a while" "I really needed to be kept safe"	"Being overprotective" "This ward cannot keep me safe - I need to be in control of myself to be here"
Enabling	"Working things through" "People were actually trying to help me" "Talking as a way of keeping me safe" "Shared decisionmaking so I feel I have some control"	"The support is only really there if you are unwell" "There is a lack of help to change behaviours" "They need a more active program" "You are supported in being grotty" "Staff have got to find a way through, of people getting caught up and lost in the system"
Maintaining Belief	"___ [primary nurse] always thought I would make it"	"You are not expected to cope" "They make it acceptable to be unwell"

Being with, in this study, was reflected in patients descriptors of "good" nurses as being available to talk, "having a really good relationship..." and expressing concern about the patient's wellbeing. Conversely nurses who were not available to talk, who were abrupt, or who used defensive avoidance manoeuvres such as stock answers to patient requests - "have a spa bath and relax", or limiting their contact with patients, were perceived by patients as non-caring.

Doing for, in this study, can be seen as reflected in patient statements such as "I really needed to be kept safe" and "I wanted somebody to take responsibility for me". For patients who were out of control (as described on pp.138-140) *taking control* was perceived by them as caring. A perceived lack of external control when a patient feared losing control - "this ward cannot keep me safe", "I need to be in control of myself to be here", or was seen by other patients to be out of control, was perceived by patients as non-caring; as was excessive control as in "being over protective" or the use of power-coercive strategies such as the threat of committal.

Patient statements which reflected the category of *enabling* included "people were actually trying to help me", "talking as a way of keeping me safe", and "shared decisionmaking so I feel I have some control". The focus of nurse patient interaction was on "working things through" which included support and therapeutic confrontation (as described on pp.155-156). The absence of this enabling process was reflected in patient statements such as "the support is only really there if you are unwell", " there is a lack of help to change behaviours", "the ward needs a more active program", "you are supported in being "grotty", and "people get lost in the system. Staff have got to find a way of people getting caught up and lost". Enabling acts are predicated on positive expectations of change, hence the dominant belief system in the ward operated as a constraining force on these kinds of interventions with patients.

Maintaining belief was perceived by patients as integral to caring as a therapeutic intervention - "____ [primary nurse] always thought I would 'make it'!". Yet many patients in this study indicated this characteristic was lacking. "You are not expected to cope", and "they make it acceptable to be unwell". This finding is not surprising given the dominant belief system operating in the ward. In the absence of positive staff expectations as to patients' abilities to cope with adversity, to learn new skills, and to "make it" in the "outside world", caring, expressed as nurturance and acceptance, and the provision of a safe haven, tended to reinforce or support illness behaviours as suggested by Slavinsky and Krauss (1982).

It is clear from the discussion above that nurses' acceptance of the moral imperative of caring did not always result in acts which patients perceived as caring. Reverby (1987) suggested that nurses are caught in a dilemma created by a mandate to care (caring, as distinct from the provision of care) in a society that does not value caring, however in this study caring was the predominant value expressed by medical and nursing staff and was reflected in the ethos of humanitarian caring in the ward. Thus other explanations must be sought for the failure of the expressed moral imperative of caring to lead to caring acts, in the form of supportive interpersonal relationships or therapeutic interventions, as expected by patients, and suggested by nurse theorists such as Gadow (1985) and Watson (1985). One explanation lies in the impact of the dominant belief system on caring acts as outlined in the previous section. Another explanation might be a lack of knowledge or education on the part of nursing staff in relation to the meaning of caring in this setting, and its implications for nursing practice and patient outcomes. A third explanation relates to the organisation of care in the study setting.

The organisational context of caring and control

It has been suggested that the notion that caring acts are mandated or inherent in a social context "renders the acts themselves, and the people who perform them, invisible" (Greenleaf,1991, p.72). Moreover, the relationship between caring and controlling acts and the social context in which they occur must be explicated in order to understand why and how such acts do or do not take place. As Greenleaf (1991) stated:

> Caring [and controlling] acts have an influence on their social context, and are influenced by them. Furthermore, the relationship is not an equal one. Caring [and controlling] acts can enhance, or by their absence diminish the moral definition of the context.... The social context on the other hand, must provide the necessary supports if caring [and controlling] acts are to be sustained. If the social context establishes an intent for caring [and controlling] acts to occur but fails to provide the necessary resources to sustain them, caring [and control] will fail in spite of the most heroic efforts of individuals to sustain it alone. (p.72)

In the study setting, the nurses' inability to set boundaries on their practice (pp.110-111), the lack of boundaries on the ward environment, and the provision of an after hours service by ward nurses (pp.117-121), contributed to an organisational context which was not supportive of sustained integrated caring and controlling acts by ward nursing staff.

Ward nurses lack of control over their practice

Ward nurses experienced a lack of control over their practice. This lack of autonomy in part related to the subordinate position of nursing in inpatient care. In hospital settings nurses have traditionally worked in a subordinate position to the medical profession. Nurses accept responsibility for the day to day care of patients, while physicians make decisions about patient admissions, treatment regimes, leave and discharges, which nurses must action or coordinate. Thus nurses have responsibility with little authority or right to autonomous decisionmaking about patient care. This position of responsibility without authority has long been a pervasive problem in nursing. It in part underlies the

paradoxical situations which arose in the ward when nurses attempted to keep nonpsychotic patients "safe" (pp.151-153). As May and Kelly (1982) commented, such patients "call to attention the fragility of nursing authority by rejecting, implicitly or explicitly, the services - help, advice, treatment - that the psychiatric nurse stands ready to provide" (p.280).

Nurses experienced relatively more autonomy in the provision of the after hours service, although decisions about admission, committal and medication change remained the prerogative of on-call medical staff. Nurses could influence such decisions with traditional doctor/nurse games, however the medical altruism expressed by medical staff reflected in the comment "somebody has to do something", not infrequently resulted in admissions with which either ward or continuing care nurses disagreed.

The physical environment of the ward

The open "liberal" unstructured environment of the study ward was valued by staff and patients. It contrasted sharply with the locked inpatient unit at the psychiatric hospital to which committed patients were sent. The latter was a locked, rigidly boundaried unit comparable to those described by Kavanagh, (1988, 1991) and Morrison (1990a, 1990b). The study ward lacked an attached safe care facility; that is a separately staffed, safe, clearly boundaried, low stimulus, locked environment for committed patients, where psychotic patients could reintegrate and establish their ego boundaries, and where routines and rituals could be established to ensure the safety of acutely suicidal patients. Thus, without the environmental controls traditionally available in a locked unit, and in the absence of an attached safe care facility, nursing staff often found themselves responsible for patients with a diversity of needs, in an environment where they could not sustain safe care. The location of the psychiatric unit close to environmental hazards for acutely suicidal patients such as busy roads, an overbridge above a railway line, a high

tower in the railway yards, and a little used stairwell in the main hospital, contributed to the difficulties staff experienced in keeping such patients safe.

Rule structure in the study ward

The lack of a clearly articulated rule structure in the study ward - that is unit rules or guidelines applicable to all patients (Morrison, 1987; Sebastian, Kuntz & Shocks, 1990), contributed to the difficulties experienced by nurses in providing effective and appropriate limit setting on patient behaviours. The attempt to respond to each situation on an individual basis (p.145), and the lack of clarity about the respective rights and responsibilities of patients and staff in the ward (pp.143-144; 152-154) were consequences of this lack of rule structure. Furthermore there were not clear outcomes for patients in relation to out of control behaviour. Such behaviour was tolerated rather than sanctioned (pp.136-137), for example "taking off" resulted in patients being placed "on leave" rather than being discharged, although their status was that of voluntary patients (pp.141-142). However violence toward others was not tolerated; indeed there was a *norm of nonviolence* in the ward which was enforced by patients and staff.

Control practices in the ward

Few control practices were used in the study ward, however the manner in which such controls were applied was *controlling* in style, reflecting staff attempts to exert authority over patients in a context in which the nursing staff were relatively powerless. Thus controlling practices such as constant observation, which as previously stated provides control with limited opportunity for therapeutic work (p.148); the use of behavioural contracts designed to control acting out behaviour (pp.156-158), and ultimately the threat of committal (pp.159-160) were invoked when the out of control behaviours of a nonpsychotic patient escalated rather than diminished in the "liberal" ward environment.

On some occasions a vicious cycle of interaction resulted when patients who were potentially volitional were treated as nonvolitional. Such patients felt trapped and more out of control. They tended to respond by increasing attempts to break out (take off) or to view nurses taking responsibility for their safety as giving permission to act out. Such acting-out invited more control (the threat of committal) which resulted in greater feelings of disempowerment and fear of "really losing it", such that the threat of committal might be invoked. Thus a vicious rather than a virtuous cycle of interaction was set in motion, which was not easily resolved. As Hardin et al (1985) described this process, nurses and patients "get involved in tense power struggles, each attempting to control the other, the treatment objectives, and the course of therapy." (p.91). The control practices of constant observation and 10-15 minute observations contributed to this vicious cycle (as illustrated on pp.151-153). Constant care, where one nurse is allocated to be with an acutely disturbed patient for an eight hour shift, as described by Yonge (1989) could interrupt this cycle and enable therapeutic interaction to occur.

Physical restraint was infrequently applied. Nurses expressed reluctance to restrain patients, and on some occasions, this reluctance was observed to influence their ability to work as a team when restraint was indicated. Patients with a history of violence, or potential for explosive anger were likely to be committed to the psychiatric hospital on most occasions, although special circumstances such as a concurrent serious medical condition, or the professional status of a particular patient, were observed to avert this process. The prevailing attitude was one of "open the doors and let them go", or to call in the police for assistance, rather than an expectation that patients who became violent would be controlled in the ward. However both patients and staff would intervene if another person was threatened, as illustrated in chapter five (pp.131-132).

The impact of the after hours service on inpatient care

The provision of an after hours service by ward nursing staff also impacted on the care of inpatients, as described in chapter five (pp.117-121). Outside normal working hours the demands of this service took priority over the needs of all but the acutely disturbed patients in the unit. Thus, paradoxically, the constant availability and accessibility of the after hours service to outpatients and others in crisis, limited the availability of nurse to inpatients for whom they were employed to provide care. However this situation is not unique to the study ward. Davis et al (1972) described a similar situation which arose in 1968 on a general hospital psychiatric unit with the implementation of a short-stay policy, with associated requirements for increased aftercare. Aftercare responsibilities reduced the availability of staff for inpatient care. "Given a choice between administering to inpatients or aftercare patients, the inpatients tended to be accorded second choice. After all, 'they can wait'." (p.96).

Both the requirement to be available for the after hours service, and the competing demands of acutely disturbed patients and those who were "getting better", resulted in nurses in the ward adopting a "reasoned management" approach to patient care (Krauss, 1988, p.1), in which they categorised and prioritised in a problem solving, crisis mode and focussed on managing day by day. From patients' perspectives, these nurses were seen as "too busy with the sick patients, they don't have time for the patients who are getting better". Such an approach was perceived by patients as a failure to provide expected care. The latter expected and valued a "relatedness" approach to caring (pp.114-115).

Thus the inability of ward nurses to control their practice, the absence of both environmental controls and a clearly articulated rule structure in the ward, and the competing demands arising from the after hours service, all contributed to an organisational context which was not supportive of sustained therapeutic caring

and controlling acts by ward nursing staff. Greenleaf (1991) suggested that "to care, or to attempt to provide carework in a nonsupportive context invites despair" (p.77). The reported high staff turnover, and the defensive avoidance behaviours demonstrated by some nursing staff could be viewed as indicators of such a situation.

Nurses' perceived inability to influence change

Ward nurses also experienced powerlessness in decisionmaking about broader policy issues which related to the boundaries and function of the service provided by the ward and its place in the broader mental health service. Nurses in the study ward had attempted to influence broader policy issues in 1988, by the submission of a carefully constructed and detailed planning document for mental health services which addressed the majority of the problems related to ward structure and functioning identified in this study. Thus there was, at that point in time, already an awareness on the part of nursing staff, of the structural and organisational changes which needed to occur, both in the ward and in relation to the position of the ward in the wider service. However at the time the study was undertaken, such changes had not been implemented. With the high staff turnover, many of the nursing staff on the ward during the period of the study were not aware of such plans. Others who had participated in their development were frustrated that little change had occurred at ward level and felt powerless to influence the changes they recognised were necessary to meet the diversity of inpatients' needs.

The relationships of caring and control

In the context of an acute psychiatric unit, control may be integral to caring. Taking control when a patient or situation is out of control is integral to the provision of care in an inpatient psychiatric setting. However either caring or controlling may be predominant to the extent that a unit may provide caring with

little control, as in the study ward, or control with little caring as in the units described by Kavanagh (1988, 1991) and Morrison (1990a, 1990b). These models are consistent with the custodial-caring and custodial-control frameworks for practice described by Dowland and McKinlay (1985) outlined in chapter two. Table 7.2 compares and contrasts the characteristics of these two models of psychiatric care, and adds a third model predicated on an advocacy/empowerment approach (Rose & Black, 1985), in which control is integral to caring and interventions are patient focussed, rather than meeting the needs of the system.

Table 7.2 provides an interesting comparison of the first two models of care: *caring with little control*, and *control with little caring*. Some of the characteristics outlined in these models are in marked contrast to each other, while other characteristics are common to both. Contrasting characteristics include the nurses' powerlessness *vis a vis* patients in the caring model versus their exercise of power in controlling patients in the controlling model; and the corresponding situation for patients of being out of control with permission in the former model and overly controlled in the latter. The primary mandate for nurses in each setting also differs markedly.

The lack of control in the caring model is particularly reflected in the unit structure of the study ward, as earlier described (pp.177-178). In contrast, in the controlling model the unit structure is tightly controlled at all levels, with a locked unit, rigidly boundaried environment, the availability of a seclusion room and restraints, and a rigid rule structure. The extent of control exerted in this model contributes to the "intense atmosphere and interactive cacophony" and "a roller coaster of interactive highs and lows" described by Kavanagh (1988, pp.243-244), and to the level of violence which occurs in such a setting (Morrison, 1990b).

Table 7.2 Models of Inpatient Psychiatric Care: characteristics of caring & controlling in different settings

	Caring with little control "Ethos of Care"	Control with little caring "Ethos of Control"	Control integral to caring "Ethos of humanistic control & Empowerment"
Nursing Staff	Powerless *vis a vis* patients Lack of control over practice	Controlling *vis a vis* patients Lack of control over practice	Empowering *vis a vis* patients Require control over practice
Patients	Out of control with permission	Overly controlled	Freedom within limits. Involved in decisionmaking about unit rules
Responsibility for patient behaviour and unit milieu	Nurses responsible yet little real authority	Nurses responsible yet little real authority	Joint staff/patient responsibility
Staff/Patient interaction	Assessing & responding to patient behaviours - oriented toward crisis resolution and the maintenance of a manageable ward	Observation and documentation oriented to crisis resolution rather than a longterm, patient oriented approach	Patient advocacy and patient focussed interventions with a longer term approach oriented to the person in their life context
Past/present/future orientation.	Managing day by day	Present oriented	Present/future oriented
Treatment focus	Symptom management, medication, and palliative care. Occupational therapy.	Symptom management, medication, and palliative care	Symptom management and learning skills necessary to live in the community
Unit Structure	Unlocked unit with open ward environment Diffuse boundaries between ward and other parts of the service. No intensive care or safe care facilities. Absence of unit rule structure	Locked unit with a rigidly boundaried environment.Provision of a seclusion room and restraints. A rigid unit rule structure	Open ward environment with attached intensive care facility. A clear, jointly negotiated unit rule structure
Unit milieu	A holding environment - "the ward as a waiting room"	A holding environment - "intense atmosphere & interactive cacophany ... a roller coaster of interactive highs & lows" (Kavanagh, 1988)	A rehabilitative/learning environment
Unit function	Provision of a safe haven. The maintenance of chronically mentally ill patients in community	"Putting band-aids on the Cancer of society",(Kavanagh, 1988)	Crisis intervention and rehabilitation To conserve and foster patients' abilities for autonomous living in the community
Nurses' Mandate	A moral obligation to care	To maintain order	The restoration of power
Unit Subculture	A culture of chronicity A norm of nonviolence	A culture of volatility & suppression A tradition of toughness (Morrison,1990b)	A culture of acceptance and hope

The differences or contrasts outlined above are to be expected in models where caring and controlling are represented as separate concepts, and one or the other predominates in each setting. However other characteristics outlined in Table 7.2 are common to both the caring and the controlling models. The nurses' lack of control over their practice, their responsibility for patient behaviour and the maintenance of order, despite having little real authority in the work setting, and the reasoned management approach to staff-patient interaction which resulted from the need to keep the ward manageable or maintain order, are all characteristics common to both settings. They reflect the subordinate position of nursing, with responsibility yet little authority (as described on p.176). Similarly the present time orientation (managing day by day), the treatment focus of symptom management, medication and palliative care, and the functioning of the units as holding environments for a revolving door population of chronically psychiatrically disabled patients, are characteristics common to both models which stem from the dominance of the medical model of psychiatric illness in both settings.

It is important to note that the patient populations in the units described by Kavanagh (1988, 1991) and Morrison (1990a, 1990b) differ greatly from that of the study ward, in terms of gender and ethnic mix, levels of acuity, histories of violence and proportions of involuntary admissions (p.43; pp.71-72). Patients such as those described by Kavanagh and Morrison would normally be rerouted to the psychiatric hospital from the study ward.

The third model outlined in Table 7.2 illustrates a context where control is integral to caring. This model will be discussed in a later section of this chapter, but first a typology of control practices used in each model is outlined.

Table 7.3 Typology of control practices in different settings

CONTROL PRACTICES	SETTINGS		
	Caring with little Control	Control with little caring	Control integral to caring
Locked unit	-	*	-
Environmental Restrictions[1]	-	*	-
Rule Structure[2]	-	rigid	jointly negotiated
Seclusion facilities	-	*	-
Safe care unit	-	-	*
Physical restraint	rarely	*	rarely
Medication	*	*	*
Time out[3]	-	*	*
Constant observation	*	*	-
or constant care[4]	-	-	*
10-15 min observations	*	*	*
Threat of committal	*	-	-
Committal	*	*	*
Behavioural contracts	*	-	*
Talking down[5]	*	-	*
Therapeutic confrontation[6]	rarely	-	*

-     Control practice is not used in this setting
*   Control practice is used in this setting.
1   Locked areas of unit, e.g. kitchen, bathroom, bedrooms, dining room. No access to sharp objects or personal possessions or clothing with which patient could selfharm. Plastic cutlery. Restricted access to cigarettes/matches etc.
2   Unit rules or guidelines applicable to all patients.
3   A period of time out from the ward environment spent in an unlocked seclusion room.
4   One nurse is allocated to be with a patient at all times during an eight hour shift (Yonge, 1989).
5   Use of verbal therapeutic techniques for calming a potentially violent patient.
6   Challenge and support to take responsibility for, and to change one's own behaviours.

A typology of control practices

Table 7.3 outlines the kinds of control practices available to nursing staff in each of the models described in Table 7.2. The control practices listed in Table 7.3 can be grouped into three categories: *environmental controls*, *unit rule structure*, and *techniques* for managing out of control behaviour. The first category includes environmental measures which restrict patients' freedom either to leave the unit, or to have unsupervised access to parts of the unit such as the kitchen, dining room, bathrooms or bedrooms; and environmental modifications to prevent self harm and minimise risk to others. The latter includes measures such as the provision of safety glass, seclusion rooms, removal of all sharp objects and rails or other fittings which could be used for self harm or as weapons against others, and the use of plastic cutlery. Similarly there may be restrictions placed on patients' access to personal possessions or clothing, cigarettes and matches or lighters. These environmental controls apply uniformly to all inpatients in the unit and are justified by the norm "it's not *you* [in particular] we don't trust" (Morrison, 1990b). Environmental controls are typically in force in controlling settings, and were absent from the study ward. A further environmental control involves the availability of a safe care facility, the provision of which enables environmental restrictions to be targeted to the needs of particular patients during an acutely disturbed phase in their illness. An open ward environment can thus be provided for patients not requiring a restricted environment.

The unit rule structure, as previously stated, consists of unit rules or guidelines applicable to all patients. These may include rules about safety issues such as bringing razor blades on the unit, rules for social interaction, and rules related to participation in therapeutic programs (Sebastian, Kuntz & Shocks, 1990; Morrison 1987). Included in this rule structure is information for patients about the outcomes of compliance or noncompliance with these rules.

The third category, that of techniques for managing out of control behaviour, includes practices in which the control ethos is dominant, such as the use of physical restraint and seclusion, and the threat of committal; while alternative techniques such as "talking down", time out (as defined in Table 7.3), therapeutic confrontation and limit setting, and the use of behavioural contracts, are predicated on a model in which control is integral to caring. Committal, to ensure the right to treatment, and the use of medication to control symptoms are also consistent with the latter model. Constant observation is distinguished from constant care (as described on p.179) in that the former provides control without caring (as illustrated on pp.151-153), while the latter provides the opportunity for therapeutic interaction to occur.

An alternative framework for care provision

Table 7.2 outlined an alternative model of care provision in which the dominant belief system is based on an advocacy/empowerment approach rather than the medical model of psychiatric illness. Within an advocacy/empowerment approach, symptom management remains integral to care, however the primary focus is not on the illness, but on working alongside patients as people who can learn to cope, to make changes in their lives, and to develop the skills necessary to negotiate issues of housing, meaningful social activity, finances and legal rights (Rose & Black, 1985). Appelbaum and Munich's (1986) view of psychiatric patients, regardless of diagnosis, as "suffering from disorders in power relations" (p.14), and their reported implementation of a program of psychosocial rehabilitation in inpatient units to address such issues, is consistent with an advocacy/ empowerment approach, as is Webster's (1990) outline of solution-focussed approaches in psychiatric nursing practice.

In this context *control is integral to caring*. Such control is humanistic, initiated in response to individual patient needs, and patients and staff are involved in

decisionmaking about unit rules and therapeutic programs. As illustrated in Table 7.3, control practices are directed toward patients' needs to regain or retain self control (time out, and "talking down"), and predicated on patients abilities to change (behavioural contracts, therapeutic confrontation and limit setting). The unit structure provides jointly negotiated unit rules, and environmental restrictions are targeted to acutely disturbed patients with the provision of a safe care facility. A unit based on this model provides a rehabilitative, learning environment rather than the holding environment of the caring and controlling models.

While there is a greater range of control practices available to nurses in this setting than in the study ward, the practices used are those in which control is integral to caring. The caring processes of *maintaining belief* and *enabling* described by Swanson (1991) are integral to this model of care provision. Thus this mode of working with patients requires nurses to frame their practice on a different belief system and knowledge base.

To function effectively within this model nurses also require increased control over their practice in relation to the social organisation of care (Table 7.2). This increased autonomy is counterbalanced by the need to share decisionmaking and control with patients in order to empower them in what has traditionally been a situation of relative powerlessness (for discussion of this point refer to pp.140-141; 159-160).

Implications of the findings for psychiatric nursing practice

The findings of this study confirm the centrality of caring in the belief system and practice of registered nurses working in an acute psychiatric setting, and support the idea that control may be integral to caring when caring is viewed as a therapeutic intervention. However the study highlights the extent to which the nature of the caring and/or controlling acts by nurses in a particular setting is

shaped by the dominant belief system and by the social organisation of care in that setting. The dominant belief system in a particular setting shapes the meanings attributed by nurses to patient behaviours, nurses' expectations of patient outcomes, and the kinds of nursing interventions which are viewed as possible or appropriate. The organisational context may or may not provide the necessary supports for caring and controlling acts by nurses to be sustained.

It is important therefore for psychiatric nurses both to address structural constraints to effective clinical practice, and to reevaluate the knowledge base and belief system underlying existing practices and the outcomes of those practices for patients. In this study the practices of constant observation (rather than constant care), the routine offering of phone-in and time out from the outside world to outpatients, and the advice to inpatients to come back early from leave if any difficulties were encountered, were examples of routine practices which were consistent with the dominant belief system, met the needs of the organisation focussed around the ward as the hub of the service, but which had unanticipated outcomes for patients. Similarly the practice of nurses taking responsibility for patients (p.152), and the subsequent difficulties experienced with some patients in establishing self responsibility (pp.153-154) warranted reevaluation.

In the study setting caring by nurses was most often observed to be expressed as nurturance and acceptance of patients' needs for a safe haven from the outside world at times of stress. Yet as Watson (1981) has noted, "caring allows for a person to be as he/she is now but also to actualise potentialities for becoming different in the future" (p.63). Patients expected nurses to spend time with them, to come to know and understand their predicaments, to find ways of helping them stay in control, feel better and to resolve their problems, and to maintain belief in their abilities to get well or to learn to live with their illnesses. Yet these expectations were often not met.

The installation of faith and hope is listed by Watson as one of ten carative factors which underpin caring in nursing. More recently, research by Swanson (1991) indicates that maintaining belief and enabling are two of five essential caring processes in nursing practice. Benner (1984) included maximizing the patient's participation and control in his or her own recovery, and guiding a patient through emotional and developmental change, as two of eight competencies in the helping role of nurses. There is a need for further examination by psychiatric nurses of the belief system and knowledge base which underpin caring and controlling acts in an acute psychiatric setting. The findings of this study suggest that of particular importance is the maintenance of belief by nurses, and the fostering of hope in the majority of patients, as to their abilities to learn new skills, to change old ways, and to manage their lives in the community in a relatively autonomous manner. There is a requirement for ongoing knowledge and skill development for psychiatric nurses to enable solution focussed therapeutic work with patients, predicated on their ability to change.

Just as the study ward was the hub of the mental health service, nurses in this setting were the glue that held the enmeshed inpatient, continuing care and after hours services together (Thomas, 1983; Benner, 1984). It was the nurses' skills in monitoring, prioritising and organising which enabled this system to function from an institutional perspective, such that psychiatrists perceived that it provided a good service, although nurses and patients were less satisfied with the organisation of care. Benner (1984) suggests that monitoring and organisational skills are a taken-for-granted function of nurses, and that nurses fail to recognise the importance of this function. If nurses in the study setting were to acknowledge and value these skills, then these management skills could be used to reorder priorities to allow for more therapeutic interaction with patients, which ward nurses presently value but feel unable to implement.

Implications of the findings for service development

Availability, accessibility and appropriateness of services

It has been suggested that one of the more complex problems in examining mental health services is "differentiating between the availability or accessibility of services, and the appropriateness of them", and that "the criteria for what constitutes 'appropriate' generally goes unexplored" (Rose & Black, 1985, p.2). However any discussion of appropriateness is influenced by the perceptual framework through which the findings are viewed. Changing the framework within which events are perceived, changes the meanings associated with the events (Watzlawick, Weakland & Fisch, 1974; Pesut, 1991).

Availability and accessibility of the study ward to known patients was valued by staff (pp.89-90), however the issue of the appropriateness of the service, particularly in terms of patient outcomes, was not addressed. Viewed from the dominant belief system of the organisation studied, the ward functioned within an ethos of humanitarian caring to provide ongoing support and care for patients with mental illness, particularly those who were chronically psychiatrically disabled. Palliative care, the provision of a safe haven, and a focus on maintaining patients living in the community by means of phone calls, time out, and intermittent admissions, were agreed upon functions of the ward. In this context the high readmission rate was seen as a consequence of fluctuations in the illness, rather than as an outcome of care. Because dependency was seen as inevitable, accessibility of the service to patients was a primary value.

However when the findings are viewed through the perceptual template of an advocacy/empowerment model, dependency and psychiatric patienthood are reframed as possible outcomes of the organisation of care, rather than as inevitable consequences of psychiatric illness. The overall unintended byproduct of encouraging dependency is to "decontextualise the person, to contour their lives as

patients in such ways as to remove or restrict their capacities for daily living in the community" (Rose & Black, 1985, pp. 15-16). The recognition of this process of *institutionalisation* in patients hospitalised in large psychiatric hospitals, was one factor which contributed to the deinstitutionalisation movement and the establishment of general hospital based acute psychiatric units. However this move may have resulted in a "shift in the locus ... of the service without a concomitant shift in approach to the redefining of, and therefore intervening into, problem situations" (Rose and Black, 1985, p.3). The finding that the same dominant belief system underlies both the *caring with little control* and *control with little caring* models outlined in Table 7.2, supports this view.

Keill (1986), in reviewing changes in general hospital psychiatric services, raised a similar possibility when he suggested that the general hospital inpatient unit could react to deinstitutionalisation by "becoming the new, local, more expensive replacement of the old rural freestanding state hospital" (p. 355). Indeed when viewed through the perceptual template of an advocacy/empowerment model, the comfortable, open environment of the study ward could be seen, (as Basaglia feared in the reform of Italian psychiatric institutions), as "a kind of 'gilded cage' where basic physical needs could be met (food, safety, shelter) but where more profoundly human needs (for autonomy, liberty, love) would be forever stifled." (Scheper-Hughes & Lovell, 1986, p.164).

An adjunctive versus a pivotal position for the inpatient service
Summergrad (1991) suggested that single units on general hospital sites, such as the ward studied, "operate more like a one-room school house, treating a highly heterogeneous patient population, rather than acting as a speciality service" (p.80). The requirement that the study ward met the needs of both general psychiatry and acute care within the open ward environment; the all encompassing embrace of psychiatry in this ward (p.105); and the function of the ward as "last resort" for

the community, are consistent with Summergrad's description. However the inpatient service provided by the ward was *adjunctive* rather than pivotal to inpatient services required for the geographical area, since the most seriously mentally disturbed patients were re-routed to a nearby psychiatric hospital, while patients with substance abuse were re-routed to the detoxification unit; and children and adolescents under 16 years of age were re-routed to the general hospital.

The practice of re-routing patients who were likely to present severe management problems because of violence or substance abuse, may explain the differences identified between the ethos of caring observed in the study ward, and the ethos of control in the units described by Morrison (1990a; 1990b) and Kavanagh (1991) outlined in Table 7.2; and the low incidence of violence on the study ward. It also explains the finding that Maori patients are not overrepresented per head of population, in patients admitted to the study ward. However the adjunctive position of the ward in the provision of inpatient services for the region will change to a more pivotal position when the new Mental Health Bill becomes law, and the psychiatric hospital to which committed patients are sent is closed. The ward will then be required to assess and treat severely mentally disturbed patients such as those described by Morrison and Kavanagh; those who most require an inpatient service.

There is debate in the psychiatric literature about the appropriateness of a pivotal or an adjunctive position for general hospital psychiatric units within the overall mental health service. Some authors believe that "the general hospital cannot become the repository for all patients without compromising what it aims to provide, namely acute care, proximal to general medical resources, for relatively brief illness periods." (Sederer, Katz & Manschreck, 1984, p.187). These authors recommended an adjunctive position for general hospital psychiatric units where

"chronic cases and severely behaviourally unmanageable patients (particularly the more violent) must be treated in other facilities" (p.187), as occurred in the study setting. Richman & Harris (1985) advocate a pivotal inpatient model for general hospital psychiatric units, consistent with British plans for mental health services, and with Area Health Board plans for the study ward. However they were careful to articulate the changes necessary to allow such a pivotal position. Appropriate safe care facilities are needed to provide care for patients who are acutely disturbed and require high levels of care in a controlled environment. Active treatment is provided to those in need of 24 hour inpatient care for short, medium or longstay periods; however needs for care, shelter and asylum are provided by community agencies with the pivotal unit providing consultation and backup support. Specialist services are developed for particular subgroups such as patients with substance abuse, disturbed adolescents, and psychogeriatric patients; however these services are closely related to the pivotal unit in a coordinated program of care. Thus the pivotal general hospital psychiatric unit becomes "the core planning and service agency [for inpatient services] in a system of unified psychiatric care" (Bachrach, 1985, p.244).

Provision of a pivotal inpatient service from the study ward

The study ward lacked a safe care facility, and thus would require structural alterations to be able to provide an inpatient service for patients requiring high levels of care in a restricted environment. The considerable distance between the study ward and the psychiatric hospital to which committed patients were sent, meant that actioning a committal order and organising a transfer required extensive staff time. The provision of a safe care unit within the building in which the study ward was located, as was proposed in the 1988 submission by nursing staff to the mental health services development group of the Area Health Board, would have considerably eased time pressures and the build up of tension in the ward which frequently occurred when a patient was committed.

The majority of the ward functions (p.92) could be described as meeting patients needs for asylum, and care, which Richman and Harris (1985) suggested should be provided by community agencies. Indeed with nursing interventions of necessity focussed on the more acutely disturbed patients, it could be suggested that it was other patients, rather than staff, who met less disturbed patients' needs for acceptance and support. With the exception of the provision of medication, the ward lacked an active therapeutic program, which Richman and Harris described as the primary function of a pivotal inpatient unit.

Continuity in care provision

The functioning of the study ward as the hub of the mental health service through the provision of the after hours service contributed not only to patient dependency, but also to structured discontinuity in care (pp.125-126). This occurred for known outpatients who used the after hours service by phoning, coming into the ward for time out, or requesting to be seen by the on-call doctor, or who were admitted. Decisions about medication and treatment plans made by ward or on-call staff were not always consistent with the directions for on-going care planned by outpatient or continuing care staff. Some patients learned to use the discontinuities between the parts of the service to achieve a change in medication or an admission; others attempted to maintain a relationship with a particular ward nurse by dropping in or phoning to talk when that nurse was on duty; yet others, who were admitted frequently, tired of telling their stories, and were reluctant to invest energy in a another relationship with a health professional, the result being that they maintained a distance from nursing staff, and expected little therapeutic interaction in return (p.123).

Psychiatrists and nursing staff saw advantages for both patients and staff in this discontinuity of care. The advantages cited were predicated on the expectation of ongoing mental illness which forms part of the dominant belief system described

earlier in this chapter. Yet Harris and Bergman (1988) suggest that continuity of care is essential in the provision of services for "revolving door" patients. This requires continuity of treatment, continuity of relationship and continuity of caring. Ideally continuity of relationship entails the same caregivers irrespective of the part of the service. While Harris and Bergman suggested such continuity be based on the inpatient setting, as in the study ward, others recommend that continuity of relationship is provided from an outpatient setting, with outpatient clinicians being involved in treatment planning and decisionmaking in the inpatient setting, if the patient is admitted. Thus the hub of the service for continuing care patients could be a community based service, with the inpatient ward providing inpatient care in an adjunctive role to the community service. Such a move would require that the after hours service also be based in the community.

Nurses played a pivotal role in the inpatient, continuing care and after hours services. As earlier stated (p.190) they were the glue that held these services together. To achieve a shift in the focus of the service rather than a shift in the locus of the service without a concomitant shift in approach to the defining of, and therefore intervening into, problem situations (p.192) it is essential that nurses work with other health professionals in the multidisciplinary team to reevaluate the knowledge base and belief system underlying existing practices and the outcomes of those practices for patients; and to critically evaluate planned changes in service development and their impact on therapeutic work with patients.

Critique of methods

In this study the primary methods of data collection were participant observation in a "not staff, not patient" role (pp. 51-52), and informal interviews with staff and patients over a period of 10 months, with secondary sources of data being written notes and other documentation. Participant observation took place on a part-time basis (three days per week). Both the part-time nature of data collection and the

choice of study setting influenced the nature of interactions with patient informants. Establishing a relationship of trust with patient informants was facilitated by the existence of a revolving door population of known patients (p.71), whose ongoing contact with the ward, or with other services within the same building, enabled repeated contacts with the researcher over a lengthy time period. Thus, ironically, the revolving door population of known patients was functional for this study as well as for the manageability of the ward (pp.121-123).

Another challenge was provided by the requirement to maintain a "not staff, not patient" role while attempting to understand "what goes on" from the perspectives of both patients and staff, when these two groups were clearly bounded and demarcated. A decision was made to "hang around" both in patient areas in and out of the ward, and in "back stage" staff areas such as the conference room used by staff at lunchtime, and the ward office. While many informal discussions took place in the latter settings, staff were not formally interviewed about issues of caring and control until the last two weeks in the study. This delay in interviewing staff assisted the researcher, as a nurse, to maintain a perspective separate from that of nursing staff and of patients, and thus to mediate these two worlds through a third, as described by Agar (1986, p.19). It was not possible to directly verify staff perceptions with those of patients and vice versa, for to do so would require the sharing of information from one group with the other.

As stated in chapter three, in the early phases of the research some of the many meetings staff held were attended by the researcher, including the change of shift "handover" meetings, and multidisciplinary team meetings where patient progress was discussed. However a choice was later made to remain in the ward to experience "what goes on" when staff go off the ward. This decision may have limited the researcher's understanding of interrelationships between nurses, and nurses' relationships with staff from other disciplines.

Similarly, the structured occupational therapy groups held off the ward, which were attended by day patients as well as inpatients were not regularly attended by the researcher; the exception being the 9.15 am "goal setting" meeting. Thus this study lacks a full picture of all the day to day activities in which inpatients were involved outside the ward. It would have been advantageous in undertaking this study to have had a co-researcher, thereby providing a fuller coverage of all of the activities in which ward nursing staff and/or inpatients in this setting participated.

As Fetterman (1989) commented, analysis in an ethnography "begins from the moment the researcher selects a problem to study, and ends with the last word in the report or ethnography" (p.88). A particular challenge inherent in this ethnographic study, has been to maintain a broad focus in attempting to understand "what goes on here", and thus to take into account the multiple levels within the health care system and the wider society within which factors impact upon the experiences of patients and staff, and on caring and controlling acts, in the research setting. Noblit and Engel (1991) describe this challenge as a holistic injunction which requires the researcher " to learn all, to take all into account, and to tell all" (p.123).

Delimitations of the study

As outlined in chapter one, this study took place in a context of change. It was an awareness of the politico-economic climate of change, and the lack of research into the functioning of general hospital based psychiatric units which provided the initial impetus for the study, and the first research question for this project. The ongoing nature of changes in the structure and funding of the New Zealand health service means that this study can claim only to provide a cross sectional representation of a psychiatric unit in transition. Nevertheless the enduring nature of the dominant belief system contributes to stability in the face of change. As earlier discussed (p.192), there may well be a change in the organisation of care

without a concomitant shift in approach to the redefining of, and therefore intervening into, problem situations.

The findings of this study are limited to the study setting and cannot be generalised to other acute units on general hospital sites. Nevertheless the service issues addressed in relation to the pivotal or adjunctive function of such units; the competing demands of a heterogeneity of patients, and the requirement under the new Mental Health Act that general hospital based psychiatric units hold and treat committed patients, are faced by all New Zealand units, particularly with the contracting number of inpatient beds for acute care as the majority of psychiatric hospitals continue to "down-size".

Issues of culture and gender, while being included in the broad focus of the study, were not observed to be predominant issues in this study, unlike the findings reported by Kavanagh (1991). This finding is explained by the adjunctive position of the ward in the service, and the tendency for Maori patients to be overrepresented amongst committed and special patients in psychiatric hospitals (p.17). As a woman researcher of European descent, my acceptance by, and rapport with male patients and Maori and Polynesian patients may have been more limited than that with women and European patients, however, the inpatient population of the ward was predominantly European, with proportionately more women than men (p.54) thus the impact of this limitation is lessened.

An exploration of the influence of culture and gender on the nature of caring and controlling interventions was beyond the scope of this study, but warrants further investigation. It was observed that differences in the ethnicity of nurses were valued by other staff, however the study ward had few Maori and Polynesian nurses and other health workers. Such staff would be consulted by other staff caring for Maori or Polynesian patients, and as a consequence could be

overburdened with additional workload, or asked to give or reveal more of themselves, such as their cultural beliefs and values, than were their European colleagues.

Questions for further study

The influence of the culture and gender of patients and nurses on the nature and outcomes of caring and controlling interventions by nurses warrants further investigation. There is a need for further examination of the belief system and the knowledge base which underpin caring and controlling acts by psychiatric nurses in the provision of acute psychiatric care in inpatient and community settings. This issue has particular importance with the implementation of the Mental Health (Compulsory Treatment and Assessment) Act (1992) which provides for nurses in any inpatient setting to detain for medical examination for upto six hours a patient whom the nurse believes to be mentally disordered; and for compulsory treatment in the community (community treatment orders) which psychiatric nurses working within the continuing care, after hours and community mental health services will be required to implement and monitor.

Further study of the after hours service provided by nurses is warranted. While the impact of this service on inpatient care has been highlighted in this study, and the range of reasons people contacted the ward was described (pp.93-95), a detailed study of patients' agendas (Molde, 1986) for presenting after hours, and the proportions of contacts which are crisis or social in nature, was beyond the scope of the present study. However secondary analysis of the transcripts of the daily logs is likely to provide such information, and would allow identification of high users of the service. Follow-up interviews could be conducted with patients who had the highest rates of contact during the 12 month period during which the daily log was transcribed. From a service perspective, alternative ways of providing an

after hours service which would both provide crisis care in the community, and so free ward nurses for therapeutic work with inpatients, warrant further exploration.

The readmission rate similarly warrants further study. Little is known about the rates of readmission to general hospital based psychiatric units in New Zealand. Indeed, at the time of the study, official statistical data from the study ward showed only the number of admissions in a period of 12 months, and the number of individuals admitted. Information linking readmissions to individual patients was not reported, nor was there any crosslinking of admission data with length of stay data. While it has been postulated in this study that the revolving door pattern of admissions is an outcome of the organisation of care, this proposition needs further investigation. For example, what meaning do patients attribute to readmission? What are the characteristics of patients who are admitted two or more times in a 12 month period? What is the relationship between use of the after hours service, and readmission for revolving door patients?

VIII

SUMMARY

In this study, ethnographic methods were used firstly to explore the issues which arise when the needs of a heterogeneous patient population are to be met in a single general hospital based psychiatric unit, and thus to describe the nature of the service provided. Secondly, the study focussed more specifically on the meaning and relationship of caring and control in psychiatric nursing practice in this setting. The objective of this study was to generate "thick description" (Geertz, 1973) of the cultural knowledge patients and nurses used to organise their behaviour and interpret their experience in an acute psychiatric unit, and to delineate the implications of this knowledge for providers and planners of mental health services.

Participant observation and ethnographic interviews were the primary methods of data collection, with analysis of documentation providing secondary data. Data was collected over a period of 12 months. Informants were selected by the researcher on the basis that they had experienced the event being studied, and that they were both willing and able to share that experience with the researcher. Thirty patients and twenty nursing staff acted as informants in the study. A "not staff not patient" role was established by the researcher, and maintained throughout the study in order to facilitate acceptance by both patient and staff informants. Observational data and informal discussion with patients and staff were recorded in fieldnotes, as close to verbatim as possible, using the language of the participants.

Data collection and data analysis followed a cyclic process where initial data analysis followed early data collection resulting in more focussed questions in subsequent data collection. Broad descriptive observations occurred alongside

these focussed observations until the end of the field study. Content analysis was undertaken to inductively derive patterns or themes from the data. Validation of data collected was achieved through the comparison and verification of information from multiple data sources. Interpretations of the findings were verified and clarified in collegial dialogue with other psychiatric nurses, and with academic colleagues.

The research setting was a 19 bed ward located in one wing of a single story building on the site of a general hospital. It provided a comfortable, open environment. The ward was staffed by registered nurses who worked permanent shifts. One psychiatrist and a psychiatric registrar took clinical responsibility for patients. The adult patient population was heterogeneous in age and presenting problems, however women were disproportionately represented (62%). All patients were voluntary admissions.

There was considerable pressure on the available beds, however many admissions were viewed by staff as "social" rather than "psychiatric" in nature. An admission stabilised situations in the community, or in other parts of the health service, and the ward milieu itself was assumed to be therapeutic. Treatment comprised medication, rest, freedom from expectations to perform within the ward, or to be responsible for things outside the unit. Patients could choose not to attend occupational therapy, and there was no structured therapeutic program in the ward. There was a high proportion of patients "known" to the service over a number of years, many of whom had multiple admissions during the study period. For many patients, being "in the system" provided lifetime access to care.

The functions of the ward thus included maintaining chronically psychiatrically disabled patients in the community, keeping people "safe", and acting as "last

resort" for the community. There was enmeshment of crisis services, continuing care services and inpatient care. Outside normal working hours the ward staff provided an after hours crisis service for the other parts of the mental health service. On some occasions nurses went off the ward in response to crisis calls. Known outpatients regularly came in to the ward for "time out"[1] from outside stress. Thus for both inpatients and outpatients the ward functioned as a place of asylum from society. For the community, the ward functioned to maintain order in society in cooperation with families, community agencies and the police. The ethos of the ward was one of humanitarian caring.

The dominant belief system in the ward included an expectation of ongoing mental illness, of chronicity over the lifetime, for the majority of patients admitted to the ward. Yet many of the patients admitted did not have a major mental disorder. Thus while it is acknowledged that a proportion of patients with a psychotic illness have a poor prognosis, and that for these patients the view of mental illness as a lifetime event is realistic, in the study ward these expectations appeared to flow on to the larger population of inpatients. The ward operated on a medical model of psychiatric illness for explanations of behaviour and expectations of outcome. Thus the high readmission rate was regarded as inevitable because of the nature of psychiatric illness. Consequently staff had low expectations of patients admitted to the ward in terms of cure, or being able to move back into the mainstream of life without ongoing dependence on the ward. The outside world was viewed by staff as tough.

There was an apparent inability or reluctance on the part of psychiatric staff to set boundaries on the mental illness service. Informal criteria for admission were established around issues of safety of the individual, and the amount of chaos

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[1] Note the idiosyncratic usage of the term *time out* in this research setting, which differed from the usage of the term in the psychiatric literature, and in other psychiatric units. Time out in this study meant time in the ward, that is to say, time out from the outside world.

created by, or lack of any alternative support for, a particular patient in the community. These criteria reflected the moral imperative of caring expressed by psychiatrists and nursing staff in this ward. Ward nurses were also unable to set boundaries on their work. Nursing work thus mirrored the position of the ward in the mental health service, receiving and responding, rather than initiating, always "on the back foot".

Because of the need to be available for the after hours service and for acute admissions, nurses were seen by patients as often not available to talk. Nurses valued talking with patients, however, paradoxically, the constant availability and accessibility of the service to outpatients and others in crisis, limited the availability of staff to inpatients for whom nurses were employed to care. The impact of the after hours service on the care of inpatients was largely unrecognised by staff outside the ward. To enable the after hours service to be provided by the ward staff without serious mishap on or off the ward it was functional that the majority of the patients were known to, and knew how the ward worked, and that there were mutually low expectations for performance between staff and patients. A variety of strategies were in place to keep the workload in the ward "manageable". For known patients an admission to the ward resulted in a change in psychiatrist and nurse, and on many occasions, discontinuity in ongoing plans for care.

The ward functioned as a waiting room which provided safe haven while patients waited to feel better. However, some patients "got lost" in the safety and security of the ward, and were reluctant to leave, particularly when problems in external situations had not been resolved. Some patients kept to themselves, while others formed friendships on the ward; they shared inside information, provided support, and intervened in out of control behaviour. The therapeutic

potential of these friendships was under-utilised, because of the absence of therapeutic groupwork for nonpsychotic inpatients.

Admissions occurred because individuals or the situations in which they lived were "out of control". Being "in control" of thoughts, feelings and behaviour was positively valued by staff and by patients. Being admitted to the ward involved a loss of power and control, thus many of the ways patients exerted control in this environment were forms of negative control. "Taking off" (leaving the ward without permission) and self harm behaviours (cutting, burning, overdosing) were not infrequent occurrences.

Different kinds of "out of control" behaviours drew differing responses from nurses. Thus disorganised, disinhibited patient behaviours were largely "absorbed" and tolerated by nurses, while withdrawn behaviours resulted in nurses providing physical care and assistance. These interactions reflected nurses' acceptance and concern for patients and produced little overt conflict. Difficulties were most evident when the mandate for care/control was to "keep patients safe".

Issues of safety and responsibility were recurring themes which arose from the data. The distinction between the provision of a "safe haven" from the outside world, and the provision of "safe care" was not always clear in discussion with staff or patients. While the provision of immediate safety was often the objective of an admission, the safety of patients was difficult to ensure in the open ward environment. Patients and nurses were aware of the paradoxes of an admission for safety reasons when the ward nurses could not really keep them safe. Nurses felt responsible for patients in a situation where they could not provide safe care. The process by which nurses gave back, or patients took back responsibility was quite unclear. There was a lack of any clear unit rules to provide boundaries for

patient behaviours, such as bringing razor blades into the ward; although there was a low tolerance for violence on the ward. The focus was on monitoring, responding to and absorbing acting-out or psychotic behaviours. Nurses used individualistic strategies, rather than shared strategies in responding to patients, and there was difficulty in coordinating planned care within and between shifts. Attempts at controlling patients' behaviour with behavioural programs were not supported by all staff.

·Thus, although the ward provided a caring environment, nurses seemed to have little ability to put limits on patients' behaviour except by medicating, by invoking the assistance of police, or by threatening or initiating committal. The perception of caring as a moral obligation, which at times was interpreted by staff as a moral obligation to provide care, and nurses' beliefs about the rights of individuals as voluntary patients restricted the options for limit setting which nurses perceived as possible or appropriate in this open ward setting. Patients most in need of limit setting learnt to escalate behaviour to gain admission, or to gain attention. The perception of the ward as a safe haven where patients could "let it all out" led to tolerance of, rather than limit setting on, acting-out behaviour.

Control in an open ward environment
Psychotic patients who were brought to the ward for admission in an acutely disturbed state, were restrained from leaving the ward, or brought back if they took off, and intramuscular medication necessary to control the acute disturbance was given. Such treatment was observed to be given in a caring manner, and nurses expressed concern that the self respect, dignity and privacy of the individual be protected, although this was very difficult within the limitations of the open ward environment. Thus for these patients (who would be

certifiable as mentally disordered in terms of the Mental Health Act), the right to treatment in this state was the over-riding consideration.

While a patient might be mentally disordered, the process of committal, with associated transfer to a psychiatric hospital, did not always take place. If possible, patients who would legally be committable were cared for in the open environment of the study ward. Reasons cited by staff for actioning the committal process included patients' history of aggression toward another patient or staff member, refusal to take medication, being a danger to themselves (such as running in front of cars), staffing levels on a particular shift being too low to implement constant observations, too many acutely disturbed inpatients for the ward to be manageable, or the patient remained disturbed over too long a period for nurses to be able to sustain the level of care required.

Nurses' actions in taking control of acutely psychotic patients by providing constant observation, medication, support and reassurance, enabled these patients to feel safe and to relinquish control. With the resolution of the acute psychotic state, such patients began to take responsibility for themselves. However psychotic patients who were well known to the service, and who presented in a less disturbed state, might be treated as if they were volitional when they were not. It appeared that such patients were often discharged from the study ward without adequate symptom management, raising the question as to whether a longer admission with more active treatment rather than time out, might enable better functioning in the community and a longer interval between admissions. Failure to take control with these psychotic patients who were less floridly disturbed, but whose level of disturbance rendered them dysfunctional in the community resulted in such patients remaining disturbed. They often made frequent use of the phone-in, and time out services after hours, but achieved little change unless a committal was instigated.

For nonpsychotic patients who reported feeling "unsafe" and needing someone to take responsibility for them, the use of traditional measures such as constant observation and medication did not appear to produce the same outcomes as for psychotic patients. Such patients, while they initially appeared to relinquish control, reported feeling trapped and powerless, and more out of control. Impulsive behaviour such as taking off, cutting and burning escalated rather than diminished, resulting in attempts at behavioural contracting and ultimately the threat of committal.

The threat of committal was often the only effective control mechanism that nurses and psychiatrists perceived they had when patients' "out of control" behaviours escalated rather than diminished in this way. This threat was perceived as very disempowering by nonpsychotic patients, who saw having a good relationship, talking things through, and shared decisionmaking, as ways of helping them to stay in control. While on some occasions with such nonpsychotic patients, the periods of constant observation were brief, with other patients these situations did not resolve quickly. Lengthy admissions resulted, with the patient feeling disempowered and hopeless, and the staff split as to the meaning of the behaviours and appropriate courses of action. The problem was usually attributed to the patient, who might be described as having a personality disorder, and viewed as unlikely to change. The focus then moved to achieving a discharge.

In this ward, families were involved as coworkers, as carers and controllers of patients. Even when psychiatrists and nurses were aware of family conflict, the underlying illness, rather than relationship problems, was the focus of care.

The relationship of caring and control

Caring and control are mandated functions of a psychiatric unit. In the context of acute psychiatric care, control is integral to caring when interventions are initiated in response to individual patient needs and based on a perspective of caring as a therapeutic intervention. However either caring or controlling may predominate in a particular setting, such that a unit may provide caring with little control, as in the study ward, or control with little caring as demonstrated in other studies.

Patients' descriptions of caring and non-caring interactions with nurses in this study reflected a perspective of caring as a therapeutic intervention. They expected nurses to spend time with them, to come to know and understand their predicaments, to find ways of helping them to stay in control, feel better and to resolve their problems, and to maintain belief in their abilities to get well or to learn to live with their illness. Yet these expectations were often not met. Nurses were seen by patients as too busy with the sick patients, and often not available to talk. Thus the moral imperative of caring expressed by nurses in this study did not always result in acts which patients perceived as caring.

The organisational context of caring and control

It is the central thesis of this study that the nature of caring and/or controlling acts arising from the moral imperative of caring expressed by nurses and psychiatrists is shaped by the social organisation of care, and by the dominant belief system of that setting. In the study ward, the nurses' lack of autonomy in their practice, the absence of both appropriate environmental controls such as an safe care unit and a clearly articulated unit rule structure, and the competing demands on nurses arising from the provision of the after hours service from the ward, contributed to an organisational context which was not supportive of sustained therapeutic caring and/or controlling acts by ward nursing staff.

Nurses thus adopted a reasoned management approach to care in which they monitored patient behaviour and the ward milieu, responding when necessary in order to keep the ward manageable and to meet the needs of the most acutely disturbed patients.

The dominant belief system in a particular setting shapes the meanings attributed by nurses to patient behaviours, nurses' expectations of patient outcomes, and the kinds of nursing interventions with patients which are viewed as possible or appropriate. As previously stated, in the study ward, the dominance of the biomedical model contributed to a view of mental illness as a life long event for the majority of patients who were admitted. Consistent with this dominant belief system, caring was most often expressed as nurturance and acceptance, which, in the absence of positive expectations as to patients' abilities to cope with adversity, to learn new skills, and to "make it" in the "outside world", tended to reinforce illness behaviours. Thus patients experienced "support in being grotty" within a *culture of chronicity* in the ward.

An alternative model of care, based on an advocacy/empowerment approach, is suggested, within which symptom management remains integral to care, however the primary focus is not on the illness, but on working alongside patients as people who are viewed as able to learn to cope, to make changes in their lives, and to develop the skills necessary for autonomous living in the community. Integral to this model, are the caring processes of maintaining belief and enabling, characteristics of caring as a therapeutic intervention which were expected and valued, though often not experienced by patients in the study ward. Control practices in this model reflect humanistic control which is instigated to meet individual needs rather than the needs of the system. Thus the unit milieu reflects a rehabilitative, learning environment, within a culture of acceptance

and hope. The implementation of this model in the study ward would require changes in both the dominant belief system, and the organisation of care.

When the findings are viewed from the dominant belief system of the organisation studied, the ward functioned within an ethos of humanitarian caring to provide ongoing support and care for patients with mental illness, particularly those who were chronically psychiatrically disabled. Palliative care, the provision of a safe haven, and a focus on maintaining patients living in the community by means of phone calls, time out, and intermittent admissions, were agreed upon functions of the ward. In this context the high readmission rate was seen as a consequence of fluctuations in the illness, rather than as an outcome of care. Because dependency was seen as inevitable, accessibility of the service to patients was a primary value. However when the findings are viewed through the perceptual template of an advocacy/empowerment model as postulated above, dependency, patienthood and the associated revolving door pattern of admissions, are reframed as outcomes of psychiatric care, rather than as inevitable consequences of psychiatric illness.

It is important for psychiatric nurses both to address structural constraints to effective clinical practice, and to reevaluate the knowledge base and belief system underlying existing practices and the outcomes of those practices for patients. The findings of this study suggest that of particular importance is the maintenance of belief by nurses, and the fostering of hope in the majority of patients, as to their abilities to learn new skills, to change old ways, and to manage their lives in the community in a relatively autonomous manner. Psychiatric nurses could be undertaking solution focussed therapeutic work with patients that is predicated on belief in the ability of the latter to change. For that to happen there is clearly a requirement for ongoing knowledge and skill development for psychiatric nurses.

APPENDIX

A Study of Patients' Experience of Psychiatric Care

<u>Name of Researcher</u>: Julie Boddy   <u>Phone</u>: (063) 69099 ext. 8585 or 7471

Patient Information Form

In this study, I am interested in learning about patients' experiences of psychiatric care. To do this, I need to talk with patients to help me to understand what it means to be admitted as a patient to *the unit*, what it is like being here and what it means to be discharged, or readmitted. Talking to me will not result in any changes to your treatment, but would help me to understand what it is like to be a patient in a psychiatric ward.

I would like to talk with you while you are in the unit, at a time and place to suit us both. You may withdraw from the study at any point, if you decide you don't want to talk to me. There is no pressure on you to take part in the study. If you choose to take part in my study, anything you tell me will be kept in confidence between us, unless I'm concerned about your safety or the safety of others. In that case I would need to talk to your nurse.

Taking part in this study will not be regarded as part of your treatment, although you may find talking to me helpful in reflecting on your situation. Later, when the study is completed, it will help doctors and nurses to understand how to better help patients referred for care in an acute psychiatric unit. Your name or any other identifying details would not be used in the research report, and the results would be made available to you and other patients.

Do you have any questions? Your rights are in no way affected by signing the consent form. It is simply a record that on the basis of your present understanding of the study you agree to take part.

You are entitled to have time to think about this study and to talk to your family if you wish, before signing the consent form.

A Study of Patients' Experience of Psychiatric Care

<u>Name of Researcher</u>: Julie Boddy   <u>Phone</u>: (063) 69099 ext. 8585 or 7471

Patient Consent Form

I ....understand the information form which was given to me, and consent to take part by talking to the researcher about my experience of being a patient in this unit. I understand that I may refuse to talk to the researcher at any time, and that neither participating in the study nor withdrawing from it, will have any effect on my treatment in the unit. My questions have been answered to my satisfaction.

Signed..   )

)........................

Witness (other than the investigator)...............................   )   Date

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<u>Statement by Researcher</u>:

I have today discussed with ....(Patient's name) the above study.

Signed..............................(Researcher) Date...................

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