The Relationship Between The Flexibility/Inflexibility Of Ward Nursing Regimes And Patient Outcomes

Jane Alexander
City University London
St Bartholomew School Of Nursing And Midwifery
Department Of Mental Health And Learning Disabilities

2005

A Thesis Submitted To The City University London In Partial Fulfilment Of The Requirements For The Degree Of Doctor Of Philosophy

CONTENTS **Page**

LIST OF TABLES AND FIGURES **Page**

ACKNOWLEDGEMENTS

I am indebted to the following for their contributions to the success of the work reported in this thesis.

Professor Len Bowers at the City University for his expert supervision, encouragement, patience and support.

St Bartholomew's Hospital Trustees for their financial support for the project.

The staff and patients of the two acute psychiatric wards that generously participated in the study.

Dr. Henk. Nijman for facilitating the pilot study interviews in the Netherlands

My colleague Dr Edward McCann for his support and sense of humour

My colleague Dr Louise Philips for her encouragement

My family and friends

Denis Alexander, my partner, for his understanding and for the sacrifices he made so that I could complete the thesis.

DECLARATION

The author grants powers of discretion to the University librarian to allow the thesis to be copied in whole or in part.

ABSTRACT

Background and aims

This thesis compared two acute psychiatric ward nursing regimes in the East End of London. The study focused on ward rules as a means of investigating the relationship between the flexibility/ inflexibility of ward nursing regimes and patient outcomes. Previous studies identified a relationship between ward rules and patient aggression. A few authors also identified a link between absconding and nurses' attitudes towards rule enforcement. However, an in depth exploration of ward rules from the perspective of staff and patients has not been undertaken previously. The study aimed to discover the content of rules within acute psychiatric wards; to explore patients responses to the rules; to evaluate the impact of rules and rule enforcement on nurses patient relationships and on ward events; and to investigate the relationship between ward rules, ward atmosphere and ward design.

Theoretical Framework

A sociological framework was used for the study, and the literature on the sociology of rules, and symbolic interactionism provided a basis for the investigation.

Design and Samples The design centred on a comparative interview study of 30 patients and 30 nurses within two acute psychiatric wards in different hospitals. Non-participant observations provided a context for the interview data.

Measures. Measures of the Ward Atmosphere Scale (WAS) Moos (1974), the Hospital Hostel Practices Profile (HHPP) Wykes et al (1982), ward incidents and levels of as required (PRN) medication were obtained.

Analysis

The analysis of the quantitative data was assisted by SPSS, and the qualitative analysis by QSR *NUDIST. Thematic and interpretative phenomenological methods were used in the analysis of the qualitative data.

Key findings and implications for clinical practice

A series of 11 interrelated concepts emerged from an analysis of the data, and a synthesis of the main themes. These findings were used to create a conceptual model. The model illustrates the relationship between the themes, and the key concept of ward stability. Recommendations for changes in clinical practice are based on the new knowledge that resulted from the data analysis, and the model explicates the evidence base for this knowledge.

Keywords

Acute inpatient settings, ward rules, service users experiences, power dynamics

INTRODUCTION

ACUTE PSYCHIATRY AND WARD RULES

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This study focuses on ward rules, which are imposed on patients who are being cared for in acute psychiatric wards because they provide a means of investigating the relationship between the flexibility/ inflexibility of ward nursing regimes and patient outcomes. The study aims to discover the content of rules within acute psychiatric wards; to explore patients responses to the rules; to evaluate the impact of rules and rule enforcement on nurses patient relationships and on ward events; and to investigate the relationship between ward rules, ward atmosphere and ward design.

Acute psychiatric inpatient wards may be part of a psychiatric unit on a general hospital site, or may be situated in a purpose built psychiatric hospital. These inpatient wards provide part of the spectrum of psychiatric services that extend out into the community, including hostels, residential facilities, community mental health centres and community psychiatric staff. The aims of inpatient psychiatric provision were defined as follows by the Department of Health (DOH) in 2001.

> "*The purpose of an adult acute psychiatric inpatient service is to provide a high standard of humane treatment and care in a safe and therapeutic setting for service users in the most acute and vulnerable stage of their illness".* p. 7

Acute psychiatric units are provided for service users whose social circumstances or acute care requirements prevent care in the community. Patients should stay in hospital for short periods ideally under six months, but problems with discharge arrangements may occasionally result in longer admissions (DOH 2001)

There are about 14,000 beds in 521 wards in England, and 138,000 patients are admitted per year with an average of 4.3m bed days per annum. Approximately 12,000 nurses, 425 Occupational Therapists and 911 doctors, which add up to a total of 13,336 personnel, staff the units (Warner et al 2002). The in patient population is composed of groups between the age of 18 and 65 years. They are placed according to where they live, and the wards relate to locality community mental health teams. Registered Nurses, unqualified nursing assistants, Consultant Psychiatrists, and Occupational Therapists staff the wards. They form part of multi-disciplinary teams, which may also include Community Mental Health Nurses, Psychologists and Approved Social Workers (ASW's), who may also be involved with patients, both inside and outside the hospital environment. Patients are allocated a key worker from the team, and this person is responsible for the coordination of their care. The multi-disciplinary team meet at the ward round, which is held for each Consultant who has patients in the ward. The ward round is a means of monitoring the progress of the patient, and for making decisions about treatment. For example, in accordance with the patient's progress, medication may be changed, and plans made for leave or discharge (Glover and Barnes 2002).

Most patients now enter and leave acute psychiatric wards within short periods of time. Shortage of beds and the increasing tendency to admit patients suffering from psychotic disorders has also put pressure on nurses to contain and treat patients intensively (Taylor & Taylor 1989). Thomas (1996) reviewed bed usage, and concluded that the majority of patients were admitted appropriately. However he found that nurses were not coping effectively with alterations in the inpatient population.

Ford et al (1998) reported a fall in the number of inpatient beds in line with an increase in community services, but they also found that admission rates have continued to rise over the past ten years. In order to

explore the pressures on acute services, and the rates of absconding by legally detained patients they conducted a one-day survey of a stratified random sample of acute psychiatric wards. They also assessed nursing input, and facilities for female patients. The results showed that the mean bed occupancy rate was 99%, with 30% of patients detained under the Mental Health Act. Inner and outer London had very high bed occupancy rates. Leave was used as a means of releasing beds, but this caused difficulties because patients frequently returned before the designated time. Approximately one third of the nurses that were on duty were not permanent members of staff, and they were mostly occupied in the intensive observation of a small number of patients. At the time of the visits, in a quarter of the survey wards, no nurses were interacting with patients.

Ward routines, activities and standards of behaviour

The care given in acute psychiatric units is focused on patients who may be physically well, and therefore a ward is not an environment full of beds, as in a general hospital. The hospital day usually begins when patients get up and dress for breakfast, for which they may, or may not require prompting and assistance. Other meals are at designated times during the day, and these coincide with medicine rounds, the last of which takes place at bedtime. Medication may include anti-psychotic drugs, minor tranquillisers, anti-depressants, and medicine for the treatment of physical problems. In addition to medication patients may be prescribed occupational therapy, or individual therapies such as cognitive behavioural therapy (CBT) and counselling. According to their individual levels of functioning they may have variable access to the outdoors, with or without a nurse escort. Levels of freedom are granted in line with patients' compliance with the amount of leave they are given, and with behavioural expectations (Plus + Group 2003). For example, if a patient consistently returns to the ward outside the designated time in a distressed state, they may be confined to the ward, or the amount of leave may be curtailed. This process is known as the step system (Bursten and Geach 1976).

In a recent study Clarke and Flanagan (2003) observed what nurses actually do. Although qualified nurses might not undertake every identified task, they are responsible for assigning them to unqualified staff, and for making sure that they are carried out. The authors' findings showed that nurses carry out observations, on which decisions about various forms of treatment are based, and draw up written care plans for each patient. Their duties also include giving out medication, arranging and serving meals, writing daily reports on patients, and participating in handovers. Handovers occur at the beginning and end of each shift or span of duty. At this time the qualified staff that are going off duty, give those who are taking over from them a verbal report on observations made on patients, changes to treatment, and specific events that occurred during the previous shift. Shift changes take place three times in every period of twenty-four hour patient care. Additionally psychiatric nurses co-ordinate care, and this involves communicating with outside agencies, or carers involved with individual patients. The authors observed that many of these duties were associated with work in the ward office rather than in patient areas.

> *"These examples illustrate the difficulties of even trying to get out of the office for appreciable amounts of time. Because of their pivotal role in running the ward, the nurses were expected to deal with almost any situation that might arise".* p.64.

In 1998 the Sainsbury Centre for Mental Health surveyed the quality of care in acute psychiatric wards. They elicited patients' views about their care and the ward environment. The findings revealed that patients disliked acute inpatient care. The wards were deficient in essential facilities, within deprived communities particularly.

Many patients, women especially, did not feel safe, and complained about a lack of privacy and cleanliness However patients appreciated a break from social pressures, contact with staff, and with other patients. The report identified improvements in patients' mental states, but long term problems, in particular social needs, were not dealt with during admission to hospital. Almost half of all patients said that they had not been given sufficient information about their illness and treatment. They identified inadequate therapeutic and multi-disciplinary contributions to care. They experienced boredom, and a lack of coordinated social activities; 40% of all patients did not participate in social or leisure activities.

The rules of the ward may be associated with specific times of return after leave, smoking areas, visiting times, substance misuse, verbal or physical aggression, and the prohibition of males/females from one another's sleeping areas. The Department of Health (2001) recommended that a code of conduct for patients should incorporate behavioural expectations. The code should also contain guidance on ward rules, which should be negotiated with service users, and patients should be given written information on reception to the wards. The Department of Health also identified a need for regular forums that encourage service user involvement in deciding how the ward is organised, and they should include what rules of conduct are appropriate.

Rule definitions

Psychiatric ward rules reflect the norms of the wider society, but they are also context specific in that they fulfil institutional functions of therapy and control. The achievement of a dynamic balance between these dual functions determines the flexibility/inflexibility of ward nursing regimes and their impact on patient outcomes. Ward rules are difficult to define because they vary widely within acute psychiatric units. The available literature on the topic of rules is abstract rather than definitive, but the following definitions were adapted from (Haralambos & Holborn 2000; Brown 1965 and Berger 1963)

Brown (1965) argued that rules fulfil certain basic human needs for the people who strive to keep them.

> *"There must be a means of subsistence adapted to a given environment; there must be provision for shelter; for the care of the young, and for the propagation of the species".* p.49

He referred to norms rather than rules, and described them as bundles of regulations that are linked with certain kinds of expected conduct. He stated that norms are important for the structure of society, and they are basically the consistent performance of learned behaviour. Norms must specify the type of behaviour, the kind of situation in which it is displayed, and the sort of person who acts in a certain manner. These concepts produce expectancy norms, and they are amalgamated in the general term social norm. They underpin activities, and are basically shared rules or guides to right or wrong behaviour. Brown stated that norms are particular to situations. They are culturally defined, because they are created and shared by members of specific societies, and form part of that culture. However, when norms for expected conduct are not laid down they become a standard against which behaviour is evaluated. Brown referred to written or explicit norms, and implicit or unwritten norms. He gave an example of an unwritten norm in which a student attends lessons in a bathing suit; although the norm is not formalised it is implicit that this form of dress is inappropriate for the social situation.

Norms are enforced through rewards and punishments, and Haralambos & Holborn (2000) stated that every society has to deal with its own particular problems, but the way that they are addressed varies in line with cultural values. The authors distinguished between norms and values.

> *"Unlike norms, which provide specific directives for misconduct, values provide more general guidelines. A value is a belief that something is good and desirable. It defines what is important, worthwhile and worth striving for".* p.4

They described how people adopt the norms and values of society. The family initiates the socialisation process. Later the educational system, peers and the mass media shape the process through which society's values are internalised by the individual.

Mead (1934) described this process in terms of a preparatory stage, a play stage, a game stage and a reference group stage. During the preparatory stage the child imitates the actions of the parent, and copies the way that they respond towards him/ herself or towards objects. At this stage interaction lacks meaning, because a symbolic understanding has not yet emerged. Until the child is able to define objects through the use of language, he/ she does not perceive the self as a separate entity with distinct characteristics. During the play stage the child learns to identify objects. Language acquisition enables the child to distinguish and label objects with words that are shared with others rather than imitated. The child also adopts the perspective of certain people denoted as significant others. They are usually role models, and through interaction with them the child acquires the ability to control his/her own behaviour. The child develops a view of the self as an object through interaction with a significant other, and for example by acting out the role of mother, father, or teacher during play. Mead argued that this stage marks the actual emergence of the self as a social object, because the child begins to take on the roles of others, and acts towards the self as they do.

The game stage symbolises organisational demands, and the ability to assume the perceptions of many people at the same time. This involves the adoption of a collective perspective, and the adult self integrates every significant relationship into one " generalised other". The self becomes less impressionable, and develops a broader view of others as society. Interaction with larger groups brings the child into contact with their rules and views, and their definition of the self. The development of the generalised other parallels the internalisation of society's rules and views, and the individual adopts society's view of the self.

> *"In one sense socialisation can be summed up by saying that what was once outside the individual comes to be inside him".* (Mead in Charon 1979. p. 53)

Human beings are capable of interpreting the significant symbols used in communication, but it is only by being involved in social life that they learn to do so. On this basis Mead distinguished between mind and self. Arguing that we use mental processes to interpret and share symbols, and at the same time retain a sense of self.

> *"The self, as that which can be an object to itself, is essentially a social structure, and it arises in social experience. After a self has arisen, it in a certain sense provides for itself its social experiences, and so we can conceive of an absolutely solitary self. But it is impossible to conceive of a self arising outside of social experience".* (Mead in Charon 1979.p.242-243).

The organisational context of rules

Shibutani identified a fourth stage of self development that arises within industrialised heavily populated societies He held that the individual has many reference groups in the form of generalised others or societies, and shares their perspectives. This includes a perspective on the self, which becomes compartmentalised because a multiplicity of roles demands a dynamic self that changes during interactions with people in various social contexts (in Charon 1979).

Williams criticised Mead because he paid too little attention to the impact of organisational forces on rule following (in Stones 1998). He argued that order does not just result from rule following. Rules give people the opportunity to take part in the process of order, and analyse the social context from which they arise. Giddens presented the concept of a duality of structure differentiating the individual as a social actor and social structure (in Seidman 2004). He perceived social forces such as organisational or class structures as the means that make action possible because individuals internalise them. They know which rules and resources are necessary for the performance of activities, and use them to perform specific social functions.

> *"These social patterns can be analysed in terms of their specific rules, and the organisation of resources and power dynamics that make up al the key structural properties of all social systems. Giddens elaborates these core categories as duality of structure, rules, resources, social systems into a general theory of the structural principles of different types of societies, and the dynamics of social change in world history".* p.144

He did not accept that individual behaviour is dependent on organisational systems within society, or that people simply conform to social norms. He perceived that individuals are able to reflect on the circumstances in which actions are performed. They are able to learn from their actions, and transform their behaviour, which means that individual action is a dynamic process of social awareness. Giddens argued that traditional social practices have been overtaken by constant developments. Institutions such as psychiatry generate information about the personal lives of individuals, and this new knowledge influences social practices.

He observed that rules are often viewed in isolation, as though they could be linked with specific activities or behaviours (in Elliott 1999). He refuted this, and stated that rules cannot be viewed in isolation from the structures that utilise and convert them into social practices. He argued that this process is bound up with the distribution of domination and power within society. He perceived that rules have two separate functions; they establish meaning and authorise forms of social behaviour. Giddens viewed the rules of social life as methods, which are utilised in the performance, and perpetuation of social practices. An awareness of social rules is a unique feature of human beings. Knowledge of the rules helps them react towards and influence various social situations. He held that the most important aspects of structure are the rules and resources that characterise organisations because they use them repeatedly. This echoes Mead's views in (1934) in that he also held that all humans are capable of interpreting the significant symbols used in communication, and this capacity is dependent on active involvement in social life. This suggests that he did not entirely disregard the impact of social forces such as power and domination on rule following behaviour.

> *"The self, as that which can be an object to itself, is essentially a social structure, and it arises in social experience. After a self has arisen, it in a certain sense provides for itself its social experiences, and so we can conceive of an absolutely solitary self. But it is impossible to conceive of a self arising outside of social experience".* (Giddens in Elliott 1999. p. 242-243).

Deviance

Arguments about power and domination are interlinked with deviancy theory. Foucault (1991) criticised the view that the humane treatment of the mentally ill began with the advent of psychiatric specialisation He highlighted the growth of mental health experts under whose authority new categories of patients were created, and subjected to psychiatric and state control. Seidman (2004) perceived that Foucault recognised the emergence of a disciplinary society in which order is preserved through systems of control.

> *"Order is maintained less through a hierarchy of ruler and ruled than through an apparatus of disciplinary techniques and discourses. Power in a disciplinary order is manifested less in the form of repression than in the production of subjects or social selves who are positioned as objects of normalising control".* (Foucault in Seidman 2004 p.189)

Foucault argued that techniques such as torture have given way to other ways of controlling the body through surveillance and regimentation. The mind of the wrongdoer is the actual target of control, and the social construction of criminality is used to rationalise the invention of various disciplinary strategies. Discipline is used to induce conformity with the norms of society. He stressed the importance of methods of control used by institutions. He perceived that they were interlinked with medical-scientific technologies, which control the activities and identities of individuals. These systems of control identify and impose norms or rules on individuals in order to regulate their behaviour (in Seidman 2004).

> *"It is not the power to enforce obedience that makes possible these social structures; rather social order is produced by a series of disciplinary strategies from confinement to systems of examination whose aim to is regulate behaviour by imposing norms of normality, health, intelligence and fitness".* p.189

Charon (1979) observed that we base our opinions of ourselves largely on the judgements of others, and this entails many consequences for social action. In his view the most important aspect of labelling theory is that the person's view of the self is formed during interaction, and this opinion gives rise to a circular process. The reaction of others leads to self-judgement, and a response, which is reacted to by others. A deviant label may lead individuals to perceive themselves as deviants because self-image hinges on the opinions of others. If they regard others as powerful or important they may accept their view of themselves. Charon discussed whether the individual was able to form an independent self-judgement in the absence of interaction. He perceived that from a symbolic interactionist perspective the person is influenced to a variable extent by their reference groups, and by significant others who are not directly involved with them. The people with whom they are actually interacting exert an influence, as do the judgements formed by an internal dialogue with the self.

By virtue of their existence rules are bound to be broken, and individuals who violate them must be controlled. Berger (1963) described the wider social processes that control behaviour. Social control is applied by the political and legal system, and by another process through which society exerts pressure on the individual to conform to rules. The most important violations are dealt with by formal systems, but if individuals fail to comply with the morals, customs and manners of a specific society then other systems of punishment are activated. Berger observed that people might be labelled as deviant if their behaviour transgresses social mores, and they may be ostracised or refused employment. Extreme lapses may result in another outcome, and the individual may be defined as mentally ill. Higgs (2003) observed that a psychiatric diagnosis carries serious consequences for the individual in that it falls within the category of a stigmatising

condition. These conditions distinguish sufferers from 'normal' people, and denote them as socially unacceptable or inferior. Diagnostic labels influence the perceptions of others, and may become a master status. This extends to other areas of the individual's life, and pushes into the background other situations in which they may be functioning well.

Bowers (1998) stated that sociologists perceive that mental illness forms a small category within a general theory of deviance as social rule breaking.

> *"Commonalities between all forms of deviance, or social rule breaking, have then been sought and applied back to mental illness in order to illuminate possible social processes in the identification and treatment of the mentally ill".* p.3

He observed that sociological theories of mental illness are incorporated into social work and nursing courses. This approach has two main features in that mental illness is viewed as deviance from social norms, and societal reactions towards the disease are stressed. He argued that the concept of deviance is used to categorise, and generalise about a group of people that cannot be neatly pigeonholed. The manner in which the mentally ill break rules is different, and labelling theory blurs rather than highlights the fact that the cause of the behaviour differs from the reactions of those who are not mentally disordered. In a review of deviancy theory Bowers observed that it is still a powerful influence within psychiatry. He cited contemporary writers such as Pilgrim & Rogers (1993) who referred to the function of psychiatry as *moral regulation*. However he maintained that despite the different terms used by social theorists all the underlying concepts of mental illness as deviance are interlinked.

> *"Labelling theory in psychiatry rests upon a conception of mental illness as deviance form the 'moral order' of society, upon the relativity of social rules, and upon the idea that social reaction creates mental illness".* p.10

Bowers argued that rule breaking by the mentally ill should not be perceived in the same way as crime or other forms of deviance. He referred to Scheff who tried to differentiate rule breaking by the mentally ill from other forms of deviance, by coining the term *'residual rule breaking'.* However Bowers pointed out that rule breaking by mentally ill people is not the norm, and many of them are completely law abiding. Labelling theorists focus on the behaviour of people with a schizophrenic diagnosis. He acknowledged that the behaviour of this group might match the concept of mental illness as rule breaking. However he argued that their behaviour could not be differentiated according to the types of rules they breach, because they are the same as those broken by everyone else. He pointed out that the rule breaking by the mentally ill arises from different motivations, and the incongruity of the social circumstances in which the actions are performed. He argued that the experiences of people who suffer from mental illness are not an artefact created by societal reactions to their behaviour. Mentally disordered people suffer great emotional distress, and professionals who care for them bear witness to this.

Deviance and rule enforcement

Theorists such as Becker (1963) defined a class of moral entrepreneurs. He observed that this group usually occupy high status positions in society, and may become professional rule creators. They identify people who deviate from the norm, and their condemnation of certain behaviours influences the creation of sub-groups or *outsiders*. The control of these groups is devolved to rule enforcement agencies, and Becker called the people

who are employed by them rule enforcers. He argued that a desire for respect motivated them to seek this kind of employment, and used the police force to illustrate his theories. He held that many of their practices could be understood in terms of their need for respect, and their collective social judgements about deviance. Becker maintained that groups classed as deviant, and those who challenge police competence or authority may be subjected to violence, or prosecuted for minor offences.

> *"Similarly we may find individual acts of enforcement based on rules at the moment solely invented to justify the act. Some of the informal and extralegal activities of policemen fall into this category".* p. 34

Becker's ideas introduce the concept of individual reactions to deviance, and it's impact on the rule enforcement role. He identified a dual process, in which rule breaking is viewed from the differing perspectives of the enforcer and the deviant. From a symbolic interactionist perspective the rule enforcement role depends on the ability of employees to agree and apply decisions that are made at a macro level, within micro situations in the workplace. Mead described how people interpret one another's behaviour. During interaction they put themselves in the other person's place in order to make sense of their reactions. For example if one person cries the other may interpret this as a sign of sadness. However this interpretation may not elicit a specific response in that the person who displays the behaviour may ignore them, respond with sadness, or try to make light of the situation with a joke. The other person may then adopt their role in order to make sense of the response. On the basis of this interpretation they may prolong or end the interaction. In this sense human interaction may be viewed as a dynamic process of clarification, with each person taking on the role of the other (in Haralmbos and Holborn 2000).

However in terms of deviancy theory this explanation neglects wider social processes that have an impact on micro level interactions. Becker's work suggested that the police internalised dominant views within society about the behaviour of certain groups, and approached rule enforcement with preconceived ideas. The way that the rules were enforced was influenced by collective as well as individual interpretations of responses to control. Bowers (1998) argued that labelling theory is based on a flawed interpretation of Mead's work. Mead did not mean that the construction of the self is totally dependent on interactions with others. He meant that in the absence of interaction children could not become social beings. Bowers perceived that labelling theorists adopt a global view of the mental processes of deviant people. Consequently rule breaking by the mentally ill is viewed from a judgemental or moralistic stance. However he regards this explanation as too simplistic because the degree to which the mentally ill are held accountable for their behaviour depends on complex factors. Within psychiatry deviance cannot be reduced to simple concepts of right or wrong, or good and bad.

Deviance is linked with the process of stigmatisation. Pilgrim and Rogers (1999) point out that a mentally ill diagnosis is primarily based on an assessment of the individual's behaviour. This entails a risk that their total identity or sense of self will be invalidated. Goffman (1963) refers to the Greek use of the term stigma, which was associated with bodily signs like cuts or burns, and marked the person as a social outcast. He observed that in modern society the use of the term is generalised to refer to any condition that marks the person as culturally inferior or unacceptable.

Disorganisation

Weber perceived that all modern organisations tended to be characterised in bureaucratic terms (in Giddens 1981). He perceived that the growth of macro social systems marked an inevitable rise in the development of bureaucracies that are set up to deal with organisational activities, which have increased in complexity. However he identified several important problems with bureaucracies, and created an ideal type or pure form of bureaucratic organisation, which incorporate the following elements.

- A clear system of authority or hierarchy
- Written rules that direct the conduct of officials at all levels of the organisation
- Officials occupy full time salaried positions
- The employee's personal life is kept separate from the organisational function
- No employees own the material resources that they use to perform their activities

Weber believed that the closer the fit between a bureaucracy and the ideal type the more efficient it would be in carrying out the goals for which it was created.

Giddens (1981) stated that Weber concentrated on official relations between members of the organisation as defined by the rules, rather than informal interactions between them. He cited Blau's study of informal relations in a government institution. The employees should have brought problems to the attention of their supervisor, rather than their colleagues. However they contravened the rules because they perceived that asking for guidance might be perceived as lack of expertise, which might affect their chances of promotion. Consequently they broke the organisational rules, and conferred with their peers. This had a dual effect in that they received advice, and their anxieties about independent decision-making lessened. These employees developed cohesive relationships, and Blau maintained that they coped more effectively with tasks. Moreover informal processes were set up that facilitated the use of initiatives that were obstructed by adherence to official organisational rules.

According to Giddens, Weber was concerned that a rise in the power of bureaucrats might cause a decrease democracy. He held that the hierarchical nature of bureaucracies and increased specialisation meant that the work of those operating near the floor of the organisation is routine fundamentally. He observed that the work force is relatively powerless in comparison with higher members of the hierarchy. Weber predicted that they might become alienated, and resigned to the role in the absence of any opportunity to exercise their own initiative. Consequently they might become defensive and rigid, in an effort to protect themselves from any further erosion of their status within the organisation.

Cohen wrote about disorganisation. He held that lack of motivation and anomie were the root causes of disorganised systems. He observed that people react to a situation of normlessness or anomie in various ways, which was influenced by their social position. He defined an organisation as a set of procedures that correspond with agreed rules, and he perceived that disorganisation breaches this orderly system. Further he held that this definition of an organisation is based on the assumption that members can work through situations and explore possible courses of action by referring to the rules. This perspective assumes that people view the rules in the same way and choose to follow them. He argued that disorganisation is bound to occur when one or both of these conditions are lacking.

He also perceived that disorganisation develops, when the situations that members face cannot be dealt with by reference to rules and procedures, or when there are no clear guidelines about ways to proceed. He observed that employees might experience a state of normlessness, anomie or meaninglessness. Cohen also believed that deficient motivation was caused by a clash between management goals for the continued operation of the system, and the ideals, interests and aims of the members. He perceived that disorganisation might be tackled in various ways.

> *"Systems may have mechanisms for restoring organisation for example by sending in replacements for confused, incompetent or disaffected personnel, or for reinforcing motivation by bringing powerful sanctions to bear".* (Cohen 1971 in Rubington and Weinberg 1971 p.60).

Cohen argued that the use of stronger controls and sanctions might be avoided if the causes of deviance within organisations are addressed. Further he perceived that certain types of deviance are an understandable reaction to specific circumstances. He held that this behaviour could act as an outlet for frustration, and indicate that part of society is dysfunctional. Deviance could highlight problems, and result in measures to address them. He cited truancy, desertion and absconding from institutions as examples of actions that expose causes of dissatisfaction, which may result in organisational changes that address underlying issues of efficiency and morale (in Rubington and Weinberg 1971).

Bowers et al (1999) in a study of acute wards found that certain wards in East London and the City Mental Health Trust had twelve more episodes of patient absconds. Other studies identified major variations in the frequency of difficult behaviours between different wards. These variations in patient outcomes may correspond with aspects of Cohen's theory about the causes of deviance within institutions. From a symbolic interactionist perspective it could be argued that deviance arises when underlying problems of morale and efficiency impact on micro level interactions between patients and staff. Consequently absconding may be caused by failures in communication or engagement, which means that the causes of potential or actual rule breaking are not addressed.

Institutions

Gehlen held that institutions are authoritarian organisations that direct human behaviour in the same way that animals are driven by instincts (in Berger and Kellner 1981).

> *"In other words institutions provide procedures through which human conduct is patterned, compelled to go, in grooves deemed desirable by society. And this trick is performed by making the grooves appear to the individual as the only possible ones".* p.104

The implementation of organisational aims depends on interactions between the members of the organisation at a lower, as well as at a higher, institutional level. Symbolic interactionism focuses on micro level interactions rather than macro level social change (Haralambos & Holborn 2000). Rules may be regarded as symbols of control. A hierarchical institution such as the National Health Service (NHS) may hand down rules but enforcement is influenced by the way that they are interpreted by patients and staff at ward level. Mead conceived that human thought; experience and behaviour are basically social (in Haralambos & Holborn

2000). People use symbols during interaction, and the most important of them are contained in speech. In Mead's view a symbol does not just represent an object or an action it identifies them in a particular way, and indicates a specific response. Symbols impute special meanings on objects and actions, and so other potential meanings are excluded. Mead maintained that humans differ from animals because they are not genetically programmed to react automatically to specific stimuli. Human survival depends on the ability of members of a given society to construct a world in which the meanings of symbols are mutually defined.

> *"Via symbols, meaning is imposed on the world of nature, and human interaction with that world is made possible".* p.1047

These concepts cohere with Gehlen's wider definition of the institution as a programming mechanism (in Berger and Kellner 1981). The acute psychiatric ward could be perceived as a place where people who may have lost the ability to share the meaning of symbols, because of mental illness, are helped to regain this capacity. Mental disorder may result in a preoccupation with internal processes. This may impair the individual's ability to interact, and they may misinterpret nursing interventions associated with rule enforcement. Consequently the dual purpose of ward rules emerges in that they are instruments of control and therapy. The ward may be conceived as a microcosm of society, and as such ward nursing regimes may reflect aspects of patients' families, or other institutions such as schools in which norms are in calculated. The way in which rules are applied demonstrates the ability of nurses to marry the dual functions of the institution, and apply them flexibly or inflexibility according to the changing needs of the individual. Arguably this cannot be achieved without high levels of engagement, and if the social control function of the institution outweighs the therapeutic purpose of hospitalisation this may have an adverse effect on patient outcomes.

Mead held that social life does not just depend on the ability to share the meaning of symbols (in Haralambos & Holborn (2000). Although this is vital to communication members of society must also understand one another's motives, and he maintained that this is achieved through a role taking process. This entails the capacity to interpret the meaning of another person's behaviour by looking at the situation from their point of view. Therefore from a symbolic interactionist perspective nurses responsibilities for rule enforcement does not just involve clarification through engagement. They must also help patients to understand the reasons for restrictions. In order to reason with patients they need to view the impact of restrictions from the patient's perspective, and in turn the patient may gradually be helped to take on the role of the other, and perceive that the rules are enforced out of concern for their welfare.

Durkheim viewed society as a boundary that contains the individual (in Berger and Keller 1981). He observed that institutions shape behaviour and views. The specific place occupied by the individual in the social system determines most of their activities. Individuals who resist this may be pressurised to conform by continual systems of control and coercion. Cotgrove (1970) held that the specialisation and sectorisation of working practices has reinforced organisational power. Organisations have a structure and ethos, and they are defined by activities that fulfil collective aims. A set of rules controls the activities of members, and appoints leaders, but organisational structures and methods are widely variable. The broad topic of organisational theory includes the outcomes of agreements made by members of the system on the structure, relationships, behaviour and efficiency of an organisation. Other variables embrace different management styles, and the variety of management techniques that can be used by organisations. Organisational theory also incorporates group motivation, and the reactions of institutions towards unpredictable events.

Role strain

Cotgrove (1970) observed that individuals assume the burden of organisational tasks, and used teaching as an example of a profession that may be subjected to role strain. The socialisation aspect of the role entails close relationships with children, but disciplinary aspects of the job may be disrupted if teachers become too involved with them. He argued that there might be a lack of consistency between the characteristics that individuals bring with them to the role, and the qualities that it demands. When this problem is viewed in symbolic interactionist terms the employee and the organisation may not share the same interpretation of the role. Teachers may stress the importance of relationships with children because they are less detached than management, or they may not understand the reasons for certain policies.

Similarly the conflicting demands experienced by psychiatric inpatient staff may induce role strain as they strive to balance therapeutic and safety aspects of the role. Merton identified the way in which employees of bureaucracies may over conform to the rules (in Cotgrove 1970). He held that they stick to them rigidly, and use them as ends rather than means, because they follow a graded career path. In return for conformity they receive promotion, security and a retirement pension. Although strict adherence to the rules may protect the individual from criticism, organisational aims may be disrupted, because pressure to conform promotes fear and rigidity amongst staff.

Merton acknowledged that it is difficult to ascertain the extent to which over conformity stems from the socialisation of the employee by the organisation, or whether work in this type of establishment appeals to people who are wary of autonomous decision-making. However from a symbolic interactionist perspective over conformity may arise because managers and workers are socially distant, and each may be unable to conceptualise or take on the role of the other. Moreover employees may make rigid interpretations of management directives if they are communicated in a formal manner. For example if the rules are handed down in the form of written policies, they may perceive that they cannot interpret them flexibly.

Within organisations that are subjected to the close scrutiny of the state and the public, such as the NHS, employees may be subjected to other intense pressures. As previously stated Cotgrove (1970) observed that organisational theory embraces the reactions of institutions towards external or unpredictable events. Within the current climate in which psychiatric hospitals operate, therapeutic goals may be sacrificed for safety aims. Cotgrove argued that the displacement of organisational goals might be avoided through changes in hierarchical systems. Argyris perceived that organisations needed to alter the demands made on employees (in Cotgrove 1970). He argued that typical organisational responses might exacerbate problems, and believed that ways should be found to increase staff autonomy throughout the organisation.

From a symbolic interactionist perspective this might help management and workers take on the role of the other, because managers would experience the effect of a decrease in power and control over the organisation. In turn workers might develop increased insight into managerial responsibilities. Conceivably the establishment of multi-disciplinary teams within acute psychiatric hospitals may represent a move towards a flattened hierarchy. Within this system communication between the various disciplines might improve, and they might develop a greater understanding of one another's activities.

The work of Goffman

Charon (1979) observed that authorities might constantly subject members of society whose capacity for self-determination is undermined by some form of impairment to humiliation and manipulation. Consequently their self-concepts may be negatively influenced by these experiences. He cited Goffman's work on total institutions as an example of the way that the individual's self judgement is taken over by other people who have a great deal of control over the physical and social environment in which they are confined. The individual is progressively redefined in a process that isolates them from reference groups and significant others outside the institution. The environment is completely controlled by a small powerful group of people, and interactions with them are directed by their collective social judgements, and their view of the self. As a result of this process the individual forms a new view of the self, one that is dependent on the behavioural expectations of others. Submission to authority is rewarded through approval, and a positive view of the self becomes dependent on compliance with institutional rules.

Goffman (1961) stated that rules are underpinned by moral judgements. He argued that psychiatry projects ideals of ethical neutrality because this is a requirement of clinical judgement and practice. However he observed that these aims could not be realised within mental institutions because patient management involves the promotion of acceptable standards of behaviour, and the application of sanctions for misdemeanours. He concluded that moral judgements are implicit during nurses patient interactions associated with rule enforcement. He perceived that the staff viewed inmates as objects, and the rules as a symbolic negation of the healing function of the institution.

> *"Psychiatric staff share with policemen the peculiar occupational task of hectoring and moralising adults: the necessity of submitting to these lectures is one of the consequences of committing acts against the community's social order".* p. 319

He conducted the research on which Asylums was based in a large American asylum many years ago, and as such the findings may not be generalisable to modern ward nursing regimes in the UK. However his work influenced important developments within psychiatry since then (Haralambos & Holborn 2000). Therefore his study may provide a reference point for what emerges from the results of this thesis. He wrote about the institution from a symbolic interactionist perspective, and sought to define the social situation of patients rather than staff. He observed that prison like conditions pertained within the hospital environment, despite the fact that patients had not committed any crimes. He portrayed ward-nursing regimes as harshly punitive with a total imbalance of power between patients and staff. He referred to the large asylum in his study as a total institution, and justified the use of this term as follows:

> *"A total institution may be defined as a place of residence and work where a large number of like situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life".* p.11

Goffman observed that total institutions limit social contact with the outside world, and prevent escape through the use of physical barriers like high walls or locked doors. He held that the vital characteristic of this type of establishment is that the boundaries that demarcate work, sleep and recreation within the wider society are removed. He observed that total institutions restrict all the activities of inmates to the same place, and that they perform them with the same group of people. He argued that outside the institution these activities would be carried out in various places with different groups for differing reasons. He drew an analogy between hospitals, prisons, monasteries, military training schools, concentration camps and ships.

He observed that institutions such as asylums combine the functions of residential communities and formal organisations. Within such places inmates' lives are regimented in conformity with an overall aim.

> *"In our society they are forcing houses for changing persons; each is a natural experiment on what can be done to the self".* p.22

He described how the institutional system managed large numbers of people. Methods of overall surveillance were used as a means of control, so that non-compliant patients could be easily identified because they stood out from the rest of the group. Goffman observed a basic split between patients and staff who perceived each other negatively.

> *"Staff tends to feel superior and righteous: inmates tend, in some ways at least, to feel inferior, weak, blameworthy and guilty".* p. 18

He observed restricted interaction between them, and noted that staff addressed patients in a particular tone of voice. He also observed that they restricted patients' access to other members of the hierarchy, and excluded them from decision making about the plans that were made for their treatment. In Goffman's view the staff concealed care plans to prevent patients' adverse reactions, which might disrupt the smooth operation of the admission process. Goffman observed that patients were routinely assigned to the sick role on admission to hospital, and he viewed this process as a basic aspect of institutional control. This perspective fits with concepts of stigma as discussed previously, in that other aspects of the self are invalidated by the diagnosis of mental illness, and confinement to hospital.

> *" Having to control inmates and to defend the institution in the name of it's avowed aims, the staff resort to the kind of all embracing identification of the inmates that will make this possible".* p. 82

He described how the process of admission to hospital caused changes in the patient's self-perception because the usual social activities that support a sense of self-identity were removed.

> *"An analysis of these processes can help us to see the arrangements that ordinary establishments must guarantee if members are to preserve their civilian selves".* p. 24

He referred to the ' pervasive house rules', and a system of privileges. This process punished disobedience by denying patients access to better social conditions, and rewarded obedience with greater levels of freedom or access to improved facilities. Goffman was interested in the external activities that sustain the self-identity rather than with internal processes, such as reflection. He observed that individuals use protective mechanisms to maintain a view of themselves, which they present to others. He believed that communal life within asylums disrupted this process, and observed that patients developed various means of self-expression to preserve a sense of personal identity. However these activities might be viewed as bizarre by the staff, and taken as further proof of irrationality. He provided many examples of this type of behaviour, and held that it could be interpreted as a rational reaction towards the way that institutional practices stripped patients of their identity.

Goffman argued that people are usually admitted to mental institutions because their behaviour has breached social conventions. He observed that an important factor in the development of what he called a 'moral career' was that the patients' rights and relationships were mostly taken away during the admission process. He spoke about a 'betrayal funnel', and observed that during each stage of the admission process those who

were involved might try to give patients the impression that they would not lose any more of the rights that they enjoyed in the community.

He maintained that the ability to compartmentalise various social roles is disrupted by admission to hospital, and he described what happens to the patient as 'mortification'. He observed that respect for patients' feelings was lacking, and that the staff discouraged emotional displays. He gave an example of this process, and observed that patients were expected to behave deferentially towards the staff when they were told what to do. He pointed out that although people may be expected to obey those in authority in the outside world, they do not have to display respect when they do so.

Mortification

Goffman observed that patients were thrown into contact with people that they might choose to avoid in the world outside the institution. They had to share personal hygiene facilities, and they were generally treated as a group rather than as individuals. They usually had to ask permission to perform activities that they could perform spontaneously at home, for example going for walks or making refreshments. During admission to hospital, personal possessions and clothing that maintain the self-image were normally removed from them.

He observed that other characteristics of mortification centred on the way that the psychiatric speciality views mental illness and behaviour. All of the patients' activities were surveilled, and they might be recorded in the notes. In Goffman's view these processes damaged patients' previous perceptions of themselves because it was difficult to hide behaviours that might be interpreted as a further evidence of illness. For example in the outside world people may be distressed by events in their personal lives, and they may display anger or weep in private, but these reactions are not exposed to public scrutiny because they can hide them from others within the privacy of their own homes. They can escape to private areas in order to gain control over their emotions in other social contexts as well, while they are at work for example. However within the confines of the ward it is much more difficult to conceal, what Goffman referred to as role disruptions from others, the private self is constantly exposed to public view, and this erodes self-esteem.

Goffman coined the term looping', and by this he meant that when patients reacted defensively to what they viewed as a personal attack then their responses became the target of the next staff criticism. For example he observed that if they obeyed orders sullenly, then the staff might interpret this behaviour as further evidence of disorder, because the patient had refused to admit that their definition of the situation was distorted. He defined this as one of the basic features of the mortification process in that patients were not allowed to spontaneously express their own definition of the situation. This meant that they had to react in a prescribed manner, or in a way that further consigned them to the sick role by a display of anger for example. They were unable to maintain social distance from the staff, or preserve a sense of autonomy because this was destroyed during the interaction.

Reconstituting the self

Goffman wrote about the ' secondary adjustments' that patients made in order to preserve a sense of self. He observed that these activities might be viewed as bizarre, and interpreted as further evidence of illness by the staff. However Goffman argued that if they were viewed from the patients' perspective these activities could be seen as ways in which patients distanced themselves from the institution. Goffman remarked that these activities are important for the maintenance of a self-identity within ordinary society. A sense of

autonomy is important for all individuals, and for example people may assert themselves by being rude or uncooperative when they are subjected to institutional control. However he observed that when inpatients reacted in this manner they might be transferred to what he referred to as a 'bad ward'.

Conclusion

The context, prevalence and enforcement of psychiatric ward rules may be influenced by complex factors other than institutional aims of safety and therapy. The historical and social contexts of acute psychiatric wards are important factors. The impact of societal reactions towards the mentally ill together with the advent of care in the community, and the intense media interest in tragic cases involving mentally ill people may have had an impact on ward nursing regimes. Pressure on beds, high acuity and the shorter duration of admission may make flexibility difficult to achieve, and nurses may adhere rigidly to the rules in order to manage large numbers of patients with complex needs.

Psychiatric nurses attitudes towards ward rules are influenced by the social and institutional context in which they operate. They have internalised the norms of society, and this may predispose them to apply concepts of right or wrong behaviour towards rule construction or during enforcement. Collective beliefs about causation, and rule breaking by the mentally ill may result in variable approaches towards non-compliant patients. Nurses may experience organisational strain if demands for safety outweigh the therapeutic function of the role. Advances within psychiatry and nurse education have provided alternatives to the medical model, and an emphasis on containment methods. This may have caused a greater emphasis on psychosocial aspects of care, and the incorporation of therapeutic strategies within ward nursing regimes.

However changes within psychiatry may cause nurses to experience greater role ambivalence as a result of the increased expectations placed upon them. They may question, and be less complacent about rule enforcement than their predecessors because the nursing role is less clear-cut than that of the staff in Goffman's (1961) study for example. Hypothetically the observations that he made about the treatment of patients should have given way to more humane and therapeutic approaches towards control. Further, the current emphasis on service user involvement should have an impact on information processes, partnerships in care, choice, and improved patient facilities. The advent of multi-disciplinary teams may have had an impact on the flexibility of ward nursing regimes because responsibilities for safety and control might be diffused amongst members. A flattened hierarchy may have decreased divisions between the medical and nursing professions, and increased each disciplines understanding of the role of the other.

The relationship between the flexibility/inflexibility of acute ward nursing regimes and patient outcomes is a broad topic. This study focuses on an exploration of ward rules in order to contract its scope in line with the research guidelines for the size of this thesis. Ward rules underpin the structure of acute psychiatric wards, whose function is to provide a safe therapeutic environment for acutely ill patients on behalf of the institution, and they are instrumental in the achievement of these dual aims. The ability of acutely ill patients to follow rules may, or may not vary in accordance with differing levels of social functioning. Institutional aims are carried out at ward level through the implementation of hospital and legal policies, and they are communicated at a micro level during nurse patient interactions involving rules. The ability to transmit the meaning of rules, and the motivation behind enforcement through therapeutic relationships with patients is central to the fulfilment of a duty of care.

'Rule' is an inherently complex concept, and made even more problematic by peculiar circumstances of psychiatric inpatient care. Ward rules are conceived as the means whereby the social structure of the environment is coded in ways that may or may not be documented. They are regarded as symbols of the wider social structure, but they are also context specific in that certain rules may only be operational within psychiatric institutions, such as those associated with enforced confinement or medication.

This introduction provided a theoretical and environmental context for the study, and a basis for the development of the thesis towards answering the research questions. Some understanding of the possible content of rules within acute psychiatric wards; patients responses to the rules; an evaluation of the impact of rules and rule enforcement on nurses patient relationships and on ward events; and the relationship between ward rules, ward atmosphere and ward design was gleaned by an exploration of the literature. These factors may influence arguments for the creation of high or low structure environments in terms of which kind of regime enables an optimum therapeutic milieu for acutely ill patients. The following section explores what has already been written about the topic of ward rules in the nursing literature. This provided further information on which to build a conceptual framework, which was used to formulate the research design

CHAPTER 1

A REVIEW OF THE LITERATURE

A REVIEW OF THE LITERATURE

Searches

In order to explore what is already known about the subject a search of CINAHL and PYSCLIT electronic databases was undertaken in November 1998. This yielded 660 nursing articles, 198 of which were obtained and reviewed. The search terms used were: rule, ward, regime, atmosphere, routine, management, structure, boundaries, limit setting, disobedient, discipline, authority, conform, compliance, non-compliance, non co-op, resist, norm, regulate, order, control, restrict, conduct.

The abstracts were read and a selection was made of those most applicable to the topic. Not all were relevant, and were not included. Many studies were concerned with patient aggression, but they did not specifically mention ward rules in relation to this topic. Other studies were associated with the acute psychiatric ward environment, but again they did not refer to ward rules. If all of the studies that were reviewed had been included because they bore an indirect relationship to the topic this chapter would have been too large in relation to limitations on the size of the thesis.

A further search, using the same terms, but accessing several more electronic databases was undertaken in July 2003. These included Pub Med, Science Direct-Social Science and Medicine, Ovid bibliographic records, Bids.ac.uk, Assia Applied Social Sciences Index & Abstracts and Ingenta. As a result of this search another 34 papers were obtained and reviewed. Relevant material was added to the review, which is compiled from a thematic perspective.

High structure

Two studies associated improved patient outcomes with highly structured regimes. One study suggested that patients preferred a highly structured environment, and another paper reported that nurses favoured this type of regime.

Jungman and Bucher (1967) studied patterns of interaction within two female wards (A and B) of a state mental hospital, and part of the study is directly related to ward rules. This comparative study aimed to evaluate the influence of ward milieu on patient behaviour. The data was collected by non-participant observation and interviews. The authors believed that different management systems within Ward A and B had a direct effect on patient behaviour, which accounted for differences in rule breaking between the wards. The patients residing in ward A understood what was expected from them in terms of behaviour, and they also knew about the sanctions that would be imposed if they broke the rules, or failed to meet behavioural standards. The authors described ward A as a benevolent authoritarian system, with clearly demarcated staff roles.

However within Ward B the lack of clear goals for the unit meant that therapeutic activities were uncoordinated and inconsistent. The nurses also allowed patients to be noisy, physically aggressive and inappropriately dressed. Jungman and Bucher argued that the lack of direction and control within the environment produced excitation among patients. The staff then employed rigid measures to manage the

situation. Within Ward B the staff vacillated between an orientation towards patient government, and an authoritarian system of ward management. The nursing team lacked cohesion, and the consultant psychiatrist had no faith in the ward system. He believed that patients recovered or failed to improve regardless of the care that they received.

Jungman and Bucher argued that the different systems of ward management overrode other possible explanations of the findings. Differences in the frequency of rule breaking between the two wards were reflected in the increased use of physical controls within ward B. The authors argued that a lack of structure, and the absence of a unifying ethos accounted for these differences, rather than age or diagnoses, which were matched. However Ward B also contained a group of longer stay chronic patients, and the authors referred to a previous study when this patient group was functioning optimally. They attributed deteriorations in patients' behaviour to changes over time in the ward system, rather than differences in chronicity between ward A and B patient groups.

Perhaps the authors should have examined the reasons for the longer hospitalisation period of the chronic group. They might have discovered that psychosocial factors influenced the reactions of patients and the length of hospitalisation. For example, divorce or lack of social networks might have led this group of patients to perceive that life within the hospital was preferable to an isolated existence in the community, and they may have behaved in ways that undermined efforts to rehabilitate them. It is also now accepted that disorders of personality may complicate major mental illness, and this factor might have made certain patients more inclined to breach the rules. If this was the case, the presence of these patients within Ward B could account for the views of the psychiatrist, which may reflect ideas about the intractability of personality disorder rather than lack of faith in the ward system.

Levinson and Crabtree (1979) described a cycle of ward tension within a therapeutic community for hospitalised adolescents. They found that a clear system of rules and limit setting was helpful during fluctuations in ward atmosphere. The authors claimed that crisis management was easier when familiar systems of control were activated, because patients might perceive the implementation of new rules as arbitrary. However this paper was based solely on a review of previous work on cycles of ward tension. The authors' observations came from their experiences within one unit, and no systematic methods of data collection were used in support of the theory.

Bursten et al (1980) based their study on Bursten and Geach's (1976) work and investigated the therapeutic value of ward policies that restrict and coerce psychiatric patients. The outcomes of patients following discharge from three wards at a Veterans Administration Hospital were compared. Ward A operated a formal step system, ward B1 was significantly restrictive-coercive, and within ward B3 compliance with activities and medication was mostly optional.

Ward A staff expected patients to enter into group activities and behave appropriately. Staff patient groups decided whether patients had earned privileges by complying with the regime, and whether they should lose privileges for rule breaking. Ward B1 staff still operated a restrictive-coercive regime to a large extent, but the ward was undergoing transition from a formal step system model to one in which all patients were to be allowed much autonomy, unless there was a risk of physical danger.

Within Ward B3 staff control over patients was minimal, patients were not made to attend activities, and medication was only enforced in cases of extreme agitation. Staff still asked patients to comply with treatment but no sanctions were employed if they refused. Patients were free to come and go, regardless of treatment compliance or the appropriateness of behaviour. Nurses, patients and family members rated behaviours at admission, during admission and at discharge. Then patients and significant others rated behaviours 6 months after discharge. The findings were that ward A patients showed better adjustment on 23 out of 55 ratings, even though only one of the ratings reached statistical significance. This ward operated a formal step system, and patients showed better adjustment than either ward B1 or B3 patients. Ward B1 patients achieved better adjustment than ward B3 patients.

This study seemed flawed in terms of inter rater reliability particularly at the six- month follow up stage. The ratings may have been influenced by the close relationships between patients and significant others. For example the family member may have been wary of upsetting the patient by giving them a low rating. Moreover, the self- rating patients may have lacked objectivity, or they may have feared consequences of reporting their actual level of functioning, for example in terms of re-admission or increased medication. Those patients who responded at six- month follow-up may have been an overly compliant group who were conditioned to report improvement. Conversely Ward B and B3 patients might be more likely to report accurately because their experiences of hospitalisation were less coercive and restrictive.

This study reflects Jungman and Bucher's (1967) findings, but expands on their work by attempting to measure patient outcomes following discharge. However the authors' findings conflict with Bursten and Geach's (1976) results. They did not identify different outcomes, but their study was limited to hospital wards. Bursten et al's findings also contrast with Alden's (1978) results in which patients' levels of functioning was adversely affected by rigid ward nursing regimes. However Alden's study was larger, and examined patients reactions during admission rather than measuring levels of functioning following discharge. Alden's study is important because it began to question staff attitudes, and introduced the argument that the quality of staff patient interaction was important. Patient outcomes were influenced by the way that staff communicated with them, and patients' perceptions of the interactions, rather than the flexibility or inflexibility of ward nursing regimes alone.

Ward rules may not be perceived as punitive or controlling by patients, and they may view limit setting as an expression of nurses' support or concern. Caplan (1993) administered the Ward Atmosphere Scale to nurses and patients within a maximum security ward in order to examine the factors that influenced their perceptions of the environment. The study identified differences between staff and patient perceptions of the ward atmosphere, and they were most discernible in the system maintenance dimension of the scale, which evaluates the orderly function of the ward. The staff perceived an above average emphasis on structured activities, and on following schedules and routines. They perceived that they communicated the importance of these tasks, and patients identified an emphasis on compliance with the ward routine. However many patients felt unclear about ward rules and staff expectations of behaviour.

The patients also perceived that staff strictly imposed ward rules and behavioural standards. Nurses perceived that they employed minimal control over patients' behaviour, but patients and staff identified good levels of support within the environment. Caplan argued that by emphasising compliance the staff demonstrated that they were motivated to maintain a safe, secure and therapeutic environment for the treatment of potentially violent patients. They achieved a balance between control and therapy because

they provided a highly structured environment that facilitated the implementation of treatment programmes. Nurses and patients also identified medium to above average levels of involvement in the environment. Caplan suggested that patients perceived nurses' insistence on consistent limit setting, structured activity and safety as expressions of caring concern for their welfare. She acknowledged that limited generalisations could be drawn from the study because the subjects were recruited from only one maximum-security hospital. However the theory reflected Kolodjera et al's (1989) psychodynamic concepts about the provision of holding environments for patients.

Lowe et al (2003) used case scenarios of real conflict events, which were rated by nurses. The results indicated that limit setting and structure were perceived as vital by psychiatric nurses, but that they could not be isolated from interventions that demonstrated respect for patients' autonomy. Differences in judgements between nurses of different status emerged from the results, and higher grades of staff were significantly more likely to favour autonomy confirming interventions.

Low structure

One study reported that high structure made no difference to patient outcomes. Two studies identified the adverse effects on patients' levels of functioning within highly structured wards. Another study advocated rule flexibility in the provision of individualised care.

Bursten and Geach (1976) tried to assess whether the step system was justified on therapeutic grounds. The step system restricts and curtails the freedom of patients in order to control behaviour, and aims to re-socialise them by using a graded series of privileges or activities. The patients' autonomy is restricted following admission to the ward, and then they are gradually allowed increasing freedom of activity without supervision. Appropriate behaviour is rewarded by the continuation and expansion of privileges, but if patients behave inappropriately they may be withheld. Rule breaking and the step system are interlinked, for example patients who leave the ward without permission may be grounded, so that they learn to ask in future.

The study was retrospective and used patients' records to compare three ward environments. Only one ward operated a formal step system, but staffing, patient diagnoses and medication levels were similar within all three wards. The results showed no differences in patient outcomes. The authors discussed whether the degree of restriction and coercion used by the ward that operated the formal step system was justified on therapeutic grounds because this measure failed to produce significant differences in patient outcomes. The study was limited because it used a retrospective method to evaluate therapeutic outcomes. The conclusions contrasted with the results of Jungman and Bucher's (1967) study, which found that a highly structured ward regime produced positive improvement in patients' levels of functioning.

Alden (1978) investigated the psychosocial environment of eight psychiatric wards by administering the Ward Atmosphere Scale to patients, and by recording nurse patient interactions. This study discussed the effect of a rigid environment on outcomes, and given that rules may be used to control rather than protect or treat patients it is of interest. The Ward Atmosphere Scale Moos (1974) has eight dimensions one of which has a subscale on control. This subscale measures how strictly nurses enforce rules, schedules or regulations.

Patients within certain wards perceived the staff as very controlling. They became progressively withdrawn, isolative and tended to express less hostility. However, within wards where the expression of anger was not discouraged the patients were more communicative, but they also tended to exhibit greater hostility and independence. Additionally Alden suggested that the quality of staff -patient interactions were important. Nurses who were unapproachable, authoritarian and rigid appeared to create an environment that was non- therapeutic for patients. Conversely nurses who communicated with patients, and were perceived to care about their problems created a social atmosphere conducive to improvement. This study elaborated on the previous articles by focusing on specific aspects of patient behaviour that arose as a direct result of the ward nursing regime, whereas (Jungman and Bucher 1967; Bursten and Geach 1976) studies provided a generalised behaviourist overview. Alden pointed to the negative psychosocial effects of rigid regimes on patients, and demonstrated that the achievement of patient compliance may be counterproductive to recovery.

Lanza et al (1994) studied the relationship between patient autonomy, ward rules and assault. The researchers examined environmental factors related to assaults committed by patients within four long term and two acute psychiatric wards. Staff and patients completed the Ward Atmosphere Scale. Incidents involving attacks against nurses were taken from nursing reports during a twelve-month period. Every time an assault occurred the ward manager completed the environment assessment questionnaire, Lanza (1988). The data collection included the location, time, date, bed occupancy rates, acuity levels and any recent environmental or policy changes.

Lanza et al argued that social rules reflect basic issues surrounding patient self-determination and the extent of staff control. The ward with the highest number of assaults in the study had the lowest autonomy score. The ward with least assaults had the highest score on autonomy, practical orientation and personal problem orientation. This ward also had the lowest score on staff control, and the ward with the highest frequency of assault reported the greatest score on this scale. The authors recommended the incorporation of therapeutic community ideals within psychiatric wards, in order to provide environments that focused on patients' interactions with each other and with nurses.

Lanza et al believed that an appropriate and consistent system of ward social rules depends on high levels of staff-patient engagement. The authors' recommended systems of patient government, community meetings, and the initiation of staff-patient partnerships in the furtherance of these aims. Lanza et al's arguments about consistency corresponded with the views of Morrison (1989), but they found that autonomy and low staff control produced fewer assaults. These results contrasted with Alden (1978) findings in which similar factors increased patient hostility.

Patients classed as personality disordered may react particularly adversely to limit setting. Johansen (1983) discussed the impact of the behaviour of patients with severe personality disorder within a hospital inpatient unit. He observed that this group often ignored ward rules because of their limited tolerance for frustration, and the perception that the rules do not apply to them. Johansen used a clinical vignette to describe reactions to arson within a psychiatric unit. Rules to prevent further arson became so complex that individual treatment plans were decimated. Many patients objected to the new rules. They made more demands on the staff and they responded with anger and withdrawal. Eventually a guard was employed to patrol the corridors during the night, and this measure together with the practice of not

allowing patients lighting materials continued long after the actual event had passed. Johansen used the vignette to illustrate a link between rigidity and reactive ward policy.

Johansen argued that constant flexibility must be used in order to provide individualised care, because as chronically ill patients may be neglected as a result of setting limits for personality disordered groups because manipulative patients frequently use rules to shift even more attention on to them. He maintained that these processes might be ameliorated if nurses employ greater rule flexibility, and explore the emotions that produce manipulative behaviour. Johansen argued for that rule flexibility should be combined with greater structure, and these recommendations may be very difficult to implement in practice. This view contrasted with Levinson and Crabtree (1979) recommendations. They advocated strict adherence to the rules at all times in order to avoid arbitrary decision making during crises.

Nurse patient interaction and ward rules

Three studies focussed on the relationship between nurse patient interaction during rule enforcement and aggressive incidents. Two studies highlighted the manner in which nurses enforced the rules from the perspective of power relations and levels of high expressed emotion.

Patient violence may be precipitated by the way that nurses' manage issues of control. Roper and Anderson (1991) described how violence might be provoked when nurses denied patients' requests, and enforced the ward rules. The researchers conducted independent research projects within two different care settings and patient populations. They conducted open-ended interviews with patients and staff on the topic of physical restraint. Medical notes were used to collect data on individual patients and the restraint episode. Observations were conducted for six months, but no information was available on the number of staff who were interviewed and the means of selection.

Common themes emerged in relation to issues of control, and the interactional dynamics of violence within the wards. Roper and Anderson found that the staff focused on the topic of control during the interviews. Staff patient interactions associated with control centred on two issues. Nurses used the ward structure to maintain control, and they denied patients' requests. The authors gave an example of a ward incident that was provoked by rule enforcement. The nurses prevented a patient from going to bed outside of a designated rest period, and the researcher interpreted the intervention as controlling, but this incident may have been observed in isolation from the context of overall nursing care. The researchers perceived counter-transference reactions amongst nurses, and interpreted the intervention negatively, but they may have been acting in the patient's best interest. For example the patient may have been suffering from sleep reversal. The nurses remained firm in the face of the patient's aggression, and the incident culminated in seclusion. The researchers' negative interpretation of limit setting may be compared with Kologjera et al's (1989) perspective. They positively interpreted a firm approach, as did Levinson and Crabtree (1979).

Ward rules may be used to exert power over patients. An observational study was based on the hypothesis that nurses use ward rules as a means of exercising power over patients. Hewison (1995) claimed that most nurse patient interactions were superficial, dominated by routine and task centred. The study was conducted within one care of the elderly ward over a three-month period, and the author generalised the findings to embrace all nurse patient interactions. Hewison argued that nurses controlled

interactions, gave orders routinely and used language to exert power over patients. Extracts from hand-written field notes were given in support of the findings, but equally valid non-controlling actions may have been unreported because of the author's pre-conceived ideas. Presumably the author was unable to observe every interaction, or what went on behind the scenes.

Hewison gave an example of an observation that was interpreted as controlling in which a nurse prevented a patient from returning to bed after breakfast. However this interpretation may have been divorced from the overall care context, and the intervention may have been motivated by concern for the patient's welfare rather than by the need to exercise power.

The way that nurses interact with patients during the course of their duties is associated with violence, and this includes rule enforcement. Whittington and Wykes (1996) found that 86% of assaults against nurses were associated with the adverse stimulation of patients. The authors analysed how frequently violence was preceded by a nursing approach or a demand that patients' perceived as unpleasant. The study was conducted on 13 wards psychiatric hospital wards. Participating wards were visited daily, and nurses were asked to provide information on any patient violence in the preceding 24 hours. Witnesses and assaultative patients were interviewed in order to test the reliability of the reports. The authors identified three main types of aversive stimulation, which included frustration, perceived attack and activity demand. The authors pointed out that nursing interventions may frustrate, induce discomfort or place demands on patients, and argued that all of these staff behaviours fall into the category of a caring professional relationship. They recognised that patients' mental states might cause them to misinterpret non-aversive staff behaviour. However they suggested that certain nurses behaved unprofessionally with the deliberate aim of aversively stimulating patients, e.g. by insulting, threatening or criticising them. This study elaborated on the work of (Lanza 1988; Morrison 1989) All of these authors studied the association between patient aggression and the role of nurses.

Finnema et al (1996) analysed the association between rule enforcement and levels of high expressed emotion amongst nurses. The study was conducted within six long stay wards. The researchers used a five-minute speech sample method and the level of expressed emotion scale to measure the levels of high expressed emotion used by nurses during interactions with schizophrenic patients. The authors hypothesised that in order to control difficult situations nurses may create ward environments dominated by rules, and they designed an educational programme to help them use alternative interventions with psychotic patients. Then they assessed whether the programme had any measurable effect on the nurses' levels of expressed emotion, and if these changes produced alterations in patients' mental states or social functioning. Finally they assessed whether changes in the ward rules occurred as a result of the intervention. They used the Hospital Hostel Practices Profile in Wykes et al (1982) as a baseline measure of the number of ward rules Finnema et al found that the levels of nurses' expressed emotion did not decline, but the number of ward rules decreased particularly relation to restrictions on activity and personal belongings. They measured the total number of ward rules at two different intervals. They fell from a mean of 24 to 18, and the authors attributed the decrease to the effect of the educational programme. Confounding factors could have caused the change, and they did not use a control group. The way that nurses' were recruited to the study was unclear, and self-selection could have biased the results. Observer effect might also have influenced the decrease in ward rules. The study augmented Whittington and Wykes (1996) findings in that high expressed emotion may evoke negative reactions from

patients in the same way as aversive stimulation. However high expressed emotion is different in that nurses may unconsciously rather than deliberately display these attitudes during interactions with patients.

A patient orientation brochure was produced, and this included information about the rules. A daily community meeting for staff and patients was introduced so that issues related to rules and other problems could be dealt with as they arose. It was difficult to ascertain how these improvements were achieved, but the authors claimed that patients perceived improvements in four out of five social climate areas as a result of the changes in structure. However nurses perceived that they had less control of the ward. The study built on previous research that advocated rule clarity (Bensley et al, 1995; Morrison 1989).

Non-compliant patients may be secluded. Muir-Cochrane and Harrison (1996) identified an association between the use of seclusion and rule breaking. They used grounded theory to study seclusion within two closed acute psychiatric wards in Australia. Seven qualified nurses with an average of eight years experience took part in the study. A semi-structured interview format was used to collect data, which covered the nature of nursing interventions and the skills employed by nurses in the seclusion of patients. A core category 'controlling' emerged in the practice of seclusion, and this was associated with the social processes involved in the maintenance of control within the two wards. The staff set limits on what was considered as acceptable or non-acceptable behaviour, and these restrictions depended on individual patient responses to the personalities of particular nurses. For example one nurse stated that patients knew what she was like, and what her limits were. Patients were forcibly restrained and secluded if they did not comply with behavioural limits or medication.

The authors stated that the findings were not generalisable, but perceived that they provided a rich insight into the use of seclusion. However it was unclear which patient behaviours needed to be controlled. References to breaches in the rules were made in terms of safety or medication refusal. However the grouping of diverse behaviours meant that information on individual incidents together with the antecedents and consequences were lost. The authors stated that the study participants volunteered, but self-selection bias might have occurred, and it is unclear whether the group of nurses who were interviewed were a representative sample. Predisposing attitudes and beliefs might have led them to volunteer, and this might have influenced the results of the study. Observer effect, and the authors' preconceived theorising or perceptions might also have distorted the data. The study echoed the findings of Roper and Anderson (1991) in which nurses made constant references about the need to control patients.

Ward rules and patient aggression

Two papers associated patient aggression with limit setting, but the authors did not investigate whether aspects of nurse patient interactions triggered incidents. Lanza (1988) studied the relationship between ward rules and patient assaults. This retrospective, epidemiological study evaluated 24-hour ward reports to identify incidents of patient assault. All assaulted nurses were interviewed to elicit information about the incident, and their relationship with patients. Ward environmental characteristics were retrospectively compared, and Lanza found that many assaults on nurses (32%) occurred within the context of limit setting. She stated that nurses set limits in the interests of patients, but conflict ensued when they imposed the rules, particularly about smoking. Lanza gave examples of limit setting which included moving

patients to another area of the ward, removing cigarettes, lighting materials and using physical restraints. Many assaults also occurred when nurses gave routine care to patients such as showering and dressing.

Lanza found that nurses had difficulty remembering what patients said prior to the incident. She categorised what was recalled as swearing, making demands that conflicted with nurses' requests and threats. However nurses recalled that many attacks from patients took place in silence, without warning and with intent to do harm. The type of contact between nurses and patients preceding the attacks was reported, but specific details about the interactions were missing. There was no way of knowing how the staff approached patients, or what they said to them prior to the attack. Lanza stated that nurses had difficulty recalling the interactions, and the study concentrated on their reactions to the attacks. This was a pilot study and Lanza stated that a prospective study could eliminate the problem of recall, and obtain more detailed information.

The findings were impressionistic because Lanza used a retrospective method to collect data, and the study grouped diverse behaviours together. Information about the antecedents and consequences of individual incidents were missing, and this meant that there was no way of knowing whether aspects of the interaction triggered patient aggression. The author leant towards psychopathology as an explanation for patient aggression. The findings contrasted with Alden's (1978) study in that the ward regimes that Lanza described also appeared highly structured, and yet patients did not seem to be intimidated by nurses. The patient groups in Alden's study withdrew and isolated in response to high levels of staff control, but Lanza's subjects tended to exhibit aggression when attempts were made to control them. This finding reflected the reactions of patients who were nursed within the less controlling wards in Alden's study.

However Alden recorded nurses patient interactions, and Lanza studied violent incidents rather than patients' perceptions. The patient samples in both studies also differed in that Lanza included psycho geriatric groups, and their misperceptions of the environment or of nursing interventions might have produced aggression. Despite the differing methodologies it did appear that the nurses in Lanza's study might not have been over-controlling in their attitudes towards patients, and if this was the case psychopathology could have influenced aggression.

Psychiatric nurses often utilise rules in order to deny patients' requests. Nijman et al (1997) examined the incidences and circumstances of patient aggression within a closed acute psychiatric admission ward. The study described the location together with the characteristics of aggressive incidents, and the researchers used the Staff Observation of Aggression scale (SOAS) to record them. They found that out of 164 violent incidents 32% were precipitated because the staff denied patients' requests. Fifteen incidents of violence were caused by other factors, such as when staff asked patients to take medication or help with activities of daily living. The study provided a useful framework for prevention, but there was no way of knowing whether the actual interaction between the patient and nurse triggered the incident. The denial of patients' requests may not have been the only precipitant, and Nijman et al recognised that communication problems between patients and staff might be an important cause of aggression. This study expanded on previous studies that explored the relationship between the frustration of patient autonomy and aggression (Roper and Anderson, 1991; Morrison, 1989; Lanza 1988).

Ethnicity

One paper focused on the relationship between rule enforcement and patients' ethnicity. Flaherty et al (1981) used the Ward Atmosphere Scale. They administered the scale to 17 black patients and 17 white patients within the same ward, in order to test whether they perceived the ward atmosphere differently. This article was pertinent because it contained a discussion on the association between the application of ward rules and ethnicity. The authors previously identified significant treatment differences between black and white patients within a psychiatric unit. The major finding was that white patients had a longer duration of stay, and more black patients left the ward against medical advice. White patients were also given more autonomy than black patients, and this led the authors' to the hypothesis that treatment variance might result in different perceptions of the ward environment

The results indicated that the two groups perceived the overall ward atmosphere differently, and the authors argued that the decreased privilege levels of black patients caused them to perceive the ward environment more negatively. The authors acknowledged that cultural differences might lead black patients to expect psychiatric wards to be less restrictive. They might form negative impressions during admission to the wards, and their reactions might increase staff defensiveness. Consequently nurses might place greater restrictions upon black patients, and display more rigidity. The restrictiveness of regimes may also evoke reduced spontaneity and autonomy in this patient group.

It is possible that there are other explanations for differences in the perception of both patient groups that may be specific to the ward in Flaherty et al's study. A diagnostic survey found no significant differences, but the sample was not differentiated by chronicity, and it is possible that this could account for some of the responses of black patients. A larger sample might also have increased the significance of the findings, and revealed more differences between black and white patients. However some statistically significant findings did emerge from the study.

Consistency

Two papers by the same author discussed the relationship between consistent rule enforcement and patient aggression. The results of the second study conflicted with the findings of the first. Another paper focused on the effects of role ambivalence on nurses' attitudes towards rules enforcement.

Morrison (1989) devised a theoretical framework for patient violence and 57 nurses collected data on 162 hospitalised patients within four hospitals. Ward rules were central to her theory and were defined as the expectations that nursing staff hold for patient participation in daily living, for example rules on smoking and visiting. She used inductive and deductive methods for the study. The methods generated from personal clinical experience and from a qualitative study. Morrison's clinical experience led her to believe that disruptive patient behaviour is associated with inconsistency between nurses, and lack of agreement about ward rules. She used grounded theory, and explored the perceptions of 11 registered nurses in relation to their expectations of patient behaviour, and of violence. The results supported the belief that different expectations of behaviour were a main factor in patient violence, Morrison used Gibb's paradigm to organise her ideas. Within this framework a specific psychiatric patient is perceived as moving through a series of stages. At each stage aspects of nurses' expectations, and patients' responses were predicted to influence violence. Gibbs (1972) developed a formal theory of control. He defined the concept of

attempted control as overt behaviour motivated by an individual's belief that the action increases or decreases the probability of some subsequent condition, and that the increase or decrease is desirable.

Morrison differentiated the therapeutic from the social rules in stage one of her model. The social rules were defined as the expectations nursing staff had for patient participation in group living. The social rules were usually precise, for example rules about smoking or visiting, and nurses gave patients direct information about them. Morrison hypothesised that social rules might not be enforced by an individual staff member with a particular patient that they were caring for on a daily basis.

The therapeutic rules were defined as the expectation that nurses' had for patients' participation in treatment. They included involvement in individual, group and family therapy. Morrison hypothesised that staff may treat patients differently in relation to the therapeutic rules. She envisaged that patient resistance; hostility, chronicity, and frequency of admission were factors that might be associated with inconsistent rule enforcement.

During stage one of the development of the model Morrison hypothesised that nurses might give patients inadequate information about compliance with ward and therapeutic rules. In stage two she hypothesised that patients might not meet behavioural expectations because they could not the rules. She based this theory on previous studies, which revealed that psychiatric patients had difficulty in performing expected behaviours during hospitalisation. Morrison linked these studies with the stage one hypothesis of the model to test the relationship between nurses' inconsistent communication of both types of rules and patient compliance. She constructed scales to measure different variables associated with the social and therapeutic rules. Then nurses completed the personal therapeutic rule scale, the general therapeutic rule scale, the social rule scale, and the social behaviour scale with one patient a week whom they cared for on a daily basis. They did this for a total of five patients each, and completed the violence scale on patients (Morrison 1993) at discharge.

The results showed that a rise in the inconsistent application of the social and therapeutic rules was associated with an increase patients' inability to adhere to them. The patients' inability to adhere to the social rules was associated with an increase in violence, but there was no correlation with breaches in the therapeutic rules and violence. The inconsistent interpretation of therapeutic rules explained 45% of the variance in patients' inability to adhere to them. The inconsistent enforcement of the social rules explained 9% of the variance in patients' inability to keep them, and in turn this accounted for 8% of the variance in violence. Morrison identified a direct negative association between the inconsistent application of the social rules and violence. Then she examined the statistical significance of the model, and added other descriptive variables. This model identified five predictors of violence, which included the discrepant interpretation of the therapeutic rules, the inconsistent enforcement of the social rules, a diagnosis of schizophrenia or substance abuse and the patient's inability to adhere to the social rules.

Later, in 1994 Morrison discussed the results of the study, and found that they conflicted with an earlier pilot study, in which nurses associated inconsistency with violence. The findings had revealed a statistically significant relationship between inconsistency and violence, but they did not predict even an average degree of violence. She suggested that inconsistency might not be as crucial as many nurses believe, and the results brought into question the efficacy of violence prevention interventions based on consistency. Morrison argued that the direct negative association between the inconsistent application of the social

rules and violence suggested that certain incidents occurred when nurses were consistent. When she included a sample of all patients from participating units in the data the findings indicated that schizophrenics were not violent, and substance abusers were. Further a history of violence preceded aggression, and duration of stay was associated with inconsistent staff expectations.

Morrison perceived that the model had poor predictive power, and this may be because of inherent design problems. The nursing staff sample was almost equally composed of nurses and aides. It seems likely that this might produce discrepancies in the interpretation and enforcement of the social and therapeutic rules. Differences in training and experience might have distorted the findings because both groups might have approached patients differently and might achieve different outcomes. The scales were designed as an objective means of gathering data, but staff members may have interpreted patients' behaviour differently. Differences in their psychological, social and cultural background may have led them to interpret patients' responses in various ways.

Morrison's definition of therapeutic rules was confusing in that she gave an example of patient self care, but she did not explain why this was a therapeutic rather than a social ability. She also gave an example of an item from the social rule scale in which patients should be able to be considerate of others whilst using ward facilities, and this seems to be a fairly trivial aspect of social behaviour to give as an example. Diverse behaviours were grouped together, and it was difficult to identify which specific aspects of nurse patient interaction influenced patient outcomes. The use of quantitative methods in the form of rating scales to assess qualitative interactions was problematic. Morrison acknowledged this when she referred to the poor predictive power of her (1989) model, and she went on to use qualitative methodologies to gather data on patient violence. This study elaborated on previous articles that advocated persistent and clear limit setting for psychiatric patients, but it also casts doubt on their recommendations (Jungman and Bucher, 1967; Levinson and Crabtree, 1979; Bursten et al, 1980).

Role strain and ward rules

Two papers referred to the conflicts experienced by staff over the use of authority. The responsibility for implementing institutional rules may conflict with the moral values of nurses. Lutzen (1990) used participant observation, grounded theory and a phenomenological perspective to study nurses' experiences of therapeutic relationships with patients. The data revealed a conflict between the dominant psychiatric ideology and nurses' own ideology. Four of the emergent categories were concerned with rules.

- Following the written rules indicated compliance with the authority of the hospital. There were written rules for the daily schedule, ward meetings and tasks. There were also policies for emergencies like patient violence and the use of restraints

- Following the unwritten rules referred to an implicit staff agreement that not all written rules could be adhered to in practice. One nurse stated that she deliberately medicated a patient who was not sectioned against his will, and got the doctor to support the action later. The mutual application of unwritten rules occurred when a patient knocked on the office door during handover, and none of the staff responded because they were following the unwritten rule that patients were not permitted to interrupt staff meetings

- Limiting autonomy was categorised as all the activities that restricted the patients' part in making decisions about their own care. The nurses felt that these activities conflicted with their basic values, but they believed that they were responsible for protecting patients. Locking the ward door was given as an example of a problem that was a frequent issue for debate

- Disagreeing with the institutional ideology was categorised as the way in which nurses experienced their situation in caring for patients. Medication was a major problem because doctors did not always inform the patient that they were prescribing or changing medication. The nurses also felt that they were pulled between implementing restrictions on patients ordered by the doctor, and maintaining the trust of the patient. Lutzen stated that the interviewees' felt that they were not free to give authentic psychiatric nursing care. They experienced a lack of autonomy, and although they had not internalised the norms and values of the dominant psychiatric ideology they felt forced to comply with it. One of the ways in which these conflicts were dealt with was by maintaining a professional role. This was used as a strategy for maintaining impartiality and emotional distance from patients. Examples of this strategy included analysing patients' behaviour, not engaging in casual conversations with them, wearing uniform and emphasising the ward rules. Group alliance was another way of managing ideological conflict, and nurses received psychological support from co-workers who were most in sympathy with their ideology

The number of interviews, means of selection, grade and experience of the nurses was not given, but a control group of seven experienced nurses from another hospital was mentioned. Self-selection bias may have occurred within the nursing staff sample that participated in the study. There was no way of assessing whether the interviewees were a representative sample. Their predisposing attitudes and beliefs might have led them to volunteer, and this might have influenced the results of the study. Observer effect, pre-conceived theorising and perception might also have distorted the data. Nevertheless this was one of very few studies in the literature that tackled the moral dilemmas that nurses face in relation to rule enforcement.

In a descriptive study Watkins (1979) discussed anxiety over the use of authority as a major problem that can undermine staff morale and damage the function of residential programs. He maintained that most of the conflict over the use of authority could be minimised if staff were clearer about the goals they were trying to achieve through the implementation of clear boundaries. He argued that the appropriate use of authority provides order and security. It mirrors the larger social system to which the person will return, and helps them to acquire self-control. He recommended changes in the organisational system, and further training for staff in the use of authority. He cited Merton (1940) who argued that interpersonal relationships within bureaucracies are founded on role and function instead of personal feelings. Watkins stated that clinicians must reconcile their own feelings of ambivalence about the use of authority and limit setting. He argued that if people understand that their authority is legitimate because it is delegated by society through the institution, and if they do not exceed this remit they will become comfortable with the use of control. He pointed out that clients require the security of firm boundaries from staff together with therapeutic engagement. He argued that both needs can be reconciled and need not conflict. He argues that staff must keep the clients need for firm boundaries uppermost in mind when setting limits to avoid

manipulation. One flaw in Watkin's recommendations appears to be that he does not appear to consider the use of clinical supervision.

Rule clarity

Two papers centred on the importance of rule clarity in the prevention of patient aggression. The importance of giving patients clear information about ward rules emerged in a study by Bensley et al (1995) that compared the views of hospital staff and patients. The authors investigated situational and interactional aspects of ward incidents involving aggression. Sixty-nine patients from eight high assault wards in two state psychiatric hospitals were interviewed about environmental and policy factors that they associated with their assaultative behaviour. A random number of wards were selected, and a questionnaire survey involving 137 nursing staff members was conducted.

The results showed that patients and staff shared many concerns. These included restrictions on smoking and access to the outdoors. However only patients identified lack of rule clarity as an important factor in influencing assaults. The authors suggested that certain incidents might be avoided if nurses clarified the rules. Further if patients were given increased access to the outdoors and to smoking areas assaults against nurses might decrease. The study recommendations reflected Morrison's (1990) recommendations for rule clarity and consistency.

Mistral and McKee (2002) analysed the impact of therapeutic community principles on a high care 14-bedded ward for the management of detained patients. The interventions incorporated improvements in communication regarding the aims and clarity of ward rules. Clear rules and sanctions were created, and communicated to all staff and patients. Rules related to smoking, alcohol, the use of illegal substances, and communal responsibility for the maintenance of the environment. This study augmented previous research that advocated rule clarity (Bensley et al, 1995; Morrison 1989).

Sanctions and ward rules

Two papers discussed the relationship between decision making, and the moral judgements that staff make in the application of sanctions for patients' misdemeanours. Richardson (1995) argued that rules of conduct must be properly devised, and established by statute in consultation with patients. Rule justification must be directly associated with the detaining authority's duty to maintain safety and control. Sanctions must be relevant, and the rules must also be applied fairly and accurately. Rule breaking should be investigated in an open and independent manner with the involvement of the patient. Richardson argued that this process would facilitate careful treatment objectives and accurate reports. She believed that this process could be therapeutic even when patients are not considered to be responsible for their actions because they are very ill. She advocated this system for serious breaches in the rules such as fire setting, assault, the use or possession of drugs, the possession of weapons, pornographic, sadistic or morbid material and sexually threatening behaviour.

She recommended the use of an independent investigator who was not associated with the clinical team, and that the duration of a disciplinary sanction should not be dependent on an improvement in the patient's mental state. If a therapeutic response was instituted this should be carefully explained to patientsso that they did not regard the measure as punitive.

Richardson's ideas are good in that they provide structure and consistency in institutional responses to serious breaches in the rules. However the sanctions might be difficult to apply because of the inconsistent opinions of those involved about the culpability of patients with mental health problems. Even when the implementation of the policy is designed to be therapeutic the process might place severely ill patients under considerable duress and exacerbate their symptoms. The efficacy of therapeutic sanctions might also be undermined, and it would be very difficult for patients who went through what amounted to a trial process to believe that the application of sanctions was for their welfare. A formal process of sanctions may not seem inappropriate for use in mental health settings, but a modified version of the system might provide a consistent, and less arbitrary response to rule breaking by psychiatric patients.

The number of ward rules may reflect the social climate of the ward. Aubrey et al (1996) administered the Ward Atmosphere Scale to staff and patients to measure the effect of changes in the environment of an acute psychiatric ward, which had relocated from a mental institution to a general hospital site. The data was used to inform program development. Specific changes were implemented, which included limiting searches of newly admitted patients and allowing them to keep personal possessions. The ward door was left open more frequently, and a decrease in routine checks on patients was instituted. The pass system was reviewed, and a policy was developed that reflected the patients' different levels of functioning. The pass system is the means whereby decisions are made about when patients are allowed to leave the unit, for what length of time and when they must return.

Crichton (1997) studied the moral judgements that nurses make when patients break the rules. He used a case vignette design, and showed nurses videotape of one patient assaulting a nurse, and of another patient setting off a fire alarm in the absence of a fire. The vignettes were shown to a representative random sample of nursing staff from a range of psychiatric settings. The vignettes incorporated variables such as the patient's gender, race, diagnosis, statements about a history of violence, and a report about the result of the incident. The participants were asked to rate the management of the incident, and the questionnaire included one question that was designed to measure perceived moral responsibility. Nurses were asked whether they felt that mental disorder was responsible for the incident, and how much was due to the patient's free choice or lack of self control.

The results showed that nurses considered that two groups of fictitious patients acted out of choice or lack of self control, and they were classified as personality disordered or schizophrenic with a past history of violence. The nurses who blamed mental disorder for the incident preferred medication management, and those who perceived that patients could exercise choice or self control favoured sanctions. Three factors emerged from the results, which included the containment of unsafe patients, the treatment of underlying illness and moral blame. Crichton identified a censorious element in the responses, and argued that this raised questions about the regulation of nurses' reactions towards patients who break the rules. He recommended the development of a system that acknowledges the influence of moral judgements, and the introduction of procedures that might ensure justifiable responses. The essential components of the system included staff training, clinical supervision, multi-disciplinary decision-making and policies for patient appeal.

Crichton recognised that the vignette design provided little background information, which meant that the patient's behaviour was isolated from the context. Consequently nurses' judgements could not be interpreted as real life responses. He did not consider that the participants' personal experiences of patient

violence might influence the degree of censure. Crichton's recommendations reflected Richardson's (1995) ideas in that he advocated a system that might ensure fair and appropriate responses towards rule breaking. However he focused on the role of nurses in making moral judgements about patients, and Richardson concentrated on formalising responses after the decision was reached. Both studies made an important point about the need to regulate institutional responses to patient misdemeanour. Arbitrary or subjective responses may lead to the inappropriate or punitive imposition of ward rules and sanctions.

A comparative study by Crichton et al in 1998 compared the attitudes of Canadian and British nursing staff towards the management of patient misdemeanour. Nurses were shown case vignettes, and completed a semi-structured questionnaire. The Canadian results mirrored the findings in Crichton's (1997) study in that responses involving moral censure were perceived as more useful. The results showed that the use of medication and seclusion received higher ratings in the Canadian sample. Conversely talking and relaxation techniques were rated higher in the British sample. Crichton et al acknowledged that differences in the data collection methods, and in the work experience of the participants may account for these results, but the authors also hypothesized that differences in the base rate of serious violence in North America might be a factor.

Crichton (1999) examined staff attitudes towards disruptive behaviour ingroup homes for people with a learning disability. Moral judgement emerged as a major factor. Appearance, degree of learning disability and apparent danger were major variables in staff conceptions of the degree to which residents were judged to be morally responsible for their actions. This study augmented Crichton's (1997) findings in which he also recommended stronger management systems to counter the effect of censoriously driven responses to patient misdemeanour. Crichton acknowledges the limitations of the case vignette design, which divorced the incident from its social context, but he did not seem to consider that staff that had experienced violence might give more censorious responses.

Institutional influences

One paper investigated the influence of the institution in the development of authoritarian attitudes amongst nurses. The effect of a culture of control on the behaviour of nursing staff is pertinent to a study of ward rules. Morrison (1998) used causal modelling to test the hypothesis that staff might display rigid attitudes towards patients if they perceived that organisational structures neglected personal development and relationship issues in favour of control. Earlier on Morrison (1990) found that a controlling institutional culture was reflected in the authoritarian attitudes of nurses, and resulted in environments in which they evoked patient aggression through over control. She used the work environment scale (WES Moos 1981) to assess aspects of the social climate together with the opinions about mental illness scale (OMI Cohen & Struening 1962), which measures authoritarianism and social restriction. She used the violence scale (VS Morrison 1993) as a measure of patients' aggressive behaviour, towards self or others and property, and the social desirability scale (SDS) (Crowne and Marlowe 1980) to test the tendency of subjects to respond in a culturally sanctioned manner. A representative sample of nursing staff volunteers from three different state hospitals took part.

Morrison found that the most controlling staff placed greater emphasis on maintaining the organisational system, and they also believed that the mentally ill should be socially restricted. She found that younger nurses who were less satisfied with the organisation perceived more aggression and violence amongst

patients. An authoritarian ideology did not predict aggression, but other aspects of control, for example system maintenance and social restrictiveness were predictive. Morrison identified satisfaction with the hospital as the predominant emergent variable. Staff that expressed satisfaction perceived less emphasis on rules, and perceived that management provided them with greater support. They were more committed, supportive towards colleagues, autonomous, dynamic, innovative and comfortable with their physical surroundings. The results stressed the importance of analysing the effect of nurses' satisfaction with the work environment on clinical outcomes such as aggression. Morrison found that males were more authoritarian than females, and that nurses from lower socio-economic backgrounds were more controlling than those from higher groups. She concluded that over controlling attitudes amongst staff might stem from a combination of individual characteristics and organisational factors.

Morrison did not appear to consider that staff from lower socio-economic groups might not be highly trained, and they might also be in most contact with patients. If this was the case they might experience greater difficulties in handling the behaviour of psychiatric patients, and this might cause them to be more restrictive. In my own experience it was common practice to expect male nurses to manage the situation and protect female nurses when patients were aggressive. Greater exposure to patient aggression may result in more controlling attitudes amongst male nurses, and this might account for the higher incidence of this variable in Morrison's analysis. Male nurses may strive to fulfil the expectations of colleagues, and they may assume defensive stances to counter the threat of patient aggression. The study augmented the work of previous authors on the authoritarian attitudes of ward-based nurses. (Alden, 1978; Roper and Anderson, 1991; Hewison, 1995)

Absconding

One paper highlighted an association between ward rules and absconding by acute psychiatric patients. There is evidence that patients abscond because of restrictions placed upon them when they are in hospital. In a prospective study of absconding Bowers et al (1999) interviewed patients who had absconded from acute admission wards. Data about the absconding incidents and the actions taken by nurses was collected within twelve wards. Fifty two patients were interviewed after they returned to the ward.

The authors described several groups of angry leavers, and showed that one in four absconders left angrily. The researchers identified diverse reasons for absconding, and some aspects of the data are pertinent to a study of ward rules. One group of 'angry leavers' left in reaction to a stimulus. Requests for leave, for discharge, and a variety of other frustrating factors precipitated absconding. Another group of patients who suddenly left the ward were more likely to be compulsorily detained in hospital. The opportunity to leave, or unpalatable information about leave or restrictions might result in an immediate abscond. A large number of absconders (one in four) were annoyed with the staff and left the ward suddenly. Some patients described how they had tried to present well at ward rounds, but were refused leave or discharge in a way that made them feel demeaned. The authors remarked that patients may be devastated by negative responses to their requests, and these reactions may be further complicated by mental disorder.

Another group of angry leavers appeared to be involved in a conflictual relationship with psychiatry. They expressed unhappiness with enforced treatment, restrictions on freedom, and being kept in hospital

despite feeling well. All of these factors caused anger and frustration. Conflicts were exacerbated or reactivated by the restrictions imposed on them by nurses. These limits were associated with community living (e.g. smoking rules) or might be more serious and related to compulsory treatment under the mental health act (e.g. medication enforcement). The study linked absconding, which could be viewed as a form of rule breaking with the insensitive application of ward rules, and with the trivialisation of patient requests. The role of psychiatric nurses in evoking aggression and other negative reactions in patients during the performance of their duties emerged in several of the studies that have been reviewed e.g. (Roper and Anderson, 1991; Whittington and Wykes, 1996)

Psychodynamic theory

Two papers applied psychodynamic theory to the topic of rule enforcement. Psychodynamic theory may provide nurses with an alternative perspective on the role of ward rules in patient care. Kologjera et al (1989) used psychodynamic theory in a paper describing the therapeutic use of seclusion in the management of disruptive adolescent behaviour. The authors reflected on their clinical experience and employed psychodynamic concepts to support their interventions with patients. The authors believed that parents of aggressive adolescents failed to provide secure boundaries, within which children may experiment safely with new behaviours in socially acceptable and safe ways. Crichton (1998) discussed how psychodynamic theory might help staff to understand and respond to rule breaking. Classical psychodynamic theory gives a perspective on internal control and rule keeping. He drew a parallel between the encouragement of compliance with psychiatric ward rules and the parental function. He discussed how patients' previous experiences of poor parenting might be re-enacted by the institution if staff are not helped to manage the feelings engendered by rule breaking. These papers elaborate on Watkin's (1979) article he also perceived that the staff that are in most contact with patients adopted parental roles, but did not consider that psychodynamic influences might have an impact on the use of authority.

Discussion

The literature review identified an association between ward rules and patient outcomes, but the findings did not provide sufficient information for evidence based nursing practice. Nurses conducted most of the studies, and several themes emerged from the results.

Most of the studies highlighted the association between nurse-patient interaction and ward rules. A highly consistent relationship between these factors and patient aggression was replicated in the findings of several studies. Arguments about the importance of rule clarity and the consistent application of ward rules emerged from the literature. The absence of these factors was linked with patient aggression. Absconding may be viewed as a hostile act, and one study associated this behaviour with ward rules. The findings showed that patients reacted adversely when nurses responded insensitively towards their requests.

Several studies advocated highly structured environments for the modification of aggression and the improvement of patient outcomes, but an almost equal number concluded that rigid environments engendered patient violence. One author found that patients perceived nurses' inflexibility as caring, but

another researcher discovered that rigidity elicited withdrawal and isolative behaviour from patients. The literature was divided in respect of the pros and cons of highly structured environments, and needs to be more firmly grounded in evidence. The division of opinion means that we do not know whether inflexible or flexible ward nursing regimes produce better patient outcomes.

The three psychodynamic articles in the review provided an alternative, and perspective on the use of ward rules. The authors argued that highly structured environments could emotionally as well as physically contain patients. Firm boundaries and fairness may provide a corrective emotional experience particularly for personality-disordered patients. However even when a consistent theory was used the conclusions drawn were very different. Two of the authors argued for the consistent and firm application of rules during ward crises, and one author advocated flexibility to prevent the development of rigidity. In general studies that identified the specific rules that were imposed together with the antecedents and consequences seemed to be missing. Most of the studies provided no rich textual information about the actual content of nurse patient interactions.

Issues surrounding the use of sanctions against patients who breach the rules were explored, and one author advocated the institution of formal processes. Another study analysed the association between patient diagnoses and the moral judgements that nurses make. However only one study considered whether rule imposition was ethically justifiable in terms of patient outcomes. One researcher analysed the ethical conflicts that nurses experience during the course of their duties, but it is surprising that there were no studies that focused on the ethics of rule implementation. This issue may be highly sensitive in that it may highlight the relationship between punishment and treatment within psychiatry.

Ward rules are a means of removing the rights and privileges of patients. The deprivation of rights is linked with coercion as well as issues of patient and public safety. The potential to abuse ward rules to elicit patient compliance is not fully explored, and this is where issues about treatment and punishment converge. The boundaries between the treatment of psychiatric disorder and the control of behaviour are often blurred. A study that explores nurses' ethical decision making processes in relation to rule enforcement and non-compliance might illuminate this grey area. There was an obvious lack of studies that investigate the relationship between race and rule implementation, and only one study was found that explored this topic. A study that focuses on the association between ethnicity and ward rules might help to define a framework that might target the management of psychiatric patients from ethnic minorities. This might show that ward rules and policies should be revised to reflect cultural diversity.

During the course of their work psychiatric nurses impose rules on patients. Rules are employed in the provision of a safe ward environment, and to contain patients whose mental state may cause risks to themselves or to others. The view that patients are not just objecting to rule imposition during violent incidents emerged from the literature, and so does the argument that aggression is not solely produced by psychopathology. There was evidence that the way nurses interact with patients is a causative factor, and one study revealed that nurses used deliberate provocation. The authors concluded that aggression might be viewed as a rational and understandable patient response to provocation. Several researchers intimated that the way in which nurses approach patients during rule enforcement is important for the prevention of aggression. Issues associated with the controlling behaviour of nurses emerged in seven studies, and with one exception they all linked rigidity with patient aggression. The studies indicated that patients might refuse to comply and become aggressive when nurses impose the rules in an insensitive or punitive

manner. Conversely patients may view rules positively if they perceive that nurses employ restrictions out of concern for their welfare. None of the studies focused on rules specifically. The data that was related to ward rules tended to group diverse behaviours, and most studies failed to identify specific aspects of nurse patient interaction. Information about the rule that was being implemented and interactive elements were lost.

The review identified a gap in the literature in relation to a specific and comprehensive study of ward rules. The evidence pointed to an important relationship between ward rules and patient aggression. In turn this was linked with nurse patient interactions during rule enforcement. The literature review did not produce sufficiently firm conclusions on which to base an investigation of the relationship between the flexibility/inflexibility of ward nursing regimes and patient outcomes. An in depth study of ward rules addressed this important issue.issue. Arguments for the efficacy of high or low structure were divided. The gap in the literature in relation to a specific study of ward rules provided further insight into which information might answer the general research questions. The review contributed to the conceptual framework of the study. and showed which aspects of the phenomenon were not clearly understood, where this information might be found, and who might be the informants.

CHAPTER 2

METHODOLOGY

METHODOLOGY

Aims of the project

To discover the content of ward rules within acute psychiatric admission wards; to explore patients responses to the rules; to evaluate the impact of rules and rule implementation on nurse patient relationships, and on ward events; and to investigate the relationship between ward rules, ward atmosphere and ward design.

Preliminary field study

Pilot observations and informal interviews took place within two acute psychiatric admission wards in the East End of London. Five members of staff and four patients were asked to identify the ward rules, and to discuss how they were applied or used as sanctions. They were also asked to talk about the most common and important rules together with their purpose. Questions were also asked about how patients were informed about rules, and about the consistency of application. This information was used to create a list of topics and as a basis for study design.

Study design

This was an exploratory primarily qualitative study, with some additional quantitative data that contrasted two wards, using interviews and non-participant observation. The wards were assessed for atmosphere, rule variation, incident levels and PRN medication usage.

Sample

The study took place within two NHS Trusts in the East End of London. The wards were mixed gender, sectorised acute admission wards with bed numbers of 19. The wards were situated within two hospitals at different sites in the East End of London. They were selected because it was thought that they might contrast well. In a previous study by Bowers et al 1999 the results showed wide variations in absconding between the wards. For ethical reasons they are referred respectively as Y and Z ward. I attended nursing and patient-staff meetings to explain the study, and worked for a span of duty on both wards to familiarise myself with the regimes. This gave staff and patients the opportunity to ask questions about my role and the study aims.

A convenience sample of qualified, unqualified; student nursing staff and patient volunteers were interviewed. The staff sample was opportunistic in that I visited each ward for two days per week, seeking a time when the ward was quiet enough for a staff member to be released for interview. I identified a convenience sample of patients, and approached them individually following consultation with staff. The final sample consisted of 30 patients and 29 staff.

Instruments

Interviews

The information on rules that would be useful to collect and explore was identified through the literature review, the preliminary field study, and thoughts about the topic, discussion during supervision and City University Mental Health & Learning Disability departmental research team meetings. Then suitable questions were formulated for inclusion in a semi-structured interview schedule for patients and staff, which are included in the appendix. The interviews were conducted between November 1999 and March 2000. They were taped and fully transcribed by a transcribing agency. Then the documents were imported into QSR NUD*IST for analysis, and a thematic interpretative phenomenological approach was used to analyse them.

Ward data

Information on ward incidents and PRN (as required) medication levels was collected during every visit to the wards. Patients' drug sheets, ward incident record books and nursing handover reports were scrutinised. The type and frequency of PRN (prescribed as required) medication was identified and a running total was kept. The number and type of minor and major doses of tranquillisers was extracted from the patients' drug sheets. Retrospective records of ward incidents were extracted from ward incident books and nursing handover reports during each visit to the wards.

Periods of non-participant observation were used to monitor the frequency of references to ward rules by staff and patients. This data was collected through periods of general observation, attendance at nursing staff handovers, consultant ward rounds and patient staff community meetings. Four days of every week were split between the wards. All nursing handovers were attended, and daily periods of non-participant observation of approximately 4 hours per day was undertaken in between conducting interviews. Community and multi-disciplinary team meetings were accessed opportunistically.

Patients and staff completed the Hospital Hostel Practices Scale (Wykes et al 1982); this is a 52-item checklist on hospital and residential nursing home practices, and it is included in the appendix. The list incorporates restrictions on activity, possessions, meals, health and hygiene, residents' rooms and services.

Patients and staff completed the Ward Atmosphere Scale (Moos 1974). This 100 item rating scale measures perceived social climate, which enables patients and staff to give their opinions on the usual behaviours and expectations of a ward environment. This scale is included in the appendix.

The ward data was collected between November 1999-and March 2000.

Interviews

The interviews were semi-structured, and focused on the content of ward rules within each ward, how and why they were applied, how much information is given to patients about them, their use as sanctions, team consistency in implementation, visibility, relative importance, purpose, and opinions and feelings about rules.

Development of pilot

The questions were developed and discussed with the City University Department of Mental Health and Learning Disabilities research team, and amended with particular attention to the use of prompts. The interview format commenced with less intrusive factual questions, and worked towards a central focus. The interview opened with background and knowledge questions. Then sensory questions led into experience, opinion and feeling themes, and six categories emerged as per the following list. The questions for each category were designed so that both patients and staff could answer them:

- Routine questions about the background characteristics of participants.
- Knowledge questions directed at discovering what factual information the participant possessed about ward rules. It was important to find out what the person regarded as fact as opposed to opinion, belief and attitude.
- Experience or behaviour questions, focusing on what the nurse or patient was doing currently or had done recently in relation to ward rules. The aim was to elicit descriptions of experience, behaviours or activities that could have been observed but were not.
- Opinion or value questions were designed to discover what participants thought about ward rules, and focused on goals, beliefs, attitudes and values.
- Feeling questions were directed at emotional responses to experiences involving ward rules.
- Sensory questions were designed to explore what the participant had seen or heard in relation to the rules.

The interviews were planned to last for 45 minutes, but when the interview schedule was piloted within an acute psychiatric ward in the Netherlands this time schedule proved inadequate. A ward manager, three qualified nurses and one nursing assistant were interviewed and the depth of content varied considerably between individuals. More experienced staff sometimes took one and a half hours of interview time. The interview pilot drew attention to the importance of focusing on the questions, and demonstrated that it would be easy to collect interesting but potentially irrelevant data, which might prove difficult to manage during analysis. The final version may be found in appendix 1.

The Hospital-Hostel Practices Profile (HHPP, Wykes et al 1982)

This schedule was identified during the literature review, and was used as a means of gathering baseline data on what staff and patients actually believed the operational rules were on the ward. The instrument was used by Wykes et al to explore the relationship between the practices of day and residential units in relation to the social behaviour of attendees. The 52 questions refer to the ordinary daily practices of a unit, and not to special arrangements for particular individuals. A rating of zero means that the practice is not used, and a rating of one means that it has been adopted. A copy of the HHPP may be found in appendix 2.

The Ward Atmosphere Scale (WAS, Moos 1974)

Nurses and patients were asked to complete the Ward Atmosphere Scale, which measures 10 different dimensions of the atmosphere and ideology of an organisation or unit. It is a self-report questionnaire composed of 100 statements about the ward, each requiring a true or false answer. The subscales of the WAS reflect aspects of relationships, treatment and maintenance systems within the ward. The last three subscales are particularly relevant to this study because they incorporate ward rules and expectations of patient behaviour. A copy of the WAS may be found in appendix 3. The 10 dimensions and subscales are as follows:

The Ward Atmosphere Scale (WAS, Moos 1974)

Involvement	How active patients are in the functioning of the programme
Support	How much patients support each other, and how staff supports them
Spontaneity	How much patients are encouraged to act openly and express feelings
Autonomy	How independent patients are in making their own decisions
Practical Orientation	How much patients are orientated towards leaving hospital
Personal Problem Orientation	How much patients are expected to be concerned with their personal problems and feelings
Anger and Aggression	How much patients are allowed to argue, express anger and display aggressive behaviour
Order and Organisation	How much emphasis is placed on order and organisation within the ward regime
Programme Clarity	Clarity of goal expectations and rules
Staff control	The extent to which staff use measures to keep patients under necessary controls

Non-participant observation

Periods of observation were used to focus on nurse patient interaction in relation to ward rules. I rarely interacted with patients or staff, and spent time in the ward office or sat amongst patients in the day areas. I attended nursing staff handovers and Consultant Psychiatrists' ward rounds. Observation during the latter was abandoned on 19.12.1999 because ward rounds were too time consuming (4 hours per week) for the amount of relevant data that was collected. Patients and staff were aware that observation was taking place, and an information poster was placed in the day area to this effect. This may be found in appendix 4. Field notes were taken at the time of observation, but if this was not possible notes were written immediately afterwards. The field notes were transcribed and imported into QSR NUD*IST for analysis.

Preparation for the study

Prior to commencement of the study managerial and clinical support and permission was obtained. Directors of Nursing, Nurse Advisors, Ward Managers and Consultant Psychiatrists were approached, and letters of approval may be found in appendix 5. Prior to the commencement of data collection I met with ward managers, nursing staff and patients to explain the project. I also worked for one span of duty within both wards, in order to become familiar with the wards' routines, and as a means of planning the data collection.

Ethical approval

Ethical approval for the study was granted by the ELCHA research ethics committee on 22.11.99, reference N/99/071. The letter of approval may be found in appendix 6. Full information about the aims of the study and the methods was given to participants prior to interview. Copies of patient, staff and student information sheets may be found in appendix 6. No patient was approached for interview unless the ward staff confirmed that they were well enough to participate. Signed consent was obtained from patients and staff prior to interview, and a copy of the consent form may be found in appendix 7.

Data analysis

Quantitative data analysis

The WAS and HHPP scores were entered into SPSS. The interview descriptives from the QSR NUD*DIST database were imported into the SPSS file. The data was analysed for descriptive frequencies, and t tests were used to compare means. PRN medication levels and ward incident rates were recorded in the field notes. Triangulation was used in the interpretation of interview data, using ward data, field notes from non-participant observation, together with the WAS and HHPP results.

Qualitative data analysis

Thematic and interpretative phenomenological methods were used in the analysis of the data which was assisted by QSR NUD*IST. In summary this is a package for qualitative analysis, which incorporates a tutorial, and comes with a manual. It facilitates searching and indexing, supports the development of themes, and provides tools for listings. NUD*IST has a database for text and interview information. It also incorporates a coding content and structure database. Factual categories are used to describe nursing grades and the names of wards for example. Referential coding describes concepts like rule enforcement or consistency. Its range of functions also includes an advanced text search; indexing search and it can be used with other software programmes such as SPSS for the import or export of data. The project database is for text documents that can be browsed and edited. A second node database facilitates the creation of ideas; themes and all the relevant data can be coded there. These categories or themes can be reorganised, deleted, named and linked or merged.(Gahan and Hannibal 1997).

Factual coding

The transcription of patient and staff interviews began when the first six interviews were completed, and continued for some weeks after data collection had finished. The transcripts were loaded into NUD*DIST, and codes were developed for the background characteristics of the participants. Factual categories were created following discussions with the rest of the research team during meetings and my supervisor Everything pertaining to each case was put under a node for each value (e.g. Female) and below a node for each variable (e.g. Gender).

Referential coding

The transcripts were listened to and read several times. Extensive lists of key words and phrases that frequently appeared in them were extracted, and wide-ranging lists were made. A database text search for key words was initiated, and the items that emerged were read. Those not pertaining to the topic were identified and discarded. A series of codes was developed for the remaining material, and the documents were coded into these categories. Similar categories were clustered and analysed for patterns and themes, and interpretations were constructed based on questions about emergent themes. This material formed the basis of the results chapter headings. This process was discussed at departmental research meetings, and suggestions were received in relation to coding. At every stage the work in progress was monitored, and suggestions were received from my supervisor.

Certain categories were merged, and others were separated as this intensive reading of the data led to an in depth understanding. The QSR NUD*IST index tree or coding frame was adapted in line with each phase of the computer assisted analysis. The computer's capacity to do a mechanical search for a string of characters cannot replace the researcher's ability to interpret the text. However qualitative research entails access to the data, and searching text gives quick, precise access to the actual words and phrases occurring in the data. The search terms, which were used, appear at the beginning of each results chapter. QSR NUD*DIST gives a text search report showing the exact text units found, with finds in upper case, and gives some statistics about finds. For example the text search for the consistency between staff and over time section yielded approximately 44 text units. Certain finds were inappropriate, and they were discarded. However other finds were merged with other key words and phrases.

The text units were attached to a node that was labelled to denote the topic. The node system codes all the text units at which finds are made. The database finds every incidence of a string of characters, and codes all text units with finds at the new text search. It also puts that node on the node clipboard so that it can be merged or attached elsewhere in the index system. The finds were browsed, and the extracts were spread so that they could be reflected on in a wider context. Ideas were recorded in the document annotation facility. Coding was added to expanded documents, and where appropriate the text was merged with other nodes. In this way a wider selection of text was assembled around documents.

MEMOS

Concurrent with the above process notes were written on the underlying reasons for particular codes. The text searches were printed, and the extracts were read a number of times. Comments were made in the margins. These included summaries, associations and preliminary interpretations. The themes that emerged were listed separately, and were then clustered. Then they were categorised into overall themes while checking back with the original transcripts to make sure that the themes actually were related.

This enabled the process of creating a theoretical understanding of the categories, which was used as a link between the categorisation of the data and the writing up of the results. As the categories were refined they were clustered with the aim of beginning to formulate associations between categories. This process often took me back to the basic coding in order to maintain a thorough analysis of the data. A narrative account was constructed across groups of topics across transcripts. Examples from the transcripts were used to support the themes that developed (Riley, J. 1990; Miles & Huberman 1994). The number of references that pertained to each topic was noted to aid the comparison between wards, and they appear in the results chapter under the comparison sections.

Interpretative phenomenological approach

Inferences were made from the clustered themes. The essence of the interviewees' descriptive answers were extracted from the data that made up the themes. The findings were described from the perspective of the participants rather than being subjected to a theoretical interpretation. The actual words used by the participants to describe their experiences were used to join the central ideas expressed by the participants.

> *"A synthesised structure is a statement conceptualised by the researcher joining the core concepts. The structure as evolved answers the research question, 'what is the structure of this lived experience".* (Parse 2001 p.11).

Then the results of this analysis were moved up to another conceptual level to represent the meaning of the lived experience at the level of theory. For example nurses descriptions of their feelings in relation to rule enforcement were merged as role ambivalence. This concept was supported by examples from the transcripts. Other possible explanations for the data and the connections between them were checked by returning to each text unit in the cluster and ensuring that it fitted with the emergent theory. (Burns and Grove 2001; Smith, Jarman and Osborn 1999).

CHAPTER 3

DISCUSSION OF METHODS

Discussion of methods

Rationale for the choice of design

The interactive nature of the phenomenon under study (ward rules) lends itself to a qualitative perspective. Ward rules cannot be understood, imposed, or obeyed without the dynamic process of nurse-patient interaction. Therefore the concept of creating meaning through the context of the nurse patient relationship, and the patient's experience of being subjected to ward rules emerges. Phenomenological concepts of lived space, time and body are particularly relevant to psychiatric wards. Psychiatric patients are often confined against their will, and subjected to institutional life in surroundings that afford little privacy. Their autonomy may be severely restricted, and they may be subjected to enforced treatment.

The rules structure the daily life of the ward, but research into this area is limited, and it is difficult to define concepts and variables, or to generate hypotheses for a quantitative study. Moreover, quantitative research frequently seeks to obtain knowledge about social reality by explaining why something happens, whereas qualitative research aims to understand the interpretations and motivations of people (Cormack 2000). A qualitative design was chosen for this topic because within a ward situation there is much more going on than stimulus response processes in relation to the rules. There are connections to be made between meaning and interaction, with nurses and patients assuming an active decision making role (Strauss and Corbin 1990)

The study aimed to gather information on the content of ward rules; patients' responses to rule imposition; the impact of rules and rule implementation on nurse patient relationships and on ward events; and the relationship between ward rules, ward atmosphere and ward design. In order to fulfil these aims it was necessary to study these variables from the patients' perspective in terms of what they thought and did about ward rules. It was also necessary to similarly investigate nurses' perceptions and behaviour. This was particularly important because the literature revealed a link between rule imposition and patient aggression. A quantitative approach would have reduced the field of study into distinct variables from which to generalise and predict behaviour, and could explore which rules were most likely to be broken and by whom. However this design would not fill the research gap that was identified from the literature review because it would not reveal the antecedents and consequences that are associated with rule breaking.

A quantitative approach would not reveal interactive aspects of ward rules either. Glazer and Strauss (1967) opened up the possibility of exploring nurse patient interaction. They linked philosophy with quantitative and qualitative research approaches. They strove to understand the life experiences of individuals, and used phenomenology as a basis for their theory in which human interactional processes are viewed as dynamic and meaningful. Polit and Hungler (1997) defined four aspects of lived experience that interest phenomenologists, lived space or spatiality; lived body or corporeality;lived time or temporality; and lived human relation or relationality.

During their stay patients' experiences may involve restrictions on freedom. They may have to share accommodation or facilities with people that they do not know or might not choose to be associated with. Disordered thought processes may influence reactions to the environment and towards others. Their social

relationships with those close to them may be curtailed, and interactions with nurses may involve limit setting. Additionally they may be subjected to enforced confinement and medication. The psychiatric inpatient nursing role may also be perceived in phenomenological terms, and it also embraces the elements described by Polit and Hungler. Therefore the use of this theory in the analysis of the data is important because it may highlight nurse-patient interactional processes and experiences together with the influence of the social context in which they occur.

Rationale for the choice of mixed methods

The use of quantitative methods provided a means of building a more complete picture of ward events associated with the rules. Quantitative data was collected to support and validate the qualitative methods. This was important because the times for non-participant observation was limited, and even when I was present certain nurse-patient interactions or ward events were inaccessible to me because they took place outside the field of observation. Although qualitative data produced descriptive information quantitative data demonstrated the distribution patterns of rules, PRN medication which might reflect levels of rule breaking, incidents and perceptions of ward atmosphere within both study areas. This data augmented, clarified and questioned the interview material and field notes. A purely quantitative method might have measured only part of the phenomena in isolation from the context, but when combined with qualitative methods views situations and historical events may be revealed (Reimer-Leininger 1985).

However Morse (1994) argued that qualitative and quantitative methods are based on different philosophic assumptions, and should not be mixed. She argued that mixing methods violates the purpose of each, and that qualitative studies uncontaminated with quantitative statistical methods are needed to obtain deep insights into unknown areas of nursing. Morse stated that the primary function of quantitative methods is to substantiate theory, and qualitative methods have been designed to discover theory. Further, she held that in order to discover theory it is necessary to explore the diverse experiences of people in a dynamic social situation by discussing their interpretations of the world.

It is precisely because the limitations of quantitative methods were recognised that the study methods are primarily qualitative, but this choice does not negate the usefulness of them in confirming and measuring known variables. Moreover, it could be argued that a qualitative method could be influenced by my biases and theoretical orientation. I spent 18 years in clinical practice, which included various managerial roles, and I studied Counselling Psychology. So an analysis of the data could be skewed by my preconceived concepts and assumptions (Pincus and Minahan 1977). Consequently the inclusion of quantitative methods enabled me to separate myself from the phenomenon under study to a certain extent, and remain more objective.

Morse (1994) stated that the primary focus of quantitative methods is to substantiate, whereas qualitative methods are designed to discover theory. Further, she argued that in order to discover theory it is necessary to explore the diverse experiences of people in a dynamic social situation, by discussing their interpretations of the world. Various methods were discussed with my supervisor, but after weighing up the relative significance of collecting qualitative as opposed to quantitative data it was decided that a predominantly narrative form would be more appropriate. Primarily because it might facilitate the emergence of important issues, which would be supported, contradicted or complemented by the quantitative data. A quantitative methodology would have stripped the data from the social context, and

would not have explored the individual experiences of those involved. This perspective is summarised by Porter in Cormack 1991:

> "*Qualitative analysis is concerned with describing the actions and interactions of research subjects in a certain context, and with interpreting the motivations and understandings that lie behind their actions*". p.330

Reimer-Leininger (1985) argued that qualitative and quantitative methodologies need not conflict, and may provide complementary data sets, which together give a more comprehensive view of the topic under study. Strauss and Corbin (1997) referred to the interplay between qualitative and quantitative methods. Further Miles and Huberman (1994) pointed out that both types of data are useful for descriptive, investigative and exploratory purposes. They recognised that the use of pre-designed instruments such as the semi-structured interview schedule and the WAS that were incorporated in this study might narrow the focus of data collection. If the instruments are too limited this might mean that important phenomena are missed However they also argued that if the aims for data collection are clear, which they were in this case, then there is no reason to enter the field without prior instrumentation. They also stated that lack of structure might lead to the unfocused collection of unnecessary information resulting in a surfeit of data that may jeopardise the efficiency and power of analysis. The timescale for this study was limited by financial constraints, and this prompted a structured approach towards data collection, which might have been difficult to achieve if a grounded theory approach had been used for example.

Design alternatives

As stated previously alternative approaches to the topic were considered;for example a correlational design could have explored differences in the level of rule breaking between non-psychotic and psychotic patients. Or this type of study could have measured behavioural differences between ethnic groups in relation to ward rules. However, this approach is based on the assumption that all human behaviour can be measured, and that universal principles can determine and predict human behaviour (Tarling and Crofts 1998). This type of study would not identify the antecedents and consequences surrounding rule breaking, which could have exerted more influence than diagnoses or ethnicity. The grouping of diverse behaviours would for example conceal, which specific rule or type of nurse patient interaction triggered non-compliance Moreover the literature review identified an association between rule implementation and patient aggression with a gap in knowledge around this area.

An experimental design could have been used; for example an information booklet on ward rules could have been given to one group of patients, and withheld from others. Then differences in the level of rule breaking between the two groups could have been measured, but it would have been difficult to conduct this sort of study within an acute psychiatric setting for various reasons. Polit and Hungler (1997) use a health promotion example to describe the problems with this design. In the case of ward rules an experimental design would have been impractical, because there would be no way of knowing whether acutely mentally ill patients had actually read and understood the information. Further, the knowledge that they were part of an experimental group could give rise to the Hawthorne effect, and this rather than the booklet might be the cause of behavioural change (Cormack 2000).

The control of variables other than the manipulated variable would also have been difficult, as would attempts to match control group subjects with subjects in the experimental group. Patients may have

similar diagnoses but the way that individuals respond to rules is unique, and their responses may be a manifestation of pre-existing character traits or the result of social conditioning. The results of an experimental study could also be challenged on the grounds that changes might be due to the effect of time passing. Patients might become resigned to admission and to the regime, and be more inclined to adhere to the rules because of this.

A prospective design was considered whereby incidents involving rule breaking are monitored, and those involved are interviewed soon after the event. However this approach was unworkable within acute psychiatric wards-for practical and ethical reasons. An exploration of the incident might exacerbate a tense or potentially violent situation. Miles and Huberman (1994) write about the vulnerability of study participants, and the importance of reducing the risk of harm.

The choice of the most appropriate methodology was also based on my own personal orientation. I spent 17 years in clinical practice before commencing this study. During this time nursing experience was gained in managing psychiatric in patient units, and through community psychiatric nursing. My clinical experience was combined with further studies for an honours degree in Social Dimensions of Health and an MA in Counselling Psychology. Strauss and Corbin (1997) acknowledge that the preference or experience of the researcher is a valid reason for doing qualitative research. However they argue that a stronger case for validity stems from the nature of the research problem, and that a qualitative method is appropriate for understanding the meaning, nature or experience of persons with problems. The literature review identified an association between rule implementation and patient aggression with a gap in knowledge around this area. My background gave me the underpinning knowledge and experience to conduct a study of this type.

> *"The researcher's role is to gain a " holistic (systemic, encompassing, integrated) overview of the context under study: its logic its arrangements, its explicit and implicit rules".* Miles and Huberman (1994) p. 6

Sample

The wards were chosen because they were geographically close, serve similar populations demographically, with similar bed numbers and admit patients with similar mental health problems. The wards participated in a study by Bowers et al (1999). The results showed that Ward Y had the lowest and Ward Z had the highest rates of absconding of the twelve participating wards. It was thought that these wards might contrast well, and that this study might contribute to an understanding of the worrying problem of patients who abscond.

A convenience sample of 30 patients and 29 nursing staff were interviewed. This sampling method was largely determined by the study context and time constraints. If random sampling had been undertaken the study period would have been much longer, because the selected patient might have been too ill to be interviewed, and ethical requirements dictated that patients could only be interviewed if staff gave permission. Initially nurses were interviewed by appointment, but these arrangements rapidly gave way to opportunistic methods. Appointments were frequently cancelled because of low staffing levels, patient numbers, acuity and ward incidents. Random sampling was not viable because staff numbers on each ward approximated the required sample size, and in order to obtain the required number of interviews I had to interview every willing member of staff.

The risk of bias in the patient sample was possible, because those who agreed to participate may have possessed different characteristics than those who declined. The number of non-Caucasian participants was lower, and there were more refusals among this group. It is possible that a degree of bias was engendered by the amount of control staff had over who was suitable for interview, and that some patients may have been excluded because of their antipathy towards the ward regime. Only one patient refused to be tape-recorded.

Sampling bias in the nursing staff sample did not occur because the total complement of staff and students from both wards needed to be included in order to obtain comprehensive data. One member of staff from each ward refused to be interviewed, and one nurse refused to be tape-recorded. It is possible that the nurses felt under pressure to comply because everyone was being interviewed.

Interviews

The decision about what sort of interviews to conduct was partly determined by the study setting, by time and by financial constraints. The patients were acutely mentally ill, and suffered varying degrees of psychological distress. Most were receiving major tranquillisers to control and stabilise their mental state. It was predicted that this patient group would have difficulty sustaining interaction if unstructured interviews had been used, and that this format might have placed them under too much duress. Therefore for both practical and ethical reasons a semi-structured interview format was chosen.

The disadvantage of structured interviews is that important information that does not correspond with the interview schedule that structures the interaction may be missed (Cormack 2000). Semi structured interviews were chosen because they are designed to elicit both definitive and spontaneous kinds of information (Reimer 1985), but a more unstructured format might have given a less interrogatory impression to the study participants. The questions were asked in an unthreatening way, but might not been perceived as such by participants. On the other hand unstructured interviews could have gathered superfluous and unmanageable amounts of data. Cormack (2000) points out that a lack of structure may mean that participants may not say anything of relevance to the topic. Another important advantage in using semi structured questions was that the format enabled me to guide psychotic patients back into the interview schedule when they began to express deluded speech, and in some instances the structure prevented the interview from slipping into a counselling mode.

During the course of the interviews it became apparent that certain nurses and patients had difficulty with one of the categories. The particular phraseology of the experience and behaviour questions might have been at fault, or some people might have experienced difficulty conceptualising in this way. When the study was presented at a PhD student seminar it was suggested that use of the Delphi technique might have been appropriate. The questions could have been systematically refined. I could have elicited the views of experts and asked them to rank statements in order of importance (Cormack 2000). A version of this process was carried out with other members of the City University Department of Mental Health and Learning Disability research team at the start of the project, and in retrospect it may have been advisable to repeat this exercise when a certain number of interviews had been conducted to discuss responses to the questions.

It is possible that the responses of staff were inhibited by the study context, and by a perceived need to provide information that would put the wards in a good light. The fact that interviews were conducted within the wards may have inhibited responses from nurses and patients. The interviews were conducted in private but space was scarce. This meant there were frequent interruptions, and I was requested to move elsewhere because someone else needed the room. The questions may have raised the anxieties of participants because of the association between rules, sanctions and punishment. Questions about the regime were asked in the midst of ward life, and daily events were audible. A different setting away from the ward might have elicited less guarded responses, but this was not possible because of constraints on staff time and patient safety. The interviews were conducted within a condensed period of time. There was little time to reflect on the emergent data, and consequently certain subtle aspects of interaction may have been lost in the process. Cormack (2000) recommends the spacing out of interviews to counteract this problem, but the time for completion of the study was limited.

Pilot interviews

The pilot study was conducted in order to:

- Test the process of data collection and analysis
- Ascertain the appropriateness of the questions
- Practice interviewing skills

The effectiveness of the questions and the order of presentation had to be tested to ascertain whether they would elicit appropriate responses from the interviewees. Cormack (2000) points out that each question must mean the same thing to each interviewee if there is to be standardisation of data. Therefore the order of questioning and the wording has to be effective in order to gain access to the topic under investigation. The pilot study was invaluable because this exercise validated the questions, and enabled clarity. This experience also gave me the confidence to conduct the interviews in a focused manner because I was so familiar with the questions and the tape recording equipment. During the pilot phase I realised that the interviewees tended to veer from the topic of the question, or they might suddenly remember a salient fact, and I learnt to guide them back to the point without losing the momentum of the interview. This experience was invaluable later and prevented me from placing the interviewees under duress by taking up too much of their time in repeating the questions.

The Ward Atmosphere Scale

The ward atmosphere is difficult to define and may be interpreted in different ways. Non-participant observation enabled me to describe the context in which the qualitative data was collected, but the accuracy of these observations could have been influenced by my own perspective, as discussed earlier (Cormack 2000). I could have conducted more interviews, and used questions designed to gauge the ward atmosphere. It was perceived that the WAS might counteract the possible biases of the study participants as well. The WAS is used widely within psychiatry because it is perceived to be a reliable instrument for the measurement of an abstract phenomenon.

The scale may be used to describe, compare and focus on the determinants and outcomes of treatment environments (Moos 1974). It was chosen as a means of comparing environmental differences between

the two acute psychiatric admission wards in the study. Individual WAS profiles reveal individual perceptions of the treatment programme, and can be used as a means of triangulation to support or contradict interview data. Most patients needed help to complete the scale because their concentration was impaired, and it is difficult assess whether bias occurred because of the loss of anonymity. Psychiatric patients may perceive themselves as powerless and vulnerable, and may be loathe to criticise the ward environment because of this.

The Hospital-Hostel Practices Profile

The HHPP was chosen as a method of data collection because it is a basic checklist measuring the operational practices of psychiatric units. As such it provided data, which could be used as a means of comparing and exploring differences in the rules between the two wards. It could be used to quantify, and to explore variations in the rules between the two wards in this study. This scale was the only method that was found that measures the knowledge and beliefs of staff and patients about ward rules. It has the advantage of being quick and easy to complete, but it is not entirely appropriate for this study because it was designed for long stay psychiatric units rather than acute facilities.

Ward incidents

This data was gathered to provide a further means of exploring the ward regimes, and as a method of triangulation. The literature review revealed an association between the implementation of ward rules and patient violence. Consequently it was thought that ward incident information might uncover new facts and meanings (Cormack 2000). This data was collected retrospectively, and was limited by the methods that staff used to record ward incidents. They only recorded basic details of the antecedents and consequences of the incident, and the documentation might have been distorted by reporting bias. However the length of time when I was present on the wards was limited, for example incidents took place at night. Even when I was present it was impossible to be party to every event that occurred in other areas of the ward.

PRN medication levels

This data was collected to provide a further means of comparison between the two wards in the study. It was thought that levels of PRN medication might be linked to patients' adverse responses to rules, and to non-compliance. This containment measure may be used to control aggression or elicit compliance, and as such levels of PRN medication may be indicative of rigidity or lack of ward structure. However PRN medication may also be used to control extremely distressing symptoms. Checking the medication records with the ward incident book enabled me to distinguish for what purpose PRN medication was used for that particular patient. When this was hard to decipher I asked the staff to clarify the event.

Non-participant observation

Non-participant observation provided a context for the interview data. This method was confined to social situations and interactions involving rules because the time for data collection was limited. If the classic method of participant observation had been adopted I would have worked as a member of staff. This would entail caring for patients and imposing ward rules whilst remaining objective enough to describe social situations without being directly influenced by them. Participant observation might have provided a

deeper understanding of the motives of psychiatric nurses as they interacted with patients, but this would have restricted my understanding of the patients' perspective. Non-participant observation prevented me from forming biases towards the participants, which could have skewed my perceptions of ward events and the interpretation of the interview material.

The staff appeared to accept my presence at least overtly in the ward' offices, at nursing hand-over and ward rounds. I was excluded from staff meetings on both wards, and was asked to leave after a hand-over on Z ward on one occasion because the nurses wanted to have a private discussion. On reflection I believe that I should have asked more questions during periods of observation, but did not do so at the time because I was wary of increasing staff tension in my presence. However, greater interaction with staff might have diffused, rather than increased any anxiety they may have felt about being observed. If participant-observation had been possible I might have gained an insider's view of the staff group and they might have been less inhibited by my presence. The non-participant method tended to intensify feelings of being an outsider because I had worked as part of a nursing team in the past. However this method made it possible for me to retain a degree of objectivity, and to perceive situations from the nurse - patient perspective. The following quote supports the view that participant observation might have pulled me into the social world of the wards, and I might have lost the ability to perform the research function.

> *"This is extremely important, because insiders do not view the world from this standpoint, and once you become even somewhat familiar with the setting, its initial newness and strangeness also will be lost".* Jorgensen (1989) p. 57

Analysis

The issues to be studied within the thesis were located within a sociological theoretical framework with particular reference to symbolic interactionist approaches as detailed in the introduction. Symbolic interactionism focuses on the meanings, which individuals assign to events. Although they are of principal significance those meanings are only obtained through a method of interpretation. Qualitative research asks different sorts of questions than quantitative studies. Important questions in this study are what really goes on during rule enforcement and why, and what do participants feel about their involvement in controlling or being controlled. This kind of study may reveal very important information about the way that psychiatric nurses operate at ward level in relation to ward rules, when faced with the kind of organisational problems that were previously described. It is compatible with the aims of clarifying the skills that nurses use during interactions with patients involving rules. These interactions tend to be routine, and the rules underlying the structure of the ward may not be clearly visible to patients or staff. An analysis of their perceptions of these issues may be used for the benefit of both parties involved.

The strengths of this type of analysis are that it fully engages the researcher with the data. The material is read slowly, and there is less risk that quotes will be used to illustrate preconceived ideas. The way that the data is managed is clarified, and the theories that emerge relate to the experiences of the participants. This makes the method particularly appropriate for the aims of the study, in that it can show how the interviewee's conceptions of ward rules are related to their social context. It can help to show how patterns in complex relationships, such as interactions with nurses that involve rules, affect patient outcomes. However one of the problems may be that a reliance on coding text units may result in a constant pressure to place them in separate categories rather than viewing them as associated with wider themes or accounts. This may mean that the words of the participants not placed in the correct context,

and are assigned to categories created by the researcher. An in depth knowledge of the data was acquired during the course of the analysis. Intensive searches and coding of the interview transcripts in combination with a process of constant comparison ensured that themes and interpretations that emerged were completely supported by the basic data.

An interpretative phenomenological approach tries to understand how the participants themselves make sense of their experiences. Consequently it is concerned with the meanings that they hold for the person. This process attempts to explore the perceptions descriptions, experiences and circumstances instead of trying to create an objective account of them. Although the researcher tries to get close to the participants' own world this cannot be achieved directly or completely. Access depends on the researcher's own concepts, which are needed to understand the personal world of the other through the interpretative method. Throughout the process I collaborated with, and received analytical input from members of the City University School of Nursing and Midwifery Mental Health Research Team, which included my supervisor. Additionally my supervisor monitored and assessed the progress of analysis, and gave me tutorials on the use of the QSR*Nudist database. This input was an essential part of the data analysis, and helped to identify significant issues, as well as serving as a means of addressing reliability.

As previously stated the interpretation of the data could have been distorted by my own concepts, which are influenced inevitably by my clinical and counselling psychology background. The range of quotations that were used to illustrate themes and the meanings of experiences to individual participants were supported by quantitative measures of how often they appeared. Consequently the comparison between wards sections in the results chapters begin with a summary of the main themes, and the number of times references to the topic were made by individual study participants. This was done in an effort to counteract bias, and to strengthen the analysis.

CHAPTER 4

QUANTITATIVE RESULTS

QUANTITATIVE RESULTS

Rationale and description of measures

Quantitative data was collected to build an integral picture of the study areas, and to strengthen qualitative comparisons of the regimes. Certain staff-patient interactions and events were not accessible even when I was present on the wards. When designing the study it was thought that qualitative data might produce descriptive information regarding ward rules on both wards, and quantitative data would demonstrate the distribution patterns of rules, PRN medication, ward incidents and perception of ward atmosphere. Information about the background characteristics of the interviewees was imported from QSR NUD*IST into the SPSS quantitative database for analysis.

The subscales of the WAS reflect aspects of relationships, treatment and maintenance systems on the ward. The last three subscales were particularly relevant to this study because they incorporate ward rules and expectations of patient behaviour. The WAS may be used to describe and compare treatment programs because it focuses on the determinants and outcomes of treatment environments. Individual WAS profiles reveal individual perceptions of the treatment programme, and can be used as a means of triangulation to support or contradict interview data. The scale enabled a comparison between staff and patients perspectives of the usual behaviours that were expected within both wards.

Patients and staff completed the Hospital Hostel Practices Scale (Wykes et al 1982); this is a 52-item checklist on hospital and residential nursing home practices. This schedule was used as a means of gathering baseline data on what staff and patients actually believed the operational rules were within the wards. The list incorporates restrictions on activity, possessions, meals, health and hygiene, residents' rooms and services. The HHPP was used to quantify, compare and exploring differences in the rules between the two wards. It was used to quantify the ward rules and to explore variations between the two wards in this study.

During routine visits to the wards information on ward incidents and PRN (as required) medication levels was collected. Patients' drug sheets, ward incident record books and nursing handover reports were scrutinised. Ward incident data was gathered to provide a further means of exploring the ward regimes, and as a method of triangulation. The literature review revealed an association between the implementation of ward rules and patient violence. It was thought that ward incident information might uncover new facts and meaning. PRN medication levels were monitored to provide a further means of comparison between the two wards in the study, as it was thought that this data might be linked to patients' responses to rules, and to rule breaking.

PRN (as required) medication levels

91 doses of PRN medication were administered to Z ward patients and 65 to Y ward patients during the data collection period. The amount of major tranquillisers used within Z ward was greater 36.4% (n =40) as opposed to 13.65% (n =21) within Y ward. This was calculated by separating doses of minor from major tranquillisers in drug record sheets.

Ward incidents

101 incidents involving aggression, attempted absconds and actual absconds were recorded within Z ward, and no incidents were recorded within Y ward during the data collection period.

TABLES

Ward Atmosphere Scale

Description of Table 1 and Sample

Table 1 contrasts the two wards using the Students t test. There were 13 WAS forms returned by patients and staff on Ward Y, and 18 returned by patients and staff on Ward Z.

Table 1 Ward Atmosphere Scale, Ward Y and Ward Z compared

WAS subscales	Ward Y	Ward Z	t	df	sig
Involvement	5.85	4.78	1.34	29	0.19
Support	6.77	6.00	0.97	29	0.34
Spontaneity	4.38	5.72	-2.15	29	0.04
Autonomy	4.69	4.50	0.38	29	0.70
Practical orientation	5.85	6.28	-0.60	29	0.55
Personal problem orientation	4.62	5.67	-1.63	29	0.11
Anger and aggression	3.85	5.39	-2.10	29	0.04
Order and organisation	6.46	5.00	2.01	28	0.05
Programme clarity	5.23	6.06	-0.92	29	0.36
Staff control	3.31	2.39	1.23	29	0.23

The table shows that there were significant differences between the wards in the subscales of spontaneity, anger and aggression. The table also shows a trend in the direction of significance in order and organisation. Ward Y scored higher on order and organisation.

Description of Table 2 and Sample

Table 2 contrasts the two wards using the Students t test. There were 13 WAS forms returned by patients and staff on Ward Y, and 18 returned by patients and staff on Ward Z.

Table 2 Ward Atmosphere Scale, Staff and Patients compared

WAS subscales	Staff	Patients	t	df	sig
Involvement	5.11	5.11	-0.38	29	0.71
Support	6.05	6.75	-0.87	29	0.39
Spontaneity	6.16	3.58	5.35	29	0.00
Autonomy	4.53	4.67	-0.28	29	0.78
Practical orientation	6.68	5.17	2.24	29	0.03
Personal problem orientation	5.63	4.58	1.60	29	0.12
Anger and aggression	5.11	5.11	-0.19	29	0.85
Order and organisation	6.05	6.75	-0.42	28	0.67
Programme clarity	6.16	3.58	2.74	29	0.01
Staff control	4.53	4.67	-5.33	29	0.00

The table shows that there were significant differences between patients and staff in the spontaneity, programme clarity and to a lesser extent in the practical orientation subscales. Patients perceived less emphasis than staff on these subscales of the WAS.

Hospital Hostel Practices Profile

Description of Table 3 and Sample.

Table 3 contrasts the two wards using the Students t test. There were 17 HHPP forms returned by patients and staff on Ward Y, and 16 returned by patients and staff on Ward Z.

Table 3 Hospital Hostel Practices Profile, Ward Y and Ward Z compared

HHPP subscales	Ward Y	Ward Z	t	df	sig
restrictions on activity	9.76	7.75	2.58	31	0.01
possessions	3.18	3.38	-0.34	31	0.74
meals	2.18	3.31	-3.03	31	0.00
health and hygiene	1.82	1.56	0.57	31	0.58
residents rooms	2.53	2.81	-1.00	31	0.33
services	2.53	2.31	0.55	31	0.59
total score	22.59	21.50	0.73	31	0.47

The table shows that there were significant differences between the wards in restrictions on activity and meals. The respondents perceived more restrictions on activity in Y ward, and more restrictions on meals in Z ward.

Description of Table 4 and Sample.

Table 4 contrasts patients and staff using the Students t test

Table 4 Hospital-Hostel Practices Profile, Staff and Patients compared

HHPP subscales	Staff	Patients	t	df	sig
restrictions on activity	8.20	9.69	-1.78	31	0.09
possessions	3.55	2.85	1.20	31	0.24
meals	2.85	2.54	0.72	31	0.48
health and hygiene	1.65	1.77	-0.25	31	0.80
residents rooms	2.85	2.38	1.64	31	0.11
services	2.15	2.85	-1.81	31	0.08
total score	21.60	22.77	-0.77	31	0.45

The table shows no significant differences between staff and patients' scores.

The interview sample

In the following chapters, the contents of interviews of staff and patients are presented. Fifteen patients from each ward were interviewed on the topic of ward rules, a described previously in the methods chapter. The modal age group was 35 – 44 years (n = 9), and 63% of the patient sample was of a white United Kingdom background, with small numbers from a range of other ethnicities reflecting the population of the wards catchment's areas. Half of the sample were male and half female, the largest two diagnostic groups were Schizophrenia (F20-F29, n = 10) and affective and bipolar (F30-39, n = 10) ref Followed by phobic anxiety disorder, obsessive compulsive disorder, neurotic disorder (F40-48, N = 7) and mental and behavioural disorders due to psychoactive substance use (F10-19, n =3) WHO (1992). 90% (n =27) of patients had a history of previous admission to hospital. The length of stay was 0-2 weeks 53.3% (n =16) and over 2 weeks 46.7% (n =14).

Fifteen nurses from one ward, and fourteen from the other study area were interviewed on the topic of ward rules. The modal age group was 25-34 years (n =14), and 44.8% of the staff sample was of a white United Kingdom background. The next highest ethnic group was white European 20.7% (n =6) with small numbers from a range of other ethnicities. Females comprised 48.3% (n =14), and males 51.7 (n =15) of the sample. The largest two grades of staff were students 34.5% (n =10), and Grade E nurses 20.7% (n =6) Equal numbers of D and F Grade nurses were interviewed, and B and G grades made up the remainder of the sample. The interviewees' nursing experience was over one year 44.8% (n =13) and 0-1 year 17.2% (n =5). Just over half of the staff had worked on the wards for less than 1 year 51.7% (n=15) as opposed to 37.9% (n =11) who had worked there for over 1 year.

To reiterate the aims of the study were to discover the content of ward rules within acute psychiatric admission wards; to explore patients responses to the rules; to evaluate the impact of rules and rule implementation on nurse patient relationships, and on ward events; and to investigate the relationship between ward rules, ward atmosphere and ward design. The quantitative results cast further light on answers to these questions. The results cast further light on possible solutions to the research questions in that they pointed to a variation in restrictions between wards. However the grouping of diverse activities made it difficult to identify which specific restrictions were involved. Higher perceptions of spontaneity, anger and aggression by Z ward staff and patients suggested adverse responses to the rules, and difficulties in relationships. Higher levels of ward incidents and PRN medication usage on this ward were indicative of rule breaking and aggression in relation to rule implementation. Following deliberation it was thought that the WAS results could be linked with the HHPP results in that patients might have reacted adversely to higher restrictions on meals. Again the grouping of diverse behaviours made it difficult to assess which specific behaviours were involved.

The higher score on order and organisation in the Y ward results, lower scores on spontaneity, anger and aggression and more restrictions on activity in the HHPP results were indicative of higher structure, or a more oppressive ward atmosphere. The low levels of ward incidents and lower usage of PRN medication might have been linked with higher structure and better organisation, but this results could also have pointed to an oppressive ward atmosphere. When the WAS results were linked with the HHPP scores it was conceived that lower restrictions on meals could also be a factor in less aggression and anger. Significant differences between patients and staff perceptions of spontaneity,

programme clarity and to a lesser extent in the practical orientation subscales might have been an indication of the impact of rule enforcement on nurse patient relationships. These results were also suggestive of a lack of rule clarity, and a therapeutic context for rule enforcement.

The qualitative chapters that follow aimed to provide a causal description for similarities and differences in the quantitative data. These results augmented, validated, explained, clarified and provided a reinterpretation of the findings in this chapter. (Miles and Huberman 1994)

CHAPTER 5

ENFORCEMENT OF THE RULES, PUNISHMENT AND AUTHORITARIANISM

ENFORCEMENT OF THE RULES, PUNISHMENT AND AUTHORITARIANISM

One of the most prominent features of the interviews, particularly those of the staff, was the material that discussed, or asserted points of view on, the enforcement of the ward rules. A first text search was conducted for terms related to the enforcement of rules. This included a search for the words: enforcement, enforce, application, implementation, imposition, insistence, coercion, compel, require, compulsory, make, execution, administer, apply, carry out, oblige, reinforce, require, urge, prescribed, punishment, penalty, sanction, discipline, correct, penalise, abuse, victimisation, punitive, chastisement. The items that emerged from the search were read, and those not pertaining to the topic were identified and discarded. The remaining material fell into four the following four categories:

- Role ambivalence
- General methods of enforcement
- Intimidation by patients and rule enforcement
- Punishment

However, in the course of conducting the analysis, it became apparent that there was a closely related body of material in the interviews that could loosely be identified as discussions about, or examples of, 'authoritarianism'. A second text search was therefore conducted, using the following words as search terms: authoritarian, bossy, strict, rigid, harsh, severe, domineering, dogmatic, tyrannical, coercion, coerce, bully, bullying, constraint, duress, force, intimidation, pressure, threats, browbeat, control, boss, call the tune, command, conduct, direct, dominate, govern, in charge, lead, manage, manipulate, rule, steer, supervise. The items that emerged from the search were read, and those not pertaining to the topic were discarded. The remaining material fell into four additional groups

- Paternalism
- Reflective practice
- Nurses' perceptions of authoritarian enforcement
- Patients' feelings about authoritarian enforcement

These two related qualitative analyses are presented together in this chapter, and supplemented by material from the fieldwork notes taken during non-participant observation, where these were relevant.

Role Ambivalence

Some nurses disagreed with certain aspects of ward regimes, and they expressed antipathy towards the psychiatric system. They perceived that they possessed little discretionary powers in relation to other members of the hierarchy, and they were burdened by responsibilities for the enforcement of treatment rules. They were concerned that feelings of empathy might be eroded through constant exposure to emotionally draining interactions with patients. They associated rule enforcement with power, and considered that these custodial aspects of the nursing role obstructed the development of therapeutic relationships with patients.

For some nurses, this ambivalence found expression in questioning the purpose of certain rules, and resentment about enforcement ... *why should I be telling an adult to go to bed? Yeah you have to go to bed now as if they are a child or something. (Ywstn11351).* Others believed that the regime was too rigid, but they attempted to conquer these feelings during enforcement.

> *If you think about it we tend not to let people out after eleven o'clock at night. I mean if you were at home you could go out for a walk at eleven at night. Again things like making your own teas. The not smoking in dormitories, which gets flouted right left and centre, but we still go in there, and try to enforce it. I suppose they would make things better for them or give them more leeway at least. (Zwsn172285)*

The interviewees accepted that their role involved social control, but empathy for patients led to an abhorrence of the psychiatric system, and one nurse described her feelings like this ... *It must be awful so you know I don't like being part of that system, so I deal with it really. [Interviewer: So you feel what, that's part of your job really?] Well yes, there's nothing I can do about it really, apart from getting another job. (Ywan447)* The way they constructed their descriptions of rule enforcement indicated a degree of ambivalence about the use of authority, with another interviewee who said ... *for me a lot of it depends how I am feeling about things, and who I am dealing with. Sometimes you do feel very, no you can't do this, and no you can't go there, do you know what I mean? I can't think of the word, but this very authoritarian dishing out of power, do you know what I mean? (Z821555)* Other nurses' felt that they were constantly criticising patients ... *it is still a matter of do not, do not rather than do it. (Ys322339)* They readily identified with patients, and one nurse was distressed by the treatment of a young man, showing that upset about his condition tended to overspill into resentment at the need for a restrictive psychiatric system.

> *I feel sorry for example X not being able to leave because he's so young, and he reminds me of some of my friends, and it's horrible to see them in the situation they're in. I think how he chats, and how he is he could perhaps get himself into trouble outside, and I'm not much of a believer in giving all the drugs they do so that's quite hard for me, but that's not the issue. But in that situation with X it is because with X it seems that they've brought him in here at the age of seventeen given him a load of drugs, and told him he can't leave, and him we're similar in age, and why, why, why? (Zsrn111630)*

Several interviewees felt that rule enforcement hampered engagement, and one nurse elaborated on this ... *It shouldn't be like that It should be am here for you. I am your nurse I am your advocate, and I don't want to be seen as this person constantly nagging you to do this, and to do that to abide by the rules. I want to be this person that you feel you can approach, and that you can identify with perhaps or feel that you can share things with me. (Zfna224)* Patients constantly pressurised staff to change the rules in their favour, and when these requests had to be refused nurses felt their relationships with patients were put under strain ... *I mean it is part of our job, but it is hard. It won't change with any rule in piace. It is just the way patients are that is what I don't like I mean it hampers the relationship too much. (Zwsn261632)* Nurses felt that the therapeutic alliance was threatened by limit setting, and one interviewee stated ... *Say they have come back late from their leave, that can be hard sometimes because you can see them looking at you thinking I thought you were someone I could talk to. You have to be really careful how you say it so that you are not breaking that rapport with the client. (Ywsn111966).* This difficulty in reconciling the need to enforce the rules was demonstrated in a multiplicity of ways by interviewees. For example, patients were barred from the ward office, and one nurse said ... *Sometimes telling patients to go out of the office, leave the office people are scared they want to be with people. Everyone like to be with people, but you know I suppose you've got to maintain a professional level also. (Zstn487*). These contradictory

demands of relationship versus control added to nurses' feelings of ambivalence about their role within the psychiatric system as a whole.

When engaged in a period of non-participant observation I noted that the ward door was locked. The ward was quiet, and most patients were absent from the day areas apart from three individuals who were sitting together in front of the television. A nurse was sitting just outside the room with his legs stretched out in front of the door. He surveyed the corridor leading to the ward exit from this position, and effectively barred patients from leaving the room unless they asked him to move. I reflected that he did not interact with the patients at all. (ywfn17.11.99) Another interviewee equated guard duties with rule enforcement ... *to allocate one person to sit on the door and watch a piece of wood not to move that takes time. That person cannot be with the patients while he is doing that. (Zwsn261189)*

A few interviewees expressed differing views about enforced confinement of patients in the ward, demonstrating a tension between their caring role and custodial responsibilities towards patients. Certain nurses rationalised locking of the ward door on the grounds that most patients were legally detained, and that nurses were blamed when absconds occurred. However other interviewees disagreed, and one nurse said ... *the doors only locked it shouldn't be locked, but it's not locked except if section patients want to leave. It's a prison if they're locked in, people who are informal they find they are in prison, you have to explain to them it's easy for someone to slip out. (Ywfrna24)* They accepted a duty of care but expressed distress about the custodial aspects of the role, and this interviewee said ... *Yeah I find it very difficult it is devastating. (Ys322504)* One interviewee warned that nurses might develop blasé attitudes if they neglected reflective practice, and described how he felt about telling a patient about compulsory detention ... *I felt sort of split. Now I have to do it on as I said my personal feelings of that sort of taking away all basic human rights birth right, I don't know if with when I fully develop my practice I don't know maybe it will all go out the window, and I will do it without thinking, or what I find helps a lot is this whole thing on reflection, you know to go away and think about it the reasons why you have done it. The advantages and disadvantages. (Zsstn487)*

Similar conflict arose around the need to medicate patients, and several interviewees identified the administration of medication as an onerous task ... *I suppose medication trying to convince them to take their medication. You know it's like I'm forcing down their medication I feel like a prison officer having to chase and go in every day in the morning, two, nine, eighteen, six hours six o'clock, ten pm, and lecturing them about how important it is for them to take their medication. (Ys322339*) Other nurses doubted that alternatives were explored prior to enforcement, and one nurse said ... *but my way would be to try and persuade them as much as you can as a last, last resort use force. (Ywna171313)* Another nurse perceived that the process of enforced treatment damaged nurse patient relationships, just as other interviewees considered that enforcing the general wards rules for patient conduct did the same ... *Sometimes it happens, it is when someone you have a client, and you have rapport with them, and they start refusing their medication and you have to give them IM you can see that it is gone in a second. (Ywsn11196)*

Nurses' sense of distance and ambivalence about treatment rules were accentuated by the perception that consultant psychiatrists did not offer them support for the enforcement of treatment rules. During attendance at a ward round I listened to the consultant as he gave instructions to staff about the management of a patient, and reflected on the easy manner in which he delegated responsibility for rule

enforcement to the nurses ... *If he comes back ground him. It would be good if we could get a two-week admission under our belt. He's down on his luck, and very angry. So ground him. PRN Droperidol and Benzo's or nothing, and evaluate his mental state. We need a lot of sections on our open ward (said laughingly).* (Zwfn.15.11.99) Nurses incurred the wrath of patients when they implemented treatment rules.

> *Yes particularly when we are seen as the ones. The doctors do all these decisions and we are the ones on the front line. You can't go out that door. I am sorry you are on section three that is what it is. When you have someone saying I am going, and if you try and stop me I am going to smack you one. (Ywsn18231)*

Nurses found their position further compromised, on occasions, if they suspended patients' leave when their behaviour deteriorated in between ward rounds. Certain patients challenged these decisions during the next ward round, and the consultant reiterated that leave had been given at the nurses' discretion. Nurses identified this response as unsupportive, and one interviewee said ... *and then you have the patients turning round and saying you're the one that didn't want me to go. (Ys322627)* Consultants decided that patients should be confined, but left enforcement to the nurses, and another interviewee expressed anger about their lack of support ... *He doesn't have to sit on the door, and watch them he says no in the ward round every five minutes, and then buggers off. (Ys322627)*

Another interviewee perceived that patients viewed consultants in a good light because they made decisions about leave, and felt that nurses were cast in a punitive role because they implemented the rules ... *so we look like the bad ones then. (Zwsn261620)* During a period of non-participant observation I listened to the staff as they discussed a decision that had been made by the consultant during the ward round. The patient had expressed suicidal ideas, and the consultant decided that she should not leave the hospital unless a relative escorted her. One nurse said ... *They are blaming the nursing staff the doctor needs to put that in the notes the leave is called unescorted because it's not with the nursing staff we can't put her on observation when she's at home with her father, check what is in the medical notes before talking to her. Let's be more consistent so that the patient doesn't get confused either. Stipulate it in the leave book as well.* (Ywfn 16.11.99)

Admissions might not coincide with ward rounds, and this meant that patients might be confined to the ward for several days. During a period of non-participant observation I heard the staff discussing a patient. They said that the patient was not allowed any leave outside the hospital until the consultant had seen her, but this would not be for 4 days, and that the social worker would visit her children because the patient did not want them to come to the ward. One of the nurses said ... *Now he hasn't signed a seventeen there's no on else who wants to do it, and she really wants to go away outside, and the bad thing about it is that we can't let her. You cannot let your heart rule your head and policies. (Ywfn. 4.11.99)* Another interviewee felt that he imprisoned patients, rationalised enforced confinement with difficulty, particularly because he felt he had no power to determine what the rules were ... *The fact is you can't change a lot of things; you don't have the power to some of the time. maybe that will change in the future, more empowerment to nurses in order to make rules and change. (Ystn21521)*

Higher grades of staff seemed more inclined to act on their own risk assessments, and thus were less ambivalent about their role in relation to rule enforcement. I was engaged in non-participant observation, and one of the patients entered the office. One of the nurses said ... *where have you been (laughing) you*

are grounded now. The ward manager was present, and he said ... *let him out for 2 hours unescorted it's not enough for him in the grounds.* Then they discussed the situation, and decided that the patient could have 1 hour of unescorted leave until the next ward round, but this would be stopped if he failed to comply. (ywfn22.10.99) The ward manager subjected all patients to the same criteria regardless of their legal status, and he elaborated on this stance.

> *So in a way you're not helping patients by just allowing them to go because they're informal. Someone who was on a section he went to the doctor and said that wanted to go out on a Tuesday on the ward round and on the Wednesday I found out that this guy is not well, I would overturn the decision and say this is on my basis I'm saying the patient is not benefiting or he would be too much afraid and we're the right people to make the decisions, but we have to be fair, if people can go out then they should go out because at the end of the day it depends how people are feeling. (Yscn121382)*

These data as a whole illustrate the recurrent theme of nurses' ambivalence about their role in enforcing the rules. That ambivalence arose from a diverse range of sources, including tensions and conflicts between the need to build or maintain relationships with patients and yet still enforce the rules, or from the requirement to keep patients safe by containing them, whilst still maintain empathy with them and providing them with the care they required. This internal ambivalence was at its most acute around the need to keep patients confined in the ward, and ensure that they were treated with psychotropic medication. The nurses' ambivalence on these two issues of treatment rules was further intensified by the distant, unsupportive stance of medical staff, and by nurses relative powerlessness vis a vis the definition of specific treatment rules. However, the higher grade nurses, who had more effective power and say with the ward system, exhibited rather less ambivalence.

General methods of enforcement

The data contained relatively few descriptions of the interactions that occurred during rule enforcement, but they indicated that the factors outlined in the previous section might have contributed to variable approaches. Methods also varied depending on the nature of the rule being broken.

At a most basic level, nurses relied upon the regime itself to evoke compliance from patients. Several nurses perceived that patients were socialised into compliance through involvement with the regime, but on reflection some of them acknowledged that rule clarity might decrease the need for enforcement, and one nurse said ... *so everyone knows from the word go what the rules are. There are very few rules, but they're not visibly seen by patients. (Ysfrgra271)* Patients were, in general, simply expected to comply with the societal norms of ward life.

Several staff advocated rule clarification, and a reasoning approach, when this proved to be insufficient. The foundation of this approach was to remind or tell the rule to the patient who was breaking it.

> *The staff try and force the clients to be socially acceptable, for example disinhibited behaviour, or if they smoke in their bedroom, or staff will tell a patient that sexual words are inappropriate to say. They try and make the clients more socially acceptable to make them fit into society. when they are released into society they can prevent themselves being a danger to self and others. (Ystn11)*

This rule clarification was coupled with reasoning, and persistence during rule enforcement. One nurse described her approach, ... *First of all I ask patients if they know they are not allowed to smoke, saying do*

you know the areas where you are not allowed to smoke, and nine time out of ten people will say yes. There are a few patients that smoke in their rooms; a couple of them are heavily psychotic so there are problems with communication. I try not to make it sound as if I am giving orders. (Ystn2150). More sophisticated variations of this approach were also in evidence. For example:

> *Take the patient to a quiet area of the ward maybe a doctor's office nurse's office. Explain the behaviour that's expected of the patient on the ward. Explain the rationale behind those expectations. Try to come to an agreement between the ward staff and the patient in question would be the first line of method. Depending on the behaviour that's in question further action will be taken maybe by giving PRN medication if deemed necessary. (Ystn21210)*

Such carefully controlled, calm, quiet and rational confrontations sometimes had to be supplemented by persistence. Several nurses stressed the importance of combining surveillance with a patient, non-punitive approach, and one interviewee said ... *I mean what can you do shouting is not going to make it get across any further you can't, violence won't do it, you've just got to be very patient, you know keep repeating the message, and you know if someone is presenting a fire risk then watch out for that, and observe if the occasion arises. (Ystn 2150).*

However, observational data did indicate that nurses were, on occasion, prepared to give orders by shouting at patients. I was engaged in non-participant observation, and it was lunchtime. A confused female patient was wandering in and out of the office with a fork in her hand. Two qualified staff, one nursing assistant and the ward doctor were in the office. One nurse was doing the staffing rota, and the other two were engaged in social conversation with the ward doctor. Another qualified nurse was trying to organise the patients in the dining area. The nursing assistant shouted at the patient from the office, and said ... *put the fork down, and go and sit down!* Then the staff had a general discussion about the management of another patient. The nursing assistant left the office eventually, and sat the patient down. She had finished eating and the remnants of the meal were on the floor, her clothes and face. (Zwfn 5.11.99)

Inconsistencies did arise, with some nurses ignoring rules they considered minor, while other nurses went so far as to remove patients property in order to compel compliance with the same rule, considered by them to be a major issue of safety and/or propriety. For example, one interviewee said ... *with little things like the smoking there is no real consequence of them not complying with what we are saying, we can't take their cigarettes off them. Someone who is a fire risk we can take their lighter off them, but that is still not going to stop them smoking in rooms or the corridors, so there's no real consequence to that. (Zwsn261189)* However, other members of the same team called for reinforcements if patients refused to comply, and another interviewee stated ... *we take away her cigarette, and take away the lighter or whatever. (Zwcn251209).* Forceful action by a nurse was also exhibited in the following example ... *He was smelling badly he doesn't want to wash, and even if you tell him he goes in there and says yes I have done it. I just poured the shampoo on his head. He was a bit annoyed, but I said you know if you don't wash it, it will eat you. He just went in and washed. If you don't tell them most of them won't. (Ywna6jan68).*

Considerable differences of opinion were voiced in the interviews about the need to get patients to wash and the difficulties of enforcement. This was clearly a contentious issue, and for one interviewee, nursing action did not go far enough often enough.

When I first started here a year ago I really wondered one thing. If a patient is clearly a relapse of a long-term psychiatric illness, and their personal hygiene has been very poor for weeks we force them to take their medication, them to take medication, but we don't force them that is what happens in x land. If they don't take their bath and clean themselves voluntarily they will be helped to that in order to get that. In x the general belief is that makes patients feel better when they have been in that kind of condition for a while so they don't smell their own odours they don't smell that, other patients they avoid them. They tell them oh you stink go away things like that. That can be prevented if we take this one step and force them to take a bath. In order to okay I believe people should have their rights and all that, but when they are put on section some rights are taken of anyway, so why not try to make them feel like they have come from the community, and here they face other people as well as they do in the community. (Zwsn17182)

Patients' relatives might also consider that nurses did not go far enough in this regard. During a period of non-participant observation I heard a patient's relative talking to another patient. She was sitting outside the ward office, and spoke very loudly. She stated that the good nurses monitored patient's cigarettes, but the bad nurses did not care, and complained that the staff did not make him wash. She complained that ward regimes had deteriorated since nurses stopped wearing uniforms, and they no longer did things for patients. (Zwfn 14.10.99)

One interviewee raised the possibility that rule enforcement by nurses could, at times, have secondary motivations ... I *think with the power that nurses have they have to be careful that they're not abused in any way for any reason. I've got my eyes open, and I think about why someone's saying this, and why these rules have been implemented, but I've also got my eyes open to the fact that it could be that this person doesn't like this person for any reason, and they're implementing it just to shut the person up or whatever, not for the reasons benefiting the patient. (Ystn151362).*

In brief, the data gave evidence that nurses used a range of different and sometimes contradictory ways to enforce the rules, from telling and clarifying the rules, through to shouting at patients and implementing a variety of sanctions. The attitude and manner in which ward rules were enforced are returned to below, under subsequent sections, and the variation in these methods and their applications to different patients and situations further elaborated.

Intimidation by patients and rule enforcement

Variable methods of enforcement were sharply highlighted in references to intimidation, and the absence of a coherent approach to enforcement by nurses caused particular management difficulties with a group of intractable patients.

Patients who were abusive to the staff or each other were subjected to greater or lesser restrictions than passive patients, and one nurse said ... *I do feel if you get patients who have a history of possibly of aggression, who can be disruptive who may threaten it can work both ways. They can either get away with more or the rules imposed are more strict, or you get a patient who is very passive, the rules are being imposed more on them because it's easier to approach them. (Zw3cn251229)* However it was clear that there was a distinct tendency for nurses to avoid certain patients because they feared them, and this interviewee stated ... *I mean I think maybe we don't with some people we are a bit scared to enforce the rules so we let some people away with things that we wouldn't let others, and maybe we shouldn't be doing that (ywan4319)*

The risk of aggression and violence in psychiatric settings is real, and nurses' experience genuine, well-founded fear. For example, I observed during a hand-over the nurses discussing a ward incident. An extremely violent patient required restraint, and the co-ordinator of the rapid response team (RRT) needed four stitches in head wound after the incident. One nurse said ... *for the first time last week I understood what it is to be scared I was shaking inside. He was so intimidating he's such a nice young man when he's okay he asked what he had done, and apologised when we told him. I understand now that you need experience and you need to have a strong team around you. Mind you RRT are very good. X said to me don't worry you'll be all right.* Another nurse replied ... *it's awful to feel that fear but I suppose it's just the human condition.* (Zwfn 25.2.00)

Avoidance of patients, particularly when rules needed to be enforced, was therefore an avenue available to escape from anxiety provoking situations. One interviewee related the following:

> *The trouble is some of the clients are very intimidating towards the staff they're very muscular and that X started yesterday, and I came into the office out of the way. I was very nervous, and wary about coming here anyway because when I was working as a bank nurse in a secure unit a patient suddenly attacked me for no reason. (Zms5690)*

Other nurses approached patients with caution, and adopted apologetic attitudes towards them.

> *Yes the amount of times I say I am sorry. I know this must really piss you off, but I am afraid of such and such, and I am going to have to ask you to stop doing that. (Zwsn172423)*

Occasionally nurses enforced medication to contain aggression, and this could be an anxiety provoking procedure, arousing worries about the future consequences ... *there is the fear as well when you are holding the patient down to give them an injection. There is the fear that what if the patient remembers you, after that you probably have some you know revenge thing on his mind, like get you after they finish the injection, and he is feeling energetic then he will get you. You get that fear now as well, but that's not happened so far, so you know I am quite cool about it (ywna17313).*

Others were careful to assess patients' arousal levels before enforcing the rules ... *No because the more you push it they get more annoyed, or maybe aggressive, so you leave it until they are calm (ywna6jan142).* However this is a complex area, and some of the interviewed nurses argued that it was not so much rule enforcement per se that evoked hostility, but rather the manner in which it was done ... *Some staff the way they approach patients sometimes can make the patient worse, also the tone of voice, the way they talk to patients is important People come from different backgrounds, and we all talk differently so some people are not used to it, and it makes them angry. (Ymna213).*

Avoiding aggression during rule enforcement was closely related to assessments of patients' diagnoses. The particular mental state of a patient was taken into account before an attempt was made to enforce the rules, and hostile reactions by some patients, due to their symptomatology, were avoided. Nurses did not impose the rules on patients in certain diagnostic categories, and this interviewee said ... *I mean because you can't order about, or not exactly order about be firm with a psychotic patient because he'll come back to you or some of them will, and whereas with a manic depression you can tell them what to do really, and they will listen to you because that's where the difference is really (ywna171313)* Another nurse described differing responses to patient aggression, and said ... *I suppose there are subtle differences Like if a patient is fairly psychotic, and they are being quite aggressive or threatening, and you*

know it is a symptom of their psychosis that they are paranoid or something we would approach that differently, and you wouldn't go in and say I am not having you talking to me like that because it is part of their illness. You would still not accept that behaviour, and you would approach it differently. Yes you wouldn't ask everybody to go into their rooms for time out and shout and scream, but occasionally every patient will be asked each time they do (z8231).

Nurses experienced high levels of stress when agency staff replaced permanent team members. Agency nurses ignored breaches in the rules because they could not predict patients' reactions to enforcement, and they informed the permanent staff. Consequently, they bore the brunt of patient aggression, and one nurse believed that patients deliberately broke the rules when the permanent team was depleted ... *Sometimes if I find that I'm working with a lot of agency staff where I've been the spokesperson to confront a client about an issue, so I feel that can be a bit scary at times because you don't have the backup of a full team. It's not a collective decision, and you can often be targeted as you're just picking on me or whatever (zsn (1) 516).* Moreover these experiences damaged their confidence ... *At that time not getting enough support, and you feel very much alone and vulnerable I suppose because at that moment in time there might not be anyone else to back you up until the next day, or until the next shift, and sometimes coming from a word coming from the charge nurse or the ward manager carries more weight than just a regular member of staff, and who do you think you are? (Zsn (1) 516).*

Despite these pressures, many nurses remained steadfast in the face of intimidation even though they believed that certain patients were irrational and dangerous. They became inured to abuse during the process of enforcement, and one nurse described this experience ... *He would snap at me every time I say something to him, so every time I try to wake him up for medication I try to avoid it sometimes, try to give someone else to give him a call, but in most cases I used to go in there and ask him even though he shouts at me. I have to ask him this is how I got used to it now, and even if patients shout at me they shout at me (ywna171235).* Another described being courageous under intense patient pressure ... *Well for example patients smoking in their room, I had to go in there and I had to take cigarettes away from them and they were quite hostile, quite threatening, I mean that wasn't good for me, but it was something that had to be done as it was a potential fire hazard, and if they had earlier in the day attempted to burn themselves so I mean I had to go in there, but as regards to keeping the ward environment safe I mean I was so* (zwcn251332).

These data illustrate the prevalence of fear and anxiety amongst the staff, and how that anxiety shapes their behaviour around rule enforcement, at one extreme leading to avoidance of patients in order to avoid conflict, and at the other leading to courageous confrontation, perhaps in less than ideally safe circumstances. Nurses showed themselves to be sensitive to patients' symptoms and mental state, taking these into account in the interactional methods they used to try to enforce the rules. The presence of agency staff was a complicating factor, leading to further inconsistency in rule enforcement.

Punishment

Lack of consistency, and a failure to develop strategies to target patient intimidation was associated with high levels of non-compliance within Z ward. These failures evoked uncontrolled responses from nurses towards patients who breached the rules. They were judgemental, resentful and insensitive particularly towards patients who were mentally ill and who used illegal drugs. A failure to maintain ward stability led

to an increased use of containment measures, and prosecution was mooted as a viable option in the management of aggression. A strong undercurrent of anger towards patients was evident in a number of interview responses from Z ward, and in material collected during fieldwork. Three areas of rule breaking in particular attracted response from nurses that were tinged with anger: aggression, rule breaking judged to not be due to mental illness and therefore bad, and the use of illicit drugs during admission, or as a cause of admission.

One hundred and one ward incidents involving patient aggression mostly connected with medication refusal, substance abuse, and absconding were recorded in the ward incident book, or the staff handover book within one of the study areas during the data collection period. Several incidents involved the use of containment measures, and the assistance of the RRT. The following list contains examples of the type of incidents that were recorded between 26.10.1999 and 14.11.99.

- Abusive and threatening behaviour by female patient towards staff nurse
- Female patient came into the office and tried to attack nurse
- Male patient flooded his bedroom and threw chairs about in the quiet room. Restrained, given medication, transferred to intensive care ward
- Female patient threw coffee over female member of staff, restrained, given medication
- Female patient walked into office and pulled pregnant Doctor to the floor
- Male patient hostile, aggressive towards nurses, placed on Section 5 (2)
- Female patient refused oral medication given 10mg Droperidol IM after a few members of RRT were called
- Female patient making several attempts to leave the ward given IM Lorazepam
- Male patient refused oral medication including diabetic medication & stat glucose test. Given medication IM. RRT called to deal with the above
- At 9pm female patient overturned a table given medication
- Male patient let off a firework in the smoking room threw it out of the window. Searched, observe
- Female patient returned at 5am by police following abscond
- Male patient caught smoking cannabis in the male dormitory. Alleged that the Nursing Assistant had supplied him. Counselled and told that the police will be called next time. Searched and drug flushed down the toilet
- Male absconded patient returned by police at 2pm. Patient had gone to drinks machine at 11pm did not return. Had been chased by police caught riding a stolen child's bicycle. RRT called escorted back to the ward given medication.

No comparable incidents were recorded within Y ward during the data collection period. However during an episode of non-participant observation I heard a discussion about a ward incident. One of the senior nurses asked the staff why they had not recorded an incident in which one patient head-butted another, and one of the nurses replied ... *we didn't see it so how can we record it?* At which point the senior nurse said...*If Dr x finds out he will say why wasn't it recorded? Record everything they say.* (Ywfn 4.11.99) On another occasion two nurses went to a patient's home to bring her back to the ward. The patient had been missing for one day, but had not been recorded as absent without leave. (Ywfn 11.11.99) One of the staff and two of the patient interviews contained references to recent ward incidents, but I did not find any written records of these events. One patient recalled that two young males had smashed the ward's

public telephone, and another patient described an incident when an aggressive patient was transferred to a locked ward. This nurse described another event, which was not reported, and said ... *Like a patient the other day smashed a whole computer up in the office, and he said he knew what he was doing because he was angry with us for not allowing him to go out because he was grounded, because he didn't come back on time. So he smashed the whole computer up, and I felt he should contribute to something like that. (Ywna291252).* Nevertheless, it was very clear that there were far fewer incidents of difficult patient behaviour, of any sort, on Y ward.

One nurse referred to the prosecution of assaultive patients ... *and I think the violence and aggression that are being highlighted, and are being supported by senior management. I think that's a relief for us all that things are being taken up. My colleagues that have been assaulted, and I know that they have been encouraged to make incident forms out, and make statements and get the police involved. We've got a police liaison officer here as well, which I don't think we use enough to be honest, but we'll see how things go (ysn (1) 379).*

Rule breaking by some patients was seen as consciously motivated, rather than due to symptoms of psychosis or other mental disorder. As such it was sometimes referred to as 'behavioural' or 'manipulative'. I attended a ward round, and the consultant tried to account for a patient's behaviour in psychodynamic terms, but a nurse took a different view ... *Consultant: Yes she's splitting. Nurse: She is attacking people for attention because she is bored. We've told her she will prolong her admission if she continues to be aggressive. (Zwfn139)* During a another period of non participant observation I heard a nurse express her perception of a patient's behaviour ... *he's well enough to refuse to go to O/T and everything like that so he's well enough to go home. (Ywfn80)* Nurses differentiated between patients who were perceived as manipulative, and those whose behaviour arose from irrational impulses. Consequently certain patients were punished for non-compliance whilst others escaped, and one interviewee said sanctions were used. ... *Possibly if they are doing it all the time, or basically if they are just abusing the place or I think possibly manipulative. (Zwsn172181)* Another nurses reported that one patient was denied pain relief because a member of staff perceived that he sought excess attention ... *He was holding his jaw, and crouching on the floor rocking, and he said he couldn't sleep. He was told to go and try to sleep, and I thought that was ridiculous because if you do have a toothache you can't sleep, and he said he was going to accident and emergency at the weekend or something to get it sorted out. I'm not quite sure, but I felt terrible then, awkward talking to him because I knew he thought the doctor had been rung, and he hadn't. (Zsrn111416)*

The consumption of illicit drugs, either on or off the ward, also elicited judgmental and condemnatory talk from nurses, especially on Z ward. A nurse left the ward round to make a telephone call about a patient who had breached the rules, saying ... *We're not sure if he is mentally ill, we think it may be drug induced, and this is not a locked ward, and he is smoking cannabis on the ward. To take him to court do we just put him in a taxi, and bring him down. Do we do that via the police or what? (Zwfn68)*

During attendance at a nursing handover I heard the staff discuss patients who had breached the substance misuse rules.

Nurse (1): If you're picked up with half an ounce on the street you can be prosecuted.
Nurse (2): It's out of hand, collar them and tell them they can be arrested.

Nurse (3): It's easy just put him in a van, and take him to the prison. (Zwfn720)

And on a similar occasion about another patient:

> *He has been in bed most of the morning. He won't give a urine sample, and I told him you have to. He said I don't fucking have to! He is a stupid boy. His leave should be stopped if he doesn't give one tonight. Tell the consultant we're not having it on the ward, his leave is stopped. He's a bit hostile if we don't jump to it, and get his cigarettes there and then. (Zwfn134)*

During another handover the staff discussed clinical management problems, and displayed uncontrolled attitudes. One nurse stated ... *I'm on nights I'm not going to put up with this nonsense He's taking drugs no matter how many urine samples we take he'll still take them. If he needs to be in hospital he should be in hospital so he can be treated not coming and going like this she's (the consultant) got to be told we can't have this.* They continued to discuss the management of substance abuse, and another nurse said ... *It goes through phases I'm sure x has had a constant supply all the time he's been in.* (Sect 37 patient confined to the ward). *All we can do is spot searches on the ones who are under section. These men know and can hide it anywhere; we can't look in their pockets and everything.* Zwfn.12.11.99)

I attended another handover during which the staff discussed a newly admitted, young male patient with a diagnosis of drug induced psychosis, and this nurse said ... *He's bouncing off the walls and the Consultant will only give him Olanzapine. What about the weekend, his mother is against medication.* No mention was made of management methods apart from medication. The patient banged on the door several times during the handover but the nurses ignored him. I later observed that he looked extremely distressed and out of control as he ran around the day area. He was beating the walls with his fists, and eventually the staff administered a sedative injection of a powerful combination of drugs. (Zwfn.14.11.99). All these examples give significant evidence of irritation and anger with patients because of their use of illegal drugs.

The Y ward team seemed to take a more liberal attitude towards substance abuse, and the following extracts from observations made at a ward round indicated that this approach stemmed from the consultant's stance. The senior nurse said ... *he tested positive for cannabis.* The consultant ignored this statement and asked the nurse ... *What's he like on the ward?* The nurse replied ... *He goes out for leave and when he's here he's usually in bed.* Later on during the handover the senior nurse reported on the consultant's ward round, and this nurse said ... *what about his smoking dope?* The senior nurse replied ... *cannabis wasn't an issue during the ward round.* At which point the other nurse said ... *but he won't get better.* (ywfn16.11.99) My observations within the other study area indicated that nurses' attitudes towards substance abuse were driven by the consultant's attitude towards substance abuse. During a ward round the consultant said ... *you know me well enough to know that I'm not patronising you cannabis causes you to be agitated and stressed.* (Zwfn. 5.11.99)

Anger towards patient rule breaking was evident from time to time in the data, but that anger focussed especially on aggressive and assaultive behaviour, the rule breaking behaviours of non-psychotic patients, and illicit drug use. Anger from staff (and rule breaking incidents by patients) was more prevalent on ward Z.

Paternalism

Paternal concepts emerged from the data, and nurses perceived patients as children or siblings. A few nurses regarded the ward as the patients' domain, and others perceived that they were the dominant force within the environment. These concepts led to variable methods of enforcement, and certain nurses were acutely aware of patients' rights whilst others displayed authoritarian attitudes.

One nurse drew a specific analogy between psychiatric nursing and parenthood:

> *So it's similar, I can't see why we should be much different really because we are nurses we have the power just like parents have the power over the children. The nurses have got the power to assess because you'll be assessing your own children as well. Are they going to be safe, are they going to be careful at that age, a similar situation here as well? (Yscn12129)*

Another interviewee described an interaction with a patient during the enforcement of daily living activities ... *when I came around, and I saw she hadn't done her bed I went to her and said. can you please go and do your bed. If you don't tell them they don't do it. Like a younger sister to me. Go and do your bed and she said (inaudible) you are a slave driver. You know it is okay? (Ywna6jan45).* Another talked about the ward as being the patient's home (ysfgra271).

A paternal approach and ideology was particularly evident on Y ward. Paternal attitudes enabled rule enforcement because nurses perceived that were acting in the best interests of patients who were unable to take full responsibility for their own safety and well being. This approach may be interpreted as authoritarian, but the examples that emerged from the data showed that enforcement was motivated by a duty of care, and tempered with humour.

Reflective practice

A few nurses referred to the value of reflection, and perceived that this enabled therapeutic methods of rule enforcement. They blamed institutional changes within psychiatry for a shift towards authoritarianism, and referred to the high patient turnover within the wards. One nurse perceived that authoritarian methods of rule enforcement were ineffective.

> *Generally if you build up a rapport with somebody, I know because of my appearance I can be a bit intimidating so I try not to come across as ordering people about because I don't think that works anyway. I mean they may stop that behaviour while you are there, but as soon as you go then they modified that behaviour because of you not because they understand. So I generally try and encourage them to make the decisions that they will need to make in outside life. (Ywastn2120)*

Another interviewee associated authoritarianism with absconding, and said ... *yes it is easy to get out, if people want to abscond easily, but if you give them a hard time, and treat them like I'm the boss, and you are there. You have to treat them, as you would like to be treated yourself.* Another interviewee used reflective practice, and felt that this enabled nurses to avoid authoritarian responses towards patients during enforcement ... *and sometimes I think more and more nurses need to be conscious of the way of that. I mean we do it in theory, yes you sit down oh yeah right quite fascinated by it, but when it comes to putting it into practice in the ward you find you just forget about it, and it's just the human being come back there again ... and you know hence I think on a subconscious level that's the reason why nurses*

react in that way. Not conscious or it may be subconscious. ... the patient may feel defenceless, hopeless and therefore that nurse takes on that authoritative figure. (Zstn2)

A general lack of reflective practice emerged from the data, and this indicated that nurses were not adequately supported or supervised by senior staff. Isolated references showed that reflection helped nurses to combine a duty of care with therapeutic principles. The data also highlighted an association between authoritarian enforcement and absconding risk.

Nurses' perceptions of authoritarian enforcement

Some nurses expressed ambivalence about the exercise of control, as has been presented above. These comments overlapped with others that elaborated on the use of power and authority by nurses, rigid approaches to rule imposition, and the repetition required to uphold a rule. This interviewee elaborated on the conflicts that enforcement duties engendered.

> *Sometimes you do feel very, no you can't do this, and no you can't go there. Do you know what I mean? I can't think of the word, but this very sort of authoritarian dishing out power, do you know what I mean? I will let you do that. I find that very difficult some times. If you have a patient coming back asking you the same thing, it does feel like sometimes, you can't and that is every word you are saying. (Z821580)*

Several interviewees attributed the generation, or need for, a rigid approach to enforcing the rules on the pressure of work, with high patient throughput and acuity, coupled with over occupancy. The following two examples illustrate this theme:

> *There is just increased nursing observation, and increased like telling them every single time the reason why. Unfortunately because of time that just doesn't happen, and it is usually just oh don't do that, or please don't do that. Please don't do that or can you go and do that there please, or you're not allowed in there which is not ideal. (Zwsn261207)*

> *Not only can you have extra patients, who don't have anywhere to lie down during the day, and won't get one identified until seven or eight in the evening, you are going to have a lot of visitors. Increased visitors due to the ncreased number of patients. You are going to have activities like community staff coming to see their clients. I think the over crowding aspect necessitates sometimes on the part of the nursing staff there is more rigidity just in order or keep things safe, and cope with the numbers. (Z462)*

Another interviewee attributed the rigid attitudes of the staff to admission policies ... *I think there is probably a false sense of enforcement, and that is partly due to the fact that during the day we always have more patients than beds, so we are going to have three or four patients who don't have a bed or anywhere to lie down on. (Zwa443)* During a handover the nurse in charge said that the consultant psychiatrist was seeking to admit more patients, but that currently two patients were without beds. One patient was sleeping between two chairs, and another was sleeping on a Z bed (a collapsible bed). (Zwfn 16.11.99) During a period of non-participant observation I listened as two nurses discussed one of the patients. The patient had been given leave at her own request, but she returned to the ward the next day, and another patient was occupying her bed. She was lying in the corridor outside her room, and had asked for a blanket. The nurse in charge said that she would have to consult the medical registrar. (Zwfn 9.3.00) During another period of observation within Y ward the medical registrar spoke to me about the high numbers of patients who required admission, and he said ... *You are told that you cannot admit because there are no beds that puts terrible pressure on you.* (Ywfn14.11.99)

When I attended a handover the nurses reported that patient numbers (including those on leave) had reached 32, and that there were no beds available throughout the hospital. (zwfn.22.2.00). An entry in the ward incident book showed that inflexible rule enforcement was associated with staffing problems. One of the patients absconded because only one female member of staff was on duty and she could not be escorted for a walk. She was restrained by RRT and brought back to the ward. (zwfn24.11.99) However whether such restrictions were always due to pressures of work is questionable. Sometimes staff seemed reluctant to provide escorts for certain patients even when nurses were available. During another handover one of the nurses reported that the team had been too busy to take a young male patient out. The patient was entitled to fifteen minutes in the grounds under escort in the morning and afternoon. I reflected that the nurses had spent most of the morning in the ward office chatting to each other, and they had several smoking breaks. (Zwfn. 2.11.99)

Nurses' encountered difficulties when they faced situations associated with patients' sexual needs and behaviour. A few examples of an authoritarian approach towards sexual issues emerged from the data. One nurse generalised about the attitudes of staff towards sexual relations between patients, and said ... *It is still the culture of taking away, hmm what do you say their decisions so to speak. There is still the amount of control you can do this, you can't do that you know? When you asked me what you can do there are some things, yes, but some things! (Ys322523)* Another nurse elaborated on the reactions of certain staff towards the issue of patients' sexuality.

> *Again it is back to what I was saying before. In some ways a daft example. I can remember some basic things like porn mags. It is not that they are not allowed particularly, but I have seen some nurses who. I mean if you have someone masturbating in the corridor or whatever that is not really appropriate. I mean if they are stuck in hospital what they do in the privacy of their own rooms, I mean whatever. I have seen nurses sort of going down, and sort of searching patients bedrooms, and going sexually disinhibit, and all this pornography, and take it all away. Sometimes I don't know we are not particularly flexible in our thinking about those sort of things. Peoples' sort of sexual needs. Again it is a very difficult area t work within, and I wouldn't particularly want patients having rampant sex on the wards and stuff, but I think you know sometimes we are a bit inflexible, or don't want to think about it, or deal with it. (Z82132)*

Episodes of non-participant observation highlighted the adverse effects of authoritarian staff attitudes on patients' responses to rule enforcement and the generally low levels of engagement within Z ward in particular. During one episode I reflected that apart from enforcing the rules the staff had not interacted with patients between 10.30 am and 1pm. One patient stepped inside the office door, and this nurse said ... *don't come into the office please!* A male patient was sitting just outside the office with head in hands, and he was moaning. One nurse addressed another, and said ... *what's wrong with him?* The nurse replied ... *he can come and talk to me if he wants, but consultant X doesn't want him to latch on to us or he'll become another X hospital PD* (personality disorder). *(Zwfn. 9.11.99)* On another occasion I listened to a female patient as she complained to another patient's visitor about her care. She was anxious about arrangements for discharge, and complained about a lack of interaction with staff. She looked unkempt, and her tee shirt was on inside out. The relative asked her why she did not talk to the nurses, and the patient said that they were unapproachable. (Zwfn. 14.10.99)

On another occasion I observed the same patient. She was using the office telephone to make her own discharge arrangements. One of the nurses said ... *you can't just come into the office, and use the phone whenever you feel like it! You have to ask and wait. We're very busy.* The patient said ... *Can you do it now?* The nurse retorted harshly ... *No I'm having a discussion. I won't do it now! (Zwfn. 2.11.99)* On

another occasion I witnessed the antecedents and consequences of a ward incident involving the same patient. She asked one of the nurses for a drink, and I could not hear the response, but the patient shouted *... Why are you talking to me in such a horrible way, you got hold of the back of my neck as well. Why did you speak to me in such a horrible way? You know me!* Shortly afterwards the hospital reception staff telephoned the ward, and reported that the patient was threatening to cut her throat in the entrance hall. The senior nurse ran from the ward shouting ... *what am I going to do with that woman!* The nurse who had refused the patient a drink did not respond, and said that he did not want to give her too much attention. The other patients appeared unsettled by the incident, and one of them said that the patient should have her anti-depressants increased because she was worse in the morning and at lunchtime.
The patient was returned to the ward by five members of the Rapid Response Team, the nurse in charge, and a security guard who said *... You can't just let her walk around like that she could be a danger to someone else.* The nurse in charge telephoned the consultant, and said *... We have put her on a 5(4) because we brought her back against her will.* The consultant decided against compulsory detention, and prescribed close observation until arrangements were made for discharge the next day. The patient was confined to her room in her night attire, and placed under close observation. The nurse who had refused the patient's request spoke to the nurse in charge *... You said she wasn't to be given drinks.* He received an angry response *... I did not say that! All she asked for was juice; you could have given her that!* I reflected that the staff seemed to be unaware of the reactions of the other patients, and that they were not debriefed. (Zwfn 18.1.00)

This incident showed that rigidity or neglect might be influenced by nurses' negative perceptions of certain patient groups. In the case just described, the nurse suppressed a humane response, because he perceived that the patient was manipulative. The patient acted out her feelings in a self-harm attempt, and other patients were upset by the incident. The other patients were not debriefed, and their own negative interpretations of the event might have adverse consequences in terms of further absconding or aggression. The incident split members of the team, and showed that all nurses require clinical supervision to ensure a cohesive non-abusive response towards patients who present particular management problems.

The data showed that staffing problems and work pressure sometimes increase rigidity and precipitate a variety of conflicts with patients, including absconding. In addition, rigid and authoritarian attitudes were particularly visible with respect to any expression of sexuality by patients. Similarly rigid and condemnatory attitudes were evident towards any behaviour perceived to be 'manipulative', confirming evidence presented previously that such patients evoked angry responses from the staff.

Patients' feelings about authoritarian enforcement

Patients were particularly sensitive to the tone in which rules were enforced, and they described authoritarian methods of rule enforcement. They made their own interpretations when nurses enforced treatment or when other patients were transferred to locked wards. Certain patients advocated stringency, and felt that disruptive behaviour or aggression should be severely punished.

Interviews of the patients on the topic of ward rules provided plentiful information on the patients' point of view. They objected very strongly, not so much to the content of the rules, but to the manner in which nurses imposed or enforced them. Patients were aware of nurses' paternal attitudes towards rule

enforcement, and this interviewee said ... *I suppose it is a way of taking the traditions of their parents, brothers, sisters and aunts and uncles as well. (Z536)* Another interviewee described the staffs' approach towards sleep promotion, and said ... *especially in my case they were telling me off in going to bed. Go to bed! So I didn't really agree with that cause I thought I was spoken to like a child rather than an adult. (Ywp3237)* Another patient complained about the lack of privacy ... *I check when the door is locked. It is not locked they just come marching in; I don't like being reprimanded like a child. (Zp521446)* Another interviewee observed that nurses treated patients like children.

> *X you must not do it! Stop it! We are going to put you if you're being naughty you're to be moved! The other one was moved that one that had the black eye. She started throwing cups at the nurses. .... She was put on X ward on her birthday as well. (Ywp1123)*

The tone and volume used by nurses during enforcement was noted, and one patient said ... *they tell you in a horrible way sometimes ... like I am not up for my medication, and start shouting at me. (Zwp1432).* Another interviewee felt that she could not approach the nurses after they had ordered her to go to bed ... *I dislike you know as I say the evening part when you can't watch TV till a certain time, and you're frightened. (Ywp32m458)* One patient described nurse's responses when she entered the staff office ... *Go out! How long have you been standing there? Who is there, and then they'll shout at me who is that person! (Yp17111)* Another patient was upset by the manner in which the staff refused her request ... *sometimes they are nasty to you, you know. Not so nice you know? ... If I want tea they say you know the rules. The rules are we are not going to make you tea ... it doesn't make me feel very good ... it makes me feel unhappy you know. (Zp13d2516).* Patients made observations about the manner in which staff enforced the rules, and this interviewee said ... *you would hear X you can't do this Y you can't do that. You can't do this, you can't do that it's the rule, it's rules and that's what you would hear. (Yp (5) 5180)* Patients described nurses' attitudes towards behaviour that might be classed as sexually inappropriate, and this interviewee said ... *and he's so cuddly and lovely, and he wants to cuddle, and sometimes so do I. So we cuddle each other, and one of the ward nurses she doesn't like it. She gets very aggressive, and says stop it! You can't do this you can't do that, and tells us off. (Yp (5) 51305)* Another interviewee removed his clothes and exposed his body to other patients. The reaction this received from staff angered him initially because it made him feel like a child, and he said ... *I took my clothes off, and flashed in front of all the people. ... because there was an attractive woman there ... I know I shouldn't have done it, but I was scared. ... I was told go back in there, and put your clothes on! ... It made me feel small. (Zwp1145)*

Patients made their own interpretations of containment measures, and this interviewee observed other patients' reactions when they returned from a period of confinement within a locked ward.

> *And then when they come back here, they go very quiet. They go quiet, but they are on the same medication, but they are quieter, because they don't want to be put on a stricter ward, and then another stricter, stricter ward, and then another stricter ward, cos this is an easy going ward apparently. (Zp (4) 91246)*

They observed that certain patients were sent to their rooms, or were warned that they would be moved to another ward if they were disruptive, and one interviewee said ... *They made her go to bed. ... Yeah and I didn't see her till the next day because I come in here, and cried and cried, and they say if there is any more of this we are getting fed up with you, you're OTA you know what that means! And you're shipped up. Oh they don't like the word X ward! (Yp (10) 1617)* Other patients warned newly patients about the consequences of non-compliance, and this interviewee *said ... they say X you can't do that then*

you're put onto another ward, and it's a stricter ward and you don't want that. There is a slight amount of fear that goes on within this ward, but as I am the least fearful person in the whole world, it doesn't really bother me. (Zp (4) 01176) Another patient warned that medication was enforced as a means of punishment, and said ... *yes and all of a sudden bang, and if you do something like that you've got to be careful or you get an injection. You have to be careful how you behave. (Ywp32390)*

Some patients interpreted authoritarian attitudes as racist, or resented the fact that nurses from a different ethnic group to themselves enforce the rules. This young male patient did not understand the reasons for confinement, and perceived that staff were acting punitively towards him because of his ethnic background ... *They say you're not allowed to go out. You're not allowed to do this, you're not allowed to do the other, you're not allowed to do this. And then they say, your girl friends got to go. Your girl does this; your girl does the other, da, da, da. (Zp (1) 21515)* Another patient perceived that certain ethnic groups of staff were authoritarian, but did not question the imposition of control by other members of the team.

> *The last person you are talking to is a racist. I am not a racist, but there are various accents that come from Africa that are very aggressive in their sound, are you with me? That person is not meaning to be aggressive, but the way that you are told off at times. It is as if you were at school with some aggressive teacher wanting to give you the cane. As far as I'm concerned the staff in this ward generally are cool bananas they are fine. The Consultant is young, younger than me. I think she still has a lot to learn, but I am in her hands. I feel safe I feel comfortable. (Z52148)*

She described strained relationships with staff ... *when X unplugged my bath, and told me there is no bath because there is nobody to supervise it made me very angry, but I chose not to express my anger because I knew it would work against me, and that was that.* The same patient complained about nurses' attitudes towards her involvement in treatment ... *please believe me that voicing your opinion gets you into trouble. ... I say nothing they will write something down. She is aggressive. They don't like criticism. Every time I have criticised the staff I have had something detrimental written in the notes which has not been in my favour when it comes to ward rounds. So it is in my interests to say nothing. (Zp521446)*

A few patients accepted rule enforcement without demur, but others were incensed, distressed and humiliated by staff attitudes. This interviewee said ... *I mean I was stinking when I came in here for various reasons. I needed a bath I said. She started waffling to me the nurse did, and I said the only thing I want to do is take a bath. Oh no, you can't do that! I didn't flare up. I said okay and I just accepted it. I went to bed as far as I was concerned in a dirty state. I didn't feel clean. I needed a bath. This isn't mental illness talking I just needed a bath. (Zp (3) 91335)* Another patient was humiliated by the way that she was treated during an emergency admission to the ward.

> *Like when you are rushed into hospital, you just grab the first clothes you can, and everything's filthy if you haven't got round to washing it. I was going to wash my dressing gown that morning, and got bundled into hospital, and told it's dirty! I know that full well, but when you're without your detergent because you were just going shopping, and things like that, and then if you can't sleep at night. I eventually fell off to sleep at about ten in the morning, and only slept till twelve, and got ticked off for that. Do you know what I mean? [Interviewer: How does that make you feel?] Very ridiculous in front of people, and very small. (Yp (1) 41543)*

Others felt that nurses' displayed firm but non-punitive attitudes, and a few patients wished that the staff were more authoritarian. This patient gave an impression of a typical nursing approach ... *There are rules and regulations, come on now. You know like how there are rules and regulations, stick to them please.*

They're not aggressive to us, no, no not at all. They're not aggressive they don't shout and holler at you. (Yp (5) 51212) Another interviewee felt that other patients required an authoritarian approach, and said ... *well you hear occasionally a nurses shouting at a patient. Come on smoking room, like that because some of them are a bit bombed out because it is a mental institution, and they just light a cigarette up wherever they are, and then they are told to go in the smoking room. When that happens they either put their cigarette out or go in the smoking room, which is fair enough. (Zp939121)*

Some interviewees went further and suggested that other patients should be punished, for example ... *I think there should be more rules if anyone is in more than one fight they should put them in the high security wing. (Zmp5730)* Another patient expressed support for the nurses paternal approach ... *what would you let a child get away with? Which half the time is what you are dealing with here. ... If they see something is not right or dangerous that you wouldn't let a child do-because that is what you are dealing with mentally a lot of the time. You turn around and say no, and that's it you can't write all these rules down, but well they think fair enough and they let them get on with it. So it's like a common sense way of dealing with things. I think it's quite fair common sense and I think its what they use. (Zp (4) 91578)*

The patient interviews indicated that most patients resented the manner in which rules were imposed on them, or enforced by the staff. They especially resented being ordered or commanded to do things, being shouted at, and being treated in ways that, from their point of view, were disrespectful. A smaller number of patients endorsed the nurses' approaches to enforcing rules, or thought that the regime should be enforced more strictly. Patients were acutely aware that were in a vulnerable position, and saw the nurses' methods of containing disruptive behaviour (e.g. transfer to psychiatric intensive care, medication) as punishments rather than treatments. The patient data also showed that close contact between male and female patients might evoke authoritarian responses from staff, confirming the contents of the staff interviews.

Comparison between Wards

Z ward staff referred to rule enforcement twenty two times, and this theme emerged nineteen times in the Y ward interviews. Y ward staff displayed greater confidence during rule enforcement, and this suggested a more effective ward management structure. They expressed ambivalence about treatment rules, but they were able to overcome these conflicts, and this indicated team cohesion. See supporting examples from the transcripts on page 65 (ystn11351) (ywan447) (ys32239) (ywsn111966); page 66 (ys322504) (ys322339) (ywna171313) (ywsn11196); page 67 (ywfn.16.11.99) (ywfn. 4.11.99) (ystn21521); page 68 (ywfn22.10.99) (yscn121382).

The data from Y ward staff suggested that paternal, empathic and authoritarian attitudes underpinned rule implementation. They displayed a high degree of coercion. Control was rationalised in terms of a duty of care, and the data suggested a general reluctance to exercise flexibility. They focused on containment measures, and frequently referred to a lack of discretionary power when faced with situations that demanded a flexible approach. They also expressed greater frustration in relation to the role of consultants, and this suggested that the ward structure was markedly hierarchical. Y ward staff introduced the topic of locked exits, and the data showed that this method was combined with surveillance to enforce confinement. They concentrated on gaining early compliance with medication. General ward rules, for example on smoking in bedrooms, were inconsistently enforced during the admission process, and they were poorly clarified thereafter. Nurses perceived that patients naturally adjusted to the regime, and this suggested that the rules were embedded in the ward structure. See supporting examples from the transcripts on page 66 (ywfn. 17.11.99) (ywfrna24) (ys322339) (ywssn11196); page 67 (ywsn18231) (ys322627) (ywfn. 16.11.99) (ywfn. 4.11.99) (ywstn21521); page 68 (ysfragra271); page 68-69 (ystn2150).

Z ward staff expressed greater role ambivalence. They lacked confidence in the rules, and in their ability to achieve compliance. This suggested deficiencies in the ward structure. The rules were strongly associated with societal expectations of conformity, but nurses were conflicted about the extent to which these requirements should be imposed. Lack of rule clarity produced inconsistency between staff, and frequent breaches in the rules resulted in constant reinforcement involving criticism. Consequently nurses expressed greater concerns about the effect of enforcement on therapeutic relationships with patients. Patients pressurised staff to change treatment rules, and this indicated that they were not clarified during or after ward rounds. The need for constant reinforcement accentuated the levels of high expressed emotion within the environment, and non-compliance. Consultants' admission policies caused overcrowding in day areas, exacerbating the need to rigidly enforce the rules. See supporting examples from the transcripts on page 65 (zwsn172285) (z821555) (zsrn111630) (zfna224 (zstn487) (zwsn261632); page 66 (zwsn261189) (zsstn487) (zwsn261620); page 69 (zwfn.5.1199) (zwsn261189) (zwcn251209); page 70 (zwsn17182) (zwfn. 14.10.99); page 77 (z821580) (zwsn261207) (z462) (zwa443) (zwfn.16.11.99 (zwfn. 9.3.00); page 78 (zwfn.22.2.00) (zwfn.9.11.99) (zwfn.2.11.99); page 79 (zwfn.18.1.00).

The Y ward data showed that the regime embraced a socialisation function. A paternal approach enabled a coherent approach towards activities of daily living for example. However the data indicated that inequalities in relationships were intensified by a parental approach towards enforcement. Conversely Z ward staff was acutely aware of the impact of power relations, and defensive reactions towards the use of

authority were expressed in variable methods of rule enforcement. Z ward staff responded to disorder with increased rigidity, but nurses did not perceive that perhaps the inadequate structure was the cause of disorder, and that this rather than rule enforcement *per se* obstructed the development of therapeutic relationships with patients. See supporting examples from the transcripts on page 65 (z8821555) (zfna224); page 66 (zsstn487); 68 (ystn11); page 75 (zwfn 720) (zwfn134) (zwfn.12.11.99); Page 76 (yscn121290 (ywna6jan45) ysfgra271); page 76-77 (zstn2); page 77 (z821580); page 80 (ywp1123) (yp (10) 1617) (yp (1) 41543) (zwp1145); page 81 (zp521446) (zp391335)

Staff from both study areas adopted variable methods of rule enforcement, and expressed comparable degrees of anxiety in relation to patient intimidation. Lower grades of staff seemed to be inadequately supported by the system, and were particularly exposed to intimidation from patients. Y ward staff dealt with aggression summarily before it escalated. The data suggested that certain Z ward patients constantly flouted ward rules, and nurses avoided enforcement until the situation got out of hand. Patients constantly questioned treatment rules, and this indicated an ongoing lack of clarification. Z ward staff expressed more vulnerability about working with agency staff, and this suggested that this resource was utilised to greater effect within Y ward. See supporting examples from the transcripts page 69 (ystn21210); page 70 (zw3cn251229) (ywan4319); page 71 (swan 25.2.00) (zm55690) (zwsn172423) (ywna17313) (ywna6jan142) (ywna171313); page 71-72 (z8231); page 72 zsn (1) 516) (ywna171235) (zsn (1) 516) (ywna1771313); page 80 (yp (10) 1617); page 81 (ywp32390).The data from five Z ward patients reflected various responses evoked by authoritarian staff attitudes, and these included feelings of victimisation, alienation, humiliation, anger and sadness. The data indicated that patients may be aversely affected by witnessing ward incidents, or when overhearing staff threaten patients with transfer to a locked ward. Lack of debriefing may result in increased rates of aggression or absconding, and could be reflected in the rate of recorded incidents within Z ward. See supporting examples from the transcripts on Page 80 (z536) (zp521446) (zwp1432) (zp132516) (zwp1145) (zp (4) 91246); page 81 (zp (4) 1176) (zp (1) 21515) (z52148) (zp521446) (zp (3) 91335)

The Z ward data contained more references to punitive methods of enforcement for aggression, and other breaches in the rules. The Y ward data contained examples of behavioural methods of enforcement, and interventions that reflected a parental approach towards anti-social behaviour. Z ward nurses were more ambivalent about the use of control, and they displayed this during interactions with intimidating patients. They expressed more vulnerability about enforcement, and the data indicated that they received less managerial support. See supporting examples from the transcripts See supporting examples from the transcripts on page 68 (ywcn121382); page 70 (zp939121) (ywan4319) (zwfn 25.2.00); page 74 (zsn (1) 379) (zwfn139) (zwsn172181) (zwfn68) (zsrn111416) (ywna291252) (ywfn.80); Page 71 (zms5690) (zwsn171423) (ywna17313); page 71-72 (z8231) (zsn (1) 516) (ywna171235) (zwcn251332); page 75 (zwfn.720) (zwfn, 134) (zwfn.12.11.99) (zwfn 14.11.99); Page 76 (ywastn212); Page 78 (zwfn.2.11.99) (zwfn 9.11.99) (zwfn.14.10.99) (zw3cn251229) (zwfn 2.11. 99) (zwfn.18.1.00) (z82132) (ys322523); Page 80 (ywp1123) (yp (10) 1617); page 81 (yp (1) 41543); page 81-82 (yp (5) 51212).

Y ward nurses were particularly concerned about enforced confinement, and the data suggested that the ward exit was locked routinely. They were conflicted about whether the whole patient group should be confined because of the few who were an absconding risk. This suggested that Y ward nurses were more concerned about absconds than Z ward staff, which may indicate that they felt the influence of a blame culture to a greater extent, or more anxiety for patients. See supporting examples from the transcripts on

page 65 (zwsn172285) (zsrn111630); page 66 (ywfrna24) (ys322504) (zsstn487); page 67(ywsn18231) (ys322627) (zwsn261620) (ywfn. 16.11.99) (ywfn. 4.11.99 (ywstn21521)

Preliminary discussion

Nurses described feelings of ambivalence in relation to rule enforcement, and this could be interpreted as a positive reaction, in that it demonstrated an awareness of authoritarianism. The interviewees articulated this conflict, and from a symbolic interactionist perspective this reaction could be interpreted as taking the role of the other. They expressed empathy for patients, particularly those who were confined to the ward, and a dislike of the rule enforcement role, perceiving that it obstructed the development of therapeutic relationships. This finding corresponds with aspects of sociological theory related to role strain. Nurses also associated rule enforcement with power. This finding reflects the views of Giddens (1981) who argued that rules are enmeshed with the distribution of power within society, and an awareness of the role of rule enforcer as defined by Becker (1963).

During the interviews nurses verbalised conflicting feelings and views about the imposition of societal expectations upon the patients in their care. In general patients with a discrete diagnosis of severe mental illness were not treated as rigidly as those whose diagnosis was complicated by other factors, or who were regarded as personality disordered. This finding was reinforced by non-participant observation data, and it aligns with Becker's (1963) work in which he described how the collective social judgements of the police towards deviance explained variable attitudes towards rule enforcement. This finding also suggests that the rule enforcement role was influenced by wider social factors other than institutional aims of safety and therapy.

Z ward nurses expressed greater conflicts about mental illness causation and behaviour. They were split between an organic and societal reaction perspective, and the Y ward team generally embraced an organic position. The Y ward team approach led to a clear grasp of the aims of the rules, but the Z ward team failed to reach agreement on fundamental principles of care or safety. From a symbolic interactionist perspective the rule enforcement role depends on the ability of enforcers to agree upon, and apply macro level decisions within micro level interactions (Haralambos & Holborn 2000).

An analysis of the interviews together with the field notes from non-participant observation suggested that nurses generally divorced rule enforcement from therapeutic engagement. However several nurses expressed compassion for patients, but they stressed the need to keep this under control. They explained that they adopted a rigid approach to the rules in the interests of fairness and overall order, but patients described adverse reactions to what they perceived as harshness. This finding echoes Goffman's observations of nurse patient interactions in Asylums (1961). They described how nurses enforced the rules, and their accounts showed that many interactions were limited to brief exchanges in the form of orders or terse statements. The findings suggest that nurses limited interactions with patients because closeness might threaten objectivity. Mead described how people might prolong interactions, and take on the role of the other in order to clarify situations (in Haralambos & Holborn 2000). The results suggested that nurses did not do this because they experienced difficulty in reconciling the therapeutic and control function of the role.

A paternalistic approach towards rule enforcement, particularly by the Y ward team seemed to help nurses deal with the above dichotomy. This system enabled nurses to enforce, for example, rules associated with daily living skills. However an interpretation of the views expressed by patients suggested that many were infantilised and angered by this approach, and this echoes Goffman's (1961) theories in relation to mortification and stripping processes within psychiatric institutions. This finding also corresponds with aspects of social rule theory in that nurses assumed the socialisation function of the family. The Y ward interviews contain many references in which nurses described using their own experiences of families, and the way that they regarded patients as their own children or siblings.

However as Giddens (1981) observed rules cannot be divorced from the structures that form and convert them into social practices. He argues that rules are interlinked with the distribution of power and domination within society. Conceivably acutely mentally ill people may have lost the ability to share the meaning of symbols, which may include an impaired ability to follow rules, or engage in self-care. The adoption of a family structure within Y ward enabled a reconciliation of care and control, but the patient interviews suggested that staff crossed social boundaries, and humiliated patients. The results suggested that a combination of infantilisation and impersonal rule enforcement led them to misperceive the reasons for restrictions, and for nursing interventions. Again this finding reinforces the fundamental principles of symbolic interaction theory in which Mead emphasised the vital importance of the role taking process in the transmission of social rules (in Haralambos & Holborn 2000). This means that in order to reason with patients nurses must envisage the impact of restrictions from the patient's perspective. If the rules were placed within therapeutic contexts patients might perceive them as symbols of care rather than control.

Inconsistency between nurses developed in response to patient aggression. This issue predominated in the Z ward interviews, but both sets of data contain accounts of an avoidance of confrontation with intimidating patients because of the anxiety and fear that they evoked. Within Z ward this led to a situation where the nurses in charge of the ward bore brunt of a patient's hostility when rule enforcement could no longer be avoided. Concern for patient safety motivated nursing interventions, and their descriptions of events indicated that staff had become conditioned to unacceptable levels of patient aggression. They described how they placed themselves at risk during potentially dangerous situations, and these accounts suggest that more incidents occur than are actually reported. These findings correspond with the work of writers such as (Fagin et al 1996; Whittington and Patterson 1996). The interviews also contained references to fears associated with working within a blame culture, and this reflects the findings of other authors such as (Wilson and Rosenfield 1990; Pilgrim and Rogers 1999).

Nurses expressed frustrations about the rule enforcement role. The enforcement of medication, confinement and smoking rules evoked strong feelings. They verbalised feelings of ambivalence, and certain staff did not perceive that placing limits on patients for inherently good motives was integral to caring. However more experienced staff expressed less role ambivalence, and exercised greater flexibility. The interviews from both nursing teams contained few references to specific therapeutic interventions that might decrease the use of containment measures. Even though they expressed extreme frustration about an over reliance on surveillance in particular, none of the interviewees described the use of therapies that might fully utilise their expertise. They perceived that they were deskilled by the system in which they worked. However the Nursing and Midwifery Council (NMC) code of practice guidelines 2002 states that nurses must engage in evidence based practice.

They also expressed feelings of anger and frustration in relation to the role of Consultant Psychiatrists who were perceived to escape adverse reactions from patients towards the rules that they had set for nurses to enforce. This finding could be interpreted from a symbolic interactionist perspective in that it points to a breakdown in the role taking process between nurses and consultants. However consultants did not participate in this study, and any further interpretation of the results would be biased by the absence of their views. Although nurses complained about the inaccessibility of Consultant's and their control over decision making in relation to treatment rules they would not exercise independent judgements. For example they would not even take patients into the grounds without the Consultant's consent. Yet the NMC (2002) states that nurses are professionally accountable for their practice, and for patient safety. These results highlight Weber views in that he predicted that a growth in hierarchical systems heralded an increase in the defensiveness, and rigidity of lower level employees, as they strove to protect their own positions within the increasingly specialised nature of organisations (in Giddens 1981). The interviews showed that the emotional dilemmas that nurses faced, particularly in relation to enforced confinement, evoked strong feelings of ambivalence, and this was a major factor in role strain. They also verbalised concerns that were associated with the blame culture that surrounded the institution, and this reflected the impact of wider social forces on reasons for rigidity.

The data showed that nurses allowed the rules to lapse in certain instances, and imposed sanctions on patients who were judged as responsible for their actions. However mental disorganisation may have plunged patients into social chaos prior to admission, and ward rules provide an external focus on which to base other therapies. The rules include those guiding appropriate responses towards others. They provide a means of therapeutic containment for patients who may be experiencing frightening, and distressing distortions of reality. In symbolic interactionist terms the rules ground us in reality because they keep us aware of our environment and of each other through the symbol sharing process.

The incident data from Z ward showed that frequent breaches in the rules occurred. A small group of non-compliant patients caused disruption, and nurses described feelings of fear, hopelessness, rejection and anger in relation to them. The non-participant observation data reinforced this finding, and showed that nurses avoided confrontation with these patients and generally shunned them or resorted to containment measures in an effort to deal with disorder. This reaction could be interpreted as anomie, as described by Cohen who defined this state as a situation when rules do not operate, and unguided behaviour produces deviance. He argued that the use of stronger controls and sanctions within organisations could be avoided if the causes of deviance are addressed (in Rubington and Weinberg 1971). The results suggested that an inability to form relationships with these patients in combination with inconsistency between staff caused rule-breaking to escalate. This resulted in the increased use of external controls, such as the Rapid Response Team, enforced medication and seclusion.

Z ward patient expressed particularly strong feelings about the rigid enforcement of rules. For example they were denied access to bathing or refreshment facilities, and they were not given reasons for these restrictions. Risk assessments may have indicated that certain patients should be restricted for their own safety, but the data indicated that the rules were rigidly applied regardless of individual levels of functioning. Again this finding might be associated with the effects of a blame culture, and with the high turnover on acute wards. However the data showed that even when patients were given long periods of leave by Consultants they were subjected to the same degree of rigidity on their return. This finding could be interpreted from the perspective of work on stigma. For example Higgs (1995) argued that diagnostic

labels influence the views of others, and may become a master status, which may obscure other situations in which people may be functioning well. Patients described the denial of access to facilities as dehumanising.

The conflict between caring, protective and controlling aspects of psychiatric nursing emerged into sharp focus when patients expressed their sexuality. The findings correspond with Goffman's observations about the way that social activities that preserved a sense of self were removed from inmates by the staff in Asylums (1961). This finding also echoes Bowers (1998) objections to labelling theorists who tend to view rule breaking by the mentally ill from a judgemental or a moralistic stance. The findings also align with organisational theories about rigidity, and the way that over-conformity amongst employees may obstruct organisational aims. Arguably rule inflexibility deterred the development of patient autonomy, which is an important therapeutic aim of hospitalisation, and the active promotion of this goal is a requirement for nursing practice NMC (2002). Arguably nurses were struggling with the changing in patient population and high turnover (Taylor and Taylor 1989;Thomas 1996). A possible way forward might lie in the closer involvement of multi-disciplinary teams in rule construction and enforcement. This might produce better risk assessments, and lead to greater rule flexibility for patients where this is indicated.

Summary

The interviewees had difficulty in accepting devolved responsibilities for social control and treatment. Nurses dealt with ambivalence by suppressing the therapeutic aspects of the role, because the feelings evoked by patients threatened their responsibilities for containment and order. Lack of team cohesion within Z ward resulted in inconsistency between nurses during enforcement, and they avoided intimidating patients. Disorder escalated as a result, and nurses resorted to containment methods in an effort to achieve compliance. Nurses within Y ward tended to induct patients into the regime, and they allowed certain rules to lapse during the admission process. On the other hand they clamped down on aggressive patients, and those who breached treatment rules. The regime appeared successful in terms of the low rate of ward incidents, and it could be argued that patients responded positively to the tight structure.

The paucity of interpersonal relationships within both study areas, and a lack of strategic interventions involving one to one contact with patients suggested that both regimes focused on containment. Both groups of nurses did not seem to receive adequate clinical support, and Z ward staff was particularly vulnerable during interactions with intimidating patients, because the team lacked cohesion. Lack of rule clarity exposed Z ward nurses to increased pressure from patients to change treatment rules. Nurses reacted with increased rigidity, and this further polarised relationships with patients. However Y ward staff drew on therapeutic skills to a certain extent when they reinforced treatment rules. Certain aspects of the data showed that they communicated concern for patients' welfare whilst leaving them in no doubt about the consequences of non-compliance.

Nurses perceived that they possessed little discretionary powers, but they performed comprehensive assessments, and were in greater contact with patients than any other discipline. They expressed anger, frustration and guilt in relation to their role, but most refused to exercise independent judgements even when they knew that patients were subjected to harsh or unnecessary controls. However certain nurses did use discretionary powers in relation to defined amounts of leave, and this suggested that they were a more experienced group who had confidence in their own assessments.

Nurses were ambivalent about the use of control. The Y ward nursing team were supported by paternal attitudes towards rule enforcement, and this resulted in less role ambivalence. A parental approach to activities of daily living helped them to overcome conflicts about the extent to which these rules should be enforced. The Z ward team blamed organisational pressures for the rigidity of the ward environment, and the lack of control at senior level on the number of patients that the ward could safely hold contributed to this.

Patients were acutely aware of the manner in which nurses enforced the rules. Nurses threatened patients with containment measures, and this intensified negative perceptions of the regimes. They made their own interpretations of ward incidents in the absence of debriefing, and they regarded containment measures as punitive rather than therapeutic. The data showed that certain groups of patients were subjected to particularly harsh and insensitive controls. The rigid enforcement of rules governing access to personal hygiene and refreshment facilities dehumanised patients, and this suggested that nurses did not have an in depth knowledge of individuals on which to base individualised rules, or that they were influenced by other factors.

The high patient turnover within acute psychiatric units may obstruct the development of therapeutic environments, and the care context may not be conducive to intensive therapy. The data showed that nurses perceived that their rule enforcement duties impeded rapport, but these interactions may be instrumental in the development of relationships with patients and provide an outlet for psychosocial concerns. The results showed that most nurses failed to strike a balance between safety and therapy. Consequently patients reacted adversely because they did not perceive that nurses imposed boundaries out of concern for their welfare and recovery.

To reiterate the aims of the study were to discover the content of ward rules within acute psychiatric admission wards; to explore patients responses to the rules; to evaluate the impact of rules and rule implementation on nurse patient relationships, and on ward events; and to investigate the relationship between ward rules, ward atmosphere and ward design. The content of ward rules emerged indirectly from the interviews. The data showed that Z ward nurses were influenced by societal expectations of conformity, and deviancy theory as outlined in the introduction. This approach gave rise to levels of HEE (High Expressed Emotion) in the environment because nurses used constant reinforcement. Patients' and staffs' perceptions of rule enforcement and relationships illuminated the meaning of the WAS results in that the transcripts contained graphic descriptions of interactions, and ward events associated with anger and aggression. References to restrictions on access to refreshments in Z ward validated and clarified the higher score in this HHPP subscale. The field notes from non-participant observation also showed that these restrictions were associated with one ward incident.

The Z ward results showed that nurses were highly ambivalent about the rule enforcement role, and this gave rise to variable methods of enforcement. Goffman's (1961) study suggested that staff were complacent about the use of control, but nurses from both wards in this study expressed an awareness of power relations, and a dislike of rule enforcement. This finding corresponded with aspects of the literature that was outlined in the introduction on role strain within organisations. Examples from the transcripts augmented the quantitative data on the use of PRN medication and ward incidents, and the WAS data in that they also showed that Z ward was more disorganised than Y ward. Examples from the transcripts also

amplified the WAS results on spontaneity, anger, aggression and containment measures. Z ward staff encountered particular difficulties in the management of intimidating patients, and rule breaking escalated. Nurses gave way to uncontrolled emotional responses, and the use of sanctions increased. Less incompliant patients were treated harshly, and became resistive to enforcement, and this exacerbated a rise in disorder within the ward. These findings reflected aspects of the literature, in which Cohen (1971) observed the effects of disorganisation within institutions.

The Y ward results paralleled the literature on hierarchical institutions, and the effect of working within a blame culture. Examples from the transcripts highlighted the effect of an emphasis on containment measures in terms of locked exits, and the strict enforcement of rules governing leave and medication. This data clarified the Y ward HHPP results, which revealed higher restrictions on activities in that the qualitative results showed which diverse behaviours were controlled. Examples from the transcripts also showed that the ward was better organised and this augmented the WAS results on this subscale.

Y ward patients' accounts of interactions with staff involving rules highlighted the effect of paternalistic and authoritarian approaches. These results in combination with the high structure cast further light on the lower rates of spontaneity, anger and aggression in the Y ward WAS results, and lent further support to the concept of a somewhat oppressive atmosphere. However these results could not completely account for the low rates of ward incidents and lower PRN medication usage in the ward. These results might have been attributable to the early control of intimidating patients as exemplified in the transcripts from the interviews, or to an under reporting of ward incidents. The Y ward transcripts contained descriptions of events that did not appear in the ward records.

This section has confirmed that nurses experienced role strain. This manifested in rigidity and role disruption with adverse consequences for nurse patient relationships. A highly structured environment in Y ward and disorganisation within Z ward both failed to provide a balance between safety and therapy. This section has shown that role ambivalence exerted a powerful influence on general methods of rule enforcement in that staff was largely unable to reconcile both aspects of the role, and distanced themselves from patients in an effort to cope with these demands. What is beginning to emerge is that within a sociological framework of understanding the quantitative and qualitative data can be effectively integrated. This opened up the possibility of tying the findings to overarching suggestions that may account for the meaning of perceptions, behaviour and events. Recurrent themes in this chapter were role ambivalence and nurses' perceptions that enforcement obstructed therapeutic relationships with patients. In turn patients were dehumanised by an authoritarian approach. Symbolic interactionism stresses the need for an explanatory context in rule transmission, but with a few notable exceptions this method was largely missing from the data. Others factors in role strain and rigidity were associated with nursing responsibilities for patient safety, and anger about the enforcement of rules constructed by consultant psychiatrists.

The findings led to the conception that the combination of therapeutic engagement and rule enforcement might ameliorate role ambivalence amongst nurses, and patients' feelings of dehumanisation. More support for nurses through greater involvement of the multi-disciplinary team in rule construction and communication with patients might have an impact on rigidity and role strain. This might also increase compliance, and decrease adverse responses to rule enforcement, which might have a beneficial impact on ward stability. Additionally it was thought that the absence of references to supervision training and monitoring across both study sites might be a contributory factors in role strain, and restricted contact

particularly with intimidating patients. These recurrent themes formed the basis of a conceptual model that might address these issues and stimulate changes in clinical practice. Consequently a therapeutic context for enforcement and supervision training and monitoring emerged as an overarching concept in the development of the conceptual model. Effective nursing and multidisciplinary team communication re the rules formed another element of the model on which recommendations for clinical practice is based. This concept opened up the possibility of a system of tiered flexibility in which with the support of the multi-disciplinary team the rules could be individualised in line with patients' differing levels of functioning. The next chapter provided a further exploration of aspects of the research questions in terms of the consistent enforcement of rules, and the information given to patients, and the findings provided more evidence for the expansion of the model.

CHAPTER 6

CONSISTENCY AND INFORMATION GIVING

CONSISTENCY AND INFORMATION GIVING

Another major theme in the interviews was the material that discussed, or expressed feelings about consistent rule enforcement. A text search was conducted for terms related to this topic. The search terms included: consistent, regular, constant, persistent, unchanging, steady, inconsistent, unpredictable, changeable, erratic, fickle, irregular, unstable, variable, at odds, conflicting, contradictory, arbitrary, chance, discretionary, personal, random, subjective, unreasonable. The items that emerged from the search were read, and those not pertaining to the topic were discarded. The remaining material fell into ten topic categories:

- Nurses' rationales for consistency
- Inconsistency and patient care plans
- The absence of a strategy to achieve consistency
- Nurse patient relationships and consistency
- Disruptions to consistency
- Consistency over time
- Fear of intimidation and inconsistency between staff
- Patients' perceptions of consistency
- The achievement of consistency

The data analysis identified another closely related theme that could be categorised as information giving and reasoning. The consistency of staff in enforcing the rules, and of patients in following them, was closely linked to the information that both groups had about what the rules were. A second text search was therefore instituted using the following words as search terms: clarity, clear, explain, obvious, comprehend, simplify, information, inform, tell, communicate, advise, rationale, reiterate, reinforce, remind, visible, seen, apparent, conspicuous, evident, noticeable, plain, understand, unconcealed, unmistakable, known. The items that emerged from the search were read, and those not pertaining to the topic were discarded. The remaining material fell into four additional groups:

- Reasons for lack of rule clarity
- Information giving during the admission process
- Patients' perceptions of information giving and reasoning
- Information giving following breaches in the rules

These two related qualitative analyses are presented together in this chapter, and supplemented by material from the fieldwork notes taken during non-participant observation, where these were relevant.

Nurses' rationales for consistency

One way or another, most nurse respondents mentioned consistency as desirable, however they provided differing reasons for that desirability. Certain staff perceived that ward rules reflected structures that maintain conformity within society, and that psychiatric nursing embraced a corrective function.

> *What I like is where they come from and the reasons behind them of accepting everyone's individuality and seeing that, but in order for us to work collectively then we need some rules,*

like the world has rules. Like you shouldn't do this, or if you're caught doing that there is a consequence. Maybe not punishment I won't use the word punishment, but there is a consequence for this action of going outside of these rules that are there to protect you and protect us. So I'm glad for the rules that we've discussed, and we often have to revisit them because they fall down. (Zsn (1) 529)

Others compared the function of psychiatric wards with family units, and this evidenced a cultural overlap with methods of socialisation within society. However, they also associated inconsistency with aggression, and this interviewee believed that preferential treatment might invoke reactions from patients that paralleled sibling rivalry within the family ... *and I think it is more dangerous in terms of they notice that it is like children, you know they are naughty you know, you say my dad use to love me more than my sister or my sister use to get more attention more than me, although probably those children were never aware of it, but I say well with them they notice they would know, and you are just getting resentment. (Ys322431)*

Others expressed similar views, and argued that preferences for certain patients should be overcome, and that consistency should be sustained with intractable individuals in the interests of ward stability. Consistent rule enforcement had to be conspicuous so that patients perceived staff as both firm and fair, and this nurse warned that ... *Patients can tell each other that staff A has done this for me, and why hasn't she done it for you, you make the nursing care very difficult so we have to have rules for everybody, one rule. (Zstn21264)* Another interviewee said ... *we have to look at where they're at at any one time but we have rules for everybody and it's not fair that somebody would be looked at as being more favoured than another patient because then that just sets for a bad atmosphere on the ward. (Zsn (1) 1262)*

Certain staff linked rule following behaviour with order and therapy. They held that patients should be subjected to the same regime because they were all inherently irrational. They believed that the rules controlled mentally disorganised impulses by evoking fixed repetitive responses towards the environment, and this interviewee's comments illustrated these views ... *and with people with mental health problems you need a very consistent approach with all of them, and they need set rules, and the reasons why we do them, and they need those rules to be enforced and enforced, and you can't do it you can't say you are alright just this once or you can do this because you are not really a risk to anyone. (Zwsn261)*

Nurses' attitudes towards consistency were influenced by wider social structures, and by beliefs about mentally disordered behaviour. They advocated rigidity in the interests of fairness and ward order.

Inconsistency and patient care plans

Although they advocated consistency differing attitudes towards the rules produced inconsistency between staff, and the Z ward team enforced changes in treatment rules haphazardly, because nurses were so preoccupied with overall control. They monitored patients' responses to alterations in care plans irregularly, for example compliance with defined amounts of leave, and one nurse observed that discrepancies gave rise to confusion ... *and it was confusing because on the board it said right you are not supposed to go out and yet hours later she was told she could go out unaccompanied. I mean the boundaries are changing constantly so she would have ended up totally confused.* (Zwstn241)

Conversely Y ward staff advocated a strict system of monitoring changes in care plans together with rule clarity. Patients' leave was suspended if they exceeded the limits that were imposed, as the comments of one nurse demonstrated ... *and when it goes from one shift to another, and it's about ten thirtyish and then they should be back at six o'clock. They will come with their families, and say no we were here at twelve. It is written you know?* (Ywsn111609) They expressed concerns about safety, and the prevention of absconding. For example this interviewee said...*some one who has been ill, and they are on section 3 they can't leave the ward, and they go AWOL and the police turn up. It can be extremely frightening.* (Ywsn111609)

An absence of strategies for gaining compliance resulted in the inconsistent enforcement of changes in treatment rules within Z ward. However, the other team were forceful in dealing with non-compliance, and were able to sustain consistency over time. They appeared comfortable with the controlling aspects of the nursing role because they reconciled safety aspects with the micro social structure of the family.

The absence of a strategy to achieve consistency

However the staff interviews contained few descriptions of the ways that consistency was achieved with individual patients. Consistency between nurses was referred to in terms of general reinforcement rather than on a one to one basis with patients.

> *The way the ward is run everyone is treated very individual, and care packages are designed by the individual. I think there should be consistency with rules that compromise safety, there should be no leeway regarding that. Perhaps with other things what things can I think of? (Zwan26128)*

Patients are allocated a key worker during the admission process, but I attended a community meeting and the patients complained that they did not know whom their named nurses were so they did not know who to approach if they did not understand the rules. The patients were told that they could talk to their key worker, but the patients said that they did not know whom they were. It was agreed that key workers should introduce themselves to patients at the start of the shift. (Zwfn 26.10.99)

The interviews did contain accounts of the type of interactions initiated by staff. An absence of strategic interventions was highlighted in the accounts of Z ward staff in particular. They experienced difficulties in sustaining a consistent approach with non-compliant patients. These examples illustrated the levels of high expressed emotion within the ward environment, and an interviewee described the effect of methods of reinforcement on patient engagement ... *The constant nagging it also hampers your relationship with the patients as well it really does. (Zwsn2619)* Rule enforcement was perceived as an onerous task that entailed constant criticism, with monotonous and energy draining connotations. An inability to evoke compliant responses from patients influenced inconsistency, and this interviewee said ... *you get people and you just constantly tell them to clean up and they don't, and I wouldn't say that you turn a blind eye but you constantly tell them about these rules and nothing changes so. (Zwsn2514)*

The issue of inconsistency arose when I was engaged in non-participant observation, and noted that a patient was sitting with a visitor. I queried this because during a recent community meeting the patients had been told that the rule governing visiting times was to be enforced rigidly. The nurse said ... *We have been letting some visitors in if they work nights or something but now its going to be a blanket rule it*

interferes with O/T and activities, and patients need a lot of rest to get better. Shortly afterwards a patient from another ward came to visit a patient, and was told by another nurse ... *you're not allowed on the ward it's not visiting time.* (Zwfn. 9.11.99)

Although nurses recognised that patients failed to comply when a rationale for the rules was missing, they admitted that information giving was not sustained during enforcement.

> *They are told, like I was saying before you can tell them five or six times to go into the smoking room, but then you may tell them only once why, but you can keep saying it, but if they are adamant that they are not going to do what you are going to say you can say it until you are blue in the face. (Zwsn2615489)*

Others stressed the importance of consistent rule clarity, and this interviewee said ... *I mean you get sick of saying it but you just have to say it every time you see it happen when it shouldn't be happening, you have to explain why every time. (Ywan11)* However another interviewee perceived that floridly psychotic patients retained the capacity to understand instructions ... *yes I think they are made clear enough but to implement them it is sometimes even the most simple rules patients, many patients want to break them and what we lack is the consistency within the staff to implement and keep them. That the rules is implemented by that same patient all the time. (Zwsn171246)* Several nurses who dismissed lack of rule clarity as a cause of non-compliance, and argued that inconsistency between members of the team was the primary cause of patient resistance reinforced this view.

> *Inconsistency, possibly from staff to staff, rather than time if you know what I mean, it's just like at the start of the shift to allow somebody to smoke at the end of the shift, and the reason may be changes of staff rather than start at the end of the shift.* (Zwcn251122)

The views of nurses conflicted in that some believed that patients broke the rules deliberately. Others held that lack of clarification, and problems of retention were causative factors. An over reliance on methods of surveillance and reinforcement within Z ward seemed to cause particular problems with the achievement of compliance.

Nurse patient relationships and inconsistency

Others themes emerged from the interviews that conflicted with nurses espoused aims of fairness and equality. The impact of relationships with patients that developed over time was described, and one interviewee observed that colleagues were lenient with patients with a previous history of admission to the ward ... *the problem is not to rock... what is the word I am looking for...not to rock the boat in their relationship. Let something slip by to get something. Not something in return but to lose the relationship that they have. It could be a good thing and it could be a bad thing. It just dependent on the situation. (Zwsn261270)* However subjective reactions were criticised on the grounds that over attachment to patients might lead to the reinforcement of aggression.

> *She's been in institutions all her life, and I think they're trying to if they can, for example they'll give her a cigarette every now and then where I wouldn't dream of giving anyone a cigarette. But then she's been very violent recently she attacked someone last night, and got given a cigarette this morning it's an individual decision isn't it? (Zsn1216)*

Certain staff gave patients more individual attention than others, and a nurse observed that they might ignore breaches in the rules ... *Sometimes a nurse has an outstanding relationship with a patient, and they*

will spend x amount of time with them in their room or whatever, and they will see them doing something that they are not supposed to do, and it is let by because they have this wonderful relationship. (Zwsn261244)

They adopted a different approach towards certain patients who were perceived to have a genuine reason for seeking attention as opposed to those who were classed as personality disordered, and one interviewee elaborated on this ... *even though it's attention seeking there's always a reason for attention seeking, there's an underlying reason, and also if it's not being dealt with by staff in the office the need for attention is still there, and it will be sought elsewhere whether it's from other patients, the ward manager or whoever. (Ystn21323)* However other nurses perceived the expression of symptoms or requests for staff contact as maladaptive behaviour, and the rules were rigidly enforced when it was deduced that patients were deliberately breaking an unwritten rule by demanding excess attention. Certain groups of patients were immediately ejected from the office, or their requests were dismissed, but others received immediate attention, and a nurse described an incident when an appeal for pain relief was ignored ... *that's an example of how they don't particularly like this man on the ward, and I think perhaps if someone else had complained of toothache or earache they may well have got the duty doctor. (Zrn111416)* I was engaged in non-participant observation, and one of the patients was speaking to a visitor. She complained that the staff did not talk to her or ask how she was feeling. The visitor suggested that she talked to the staff, but the patient said that they were unapproachable. (Zwfn. 14.10.99)

Several nurses expressed concern about the erratic enforcement of restricted access to the ward office. Certain patients were told to leave if they entered the area frequently, but others were allowed to sit with staff, and a nurse described the type of individual that was ejected immediately ... *they would probably be more along the lines of personality disorders, maybe found or considered to be more difficult or awkward than attention seeking, more demanding. I can't say staff have their favourites, but maybe they might be more lenient towards one or two patients, but that occurs on every ward I've been on to. (Ystn21302)* They observed that this was an unwritten rule, and argued that differential treatment should be countered by rigid enforcement. Nurses cited the protection of patient confidentiality as a reason for restricted access, but during a period of non-participant observation I observed that a certain patient was allowed to remain in the office, despite the fact that he appeared acutely aware of the interactions that took place. I reflected on this, and the following extract was taken from my field notes.

> *A female patient constantly enters the office she is perceived as responsible and aware and is immediately ejected, but a male patient who is suffering from psychosis is allowed to stay in the area for long periods of time. The female patient is so anxious that she seems to be unaware of anything beyond her own needs, but she is told to leave because it is assumed that she will understand and repeat confidential information. The male patient sits at the computer desk and spins around in the chair humming quietly to himself. He appears to lack insight, but when interviewed later he was able to focus on my questions and was quite articulate, with only occasional lapses into delusional speech.* (Zwfn1250)

Other extracts from the field notes illustrated different attitudes towards differing patient groups. When I attended a community meeting one of the patients complained about the unprofessional way that staff spoke to a female patient. Another patient said that there was no one to talk to about problems of the heart. When I attended a ward round the team discussed one of the patients. One of the nurses' spoke to the consultant ... *X ward won't have her because she is a PD. We want to discharge her.* The consultant replied ... *you can't make a diagnosis based on her behaviour.* (Zwfn26.10.99)

Difficulties in the adoption of a consistent approach towards certain patients emerged on another occasion two nurses discussed a female patient's care plan, and one of the nurses said ... *A detailed contract has been drawn up, and the psychologist is going to talk to us about how to handle her. Limit setting she can walk up and down the corridor, but if she smokes in her room we will take the cigarettes away.* The patient in question came to the office door, and said ... *I'm going to go out to get 3 packets of Ibuprofen.* One of the nurses said...*don't go out if you feel like that.* The patient left the office, and the nurse said...*She's okay when I'm here but if people are too kind or friendly she will take advantage.* The other nurse replied ... *she doesn't come to me we must only talk to her one to one. Patients have their own key worker we can't all talk to her.* (Zwfn. 17.1. 00)

Consistency was influenced by nurses' previous knowledge, and by their relationships with individual patients. Certain groups of patients received less attention than others because of the judgements that staff made about the causes of mental disorder and behaviour.

Disruptions to consistency

In addition to personal relationships between staff and patients the underlying structure of the ward had an influence on consistency. Structural deficiencies were demonstrated in accounts of frequent disruptions to consistency within Z ward in particular, and frequent breaches in certain rules pertaining to:

- A ban on visitors within patients' rooms and dormitories
- Controlled access to the ward office
- Smoking within designated ward areas
- Defined amounts of leave from the ward
- Time of return to the ward following day leave

The inconsistent application of rules designed to control the behaviour of visitors caused anger and confusion amongst patients and staff, as one nurse observed ... *but there was one particular patient whose visitors often go into her bedroom, but now it has been said that no visitors are allowed. Why should she be exceptional so that the rules stand for everybody not just one?* (Zstn2121)

The ban on smoking within undesignated ward areas appeared to cause particular difficulties, and several interviewees blamed inconsistency between nurses for this. Within one of the wards a lack of entertainment facilities exacerbated problems of enforcement, and this nurse said ... *Again that can be prevented with the consistency thing, but if you are sitting there and one patient is strolling around with a cigarette and you are confined to the smoking room where there is no music and no telly you are going to get up and take your cigarette outside with the telly aren't you? (Zwsn261169)* During an interview with one of the patients I observed that she used an electric coffee-making machine to boil water for drinks, and smoked cigarettes at the open window of the bedroom. During a period of non-participant observation I observed a female patient, clad only in a transparent nightdress smoking in the corridor outside the ward. (Zwfn. 17.1.00) One interviewee commented on this type of situation:

> *So there's that side of it and the same with the smoking. It's like something that person does, and it's kind of left whereas somebody else-it's just different treatment for different patients. (Zwsn 241)*

Treatment rules were implemented inconsistently, and one interviewee described the situations that resulted from these practices ... *I think if somebody is not supposed to go out according to the board, then surely we should stick to that instead of getting mixed messages from staff members because the patient gets confused, staff are confused you don't know where you are. (Zstn241)* I was engaged in non-participant observation, and one of the patients entered the office. One of the nurses said...where have you been (laughing) you are grounded now. The ward manager was present, and he said ... *let him out for 2 hours unescorted it's not enough for him in the grounds.* Then the nurses discussed this decision, and decided that the patient could have 1 hour of unescorted leave until the next ward round, but this would be stopped if he failed to comply. (Ywfn. 22.10.99)

Nurses complained that doctors overrode multi-disciplinary methods of communication and accountability for patients' care plans. This jeopardised team cohesion, and placed nurses in a difficult position. Doctors interviewed patients, and changed medication or leave status without consultation. The changes might not be recorded in patients' notes, and they became confused and resentful when nurses refused to implement alterations without written authority. One interviewee elaborated on this ... *it does especially with medication and with leave is the main thing Like something has been said in ward round that medication is going to be decreased and the doctor hasn't got round to doing it, and we don't know from feed back that that has been discussed or the doctor has had a one to one and decided they can go home for three hours and she will forget to tell us. We are put in a very difficult position.* (Zwsn261) Doctors also ignored a ward rule that was consistently enforced by nurses, and allowed patients access to the office telephone.

Inadequate ward management systems were associated with constant failures in a unified approach towards the rules, and senior staff did not correct individual members of the nursing team for erratic behaviour. One nurse described how patients slipped through the gaps in consistency.

> *That is the main problem. You can say XYZ one day and the patient comes perhaps even on the same shift and the next day ask another person and they say ABC and you know that is not right and you have said one thing, but patients are very clever and they go and ask someone else and they are allowed to do whatever they have asked, so with things coming up with documentation and care planning that is where we can address things like that and hopefully that will stop now. The main thing is inconsistency with the staff. It's not anyone's fault its poor communication and poor feedback and the patients being a bit manipulative and a bit splitting, so we have to stand as a united body and say this is what we are doing, this is the reason why, but it is not being done. It is something we all need to work on sometimes decisions are made by primary nurse or something. If we say about leave again and people don't think it is right. I mean handovers are the time to discuss that and we will discuss it as a nursing team and come up with a solution then that is going to improve consistency. (Zsn261562)*

The data contained a solitary reference to the possible benefits of inconsistency. One nurse reported that she breached the rule about making refreshments outside designated times because this gave her an opportunity to interact with patients.

Inadequate Z ward management systems led to the inconsistent implementation of treatment rules. This problem was associated with adverse patient reactions against nurses. Senior nurses appeared to be more confident about the flexible interpretation of rules regarding leave from the ward. One nurse indirectly highlighted the rigidity of the regime because she felt the need to rationalise efforts at engagement that involved a breach in the rules associated with refreshments.

Consistency over time

Previous knowledge of patients was not the only theme that emerged from the interviews in relation to differential treatment. Certain groups of newly admitted patients were non- compliant, and they were not confronted with the rules for various reasons. Nurses experienced ambivalent feelings giving acutely ill patients information about the rules. They adopted variable attitudes towards rule enforcement out of concern for patients, but they also tried to quell resistance to admission by masking the reality of the ward regime, and one nurse admitted that rule enforcement varied at this time ... *I would say it is variable depending on the member of staff, and the situation. (Z821150)* Inconsistency also stemmed from fears about evoking aggressive responses from patients, and this interviewee said ... *again it depends what it was. I think sometimes when you have someone staff are quite frightened of. (Z821150)* Nurses consulted senior staff before they imposed the rules on intimidating patients. They monitored disruptive behaviour, and avoided confrontation. One nurse experienced anxiety when she carried out this task ... *Yes, she's very ill, yes. She's a bit manic at the moment. She goes pacing around, then goes back to her room and lights up all the time. She gets very angry if you point out to her to stop smoking in her room. (Yfna32)* However other nurses perceived that lack of consistency between staff during the admission process reinforced aggression, and they argued that unclear boundaries exacerbated patients' feelings of insecurity ... *It just made her feel that everyone else she could get what she wanted from because they were scared of her, and she knew that, but also I don't think it made her feel safe by knowing that people were scared of her. (Za8341)*

Other nurses overcame their fears in the interests of patient care.

> *[Interviewer: What do you find most difficult in working with patients in saying to them that they are not allowed to do?] When they are very, very ill. [Interviewer: And what do you find most difficult about that?] Then it is difficult to approach the person, when they are very, very ill they won't listen to what you are saying when they are very, very ill. That is the most difficult part. [Interviewer: And that is the time when you really need to get through to them?] Yes. [Interviewer: So how do you cope with that then?] You keep trying. [Interviewer: Keep trying?]. Keep trying there is no giving up. The person is ill so you keep trying. (Ywna6jan347)*

Several nurses perceived that they were softening the impact of admission, quelling resistance, and ameliorating the distress of mentally disordered or psychologically distressed patients by absolving them temporarily from the rules. Fear of an aggressive response to the rules was also a factor, but certain nurses argued in favour of the therapeutic benefits of consistency. They perceived that inconsistency was a factor in the production of aggression. Others nurses overcame their fears in the interests of patient care.

Fear of intimidation and inconsistency between staff

The effect of inconsistency between staff, and over time was illustrated by material from the Z ward interviews particularly. Following admission one group of patients continued to exhibit intimidating attitudes towards rule enforcement. This led to further inconsistency because the staff feared an aggressive response to rule enforcement.

> *Well you know, you hear it all the time who are you telling me, you know calling you this and that, but obviously in the same way people aren't so well you know. I mean think maybe we don't do it with people we're a bit scared to enforce the rules. So we let some people away with things that we wouldn't let others, and maybe we shouldn't be doing that. [Interviewer: Is that*

because of that?] Well because they might hit you. [Interviewer: Can you give me an example of this, a situation like that?] Well, yes somebody smoking in their room. It's not somebody whose scared it's just somebody who you know whose decided that's what they're gonna do, and you ask them to stop and they get very abusive. You might just leave it at that, and let them carry on rather than get into a big row you know? (Ywan179)

Nurses eschewed rule clarification, and avoided conflict by referring patients to the nurses who were responsible for the overall management of the ward. Consequently, charge nurses bore the brunt of patients' hostile reactions to consistent rule enforcement, and an interviewee described her experience...*and then we used to get a lot of abuse from patients because they felt it was us, and it wasn't the team as a whole.* (Z8226). Higher grades of staff were wary of entering patient areas, and a charge nurse described this experience ... *There was a point where we hardly dare go out of the office because the minute we went out she would just launch at us this barrage of sort of verbal abuse, and I think it would have been a lot easier to manage if everyone else was saying no.* (za8341)

Nurses attributed a lack of team cohesion to the practice of shoring up inadequacies in permanent staffing with agency nurses. Irregularities in staffing provision produced lapses in the rules because agency nurses were unfamiliar with ward regimes, and with the rules that applied to individual patients. Certain interviewees perceived that staff and patient safety was compromised because the numbers of agency workers was excessive, and a nurse reflected on this situation ... *We would seldom have a day where we would have all our nurses as permanent qualified staff there is always going to be a balance of bank or agency staff. There is very little consistency with them because you are not guaranteed the same person the next day. (Za417)*

Nurses adopted harsh attitudes towards certain patients, and avoided interactions with others because they feared intimidation. A total ban on smoking within undesignated ward areas was not enforced, and one nurse believed that a consistent approach would evoke conflict. However she observed that most patients complied with the rule, and this implied that certain aggressive patients were not restricted. Other patients perceived that nurses were vindictive when they adopted a rigid approach towards certain individuals whilst ignoring blatant breaches amongst others, and one nurse felt that inconsistency between staff was caused by a fear of aggression.

I do feel that if you get patients who have a history possibly if aggression, who can be disruptive, who may threaten, it can work both ways. They can either get away with more things or the rules imposed are more strict or you get a patient who is very passive, the rules are being imposed more on them, I mean from your point of view if you have someone who is very aggressive ... you may be more apprehensive to say,"Look don't smoke here", if you have someone who knows is relatively passive, quiet you may not hesitate to go over to them and say "Look don't smoke here". (Ywcn251230)

The failure to address problems of inconsistency between staff in the management of intimidation were externalised in rigid attitudes towards patients who were generally compliant. Nurses strove to maintain an authoritarian presence in the face of intimidation, but patients interpreted this stance as harsh and unfair.

Patients' perceptions of consistency

Several patients identified discrepancies in the rules, and their comments reflected shared perspectives with staff on those that were frequently breached or allowed to lapse. The impact of inconsistency on the reactions of individual patients, and on the ward community as a whole emerged from the data.

Patients who had been transferred from other wards within the hospital were confused by differences in the regimes, and lack of information about behavioural expectations led to resentment.

> *Everybody says something different all the nurses do something different. All the doctors say something different. Every single thing changes all the time from ward to ward it's totally different. It's, I there are some advantages to that I suppose. (Ywp (7) 1153)*

A lack of information was used as a rationale for rule breaking, and one patient described her response ... *I just keep myself to myself. I lock the door and I have a cigarette in here. I don't make a mess. It goes out of the window. I was reprimanded without knowing you can't smoke in your room. Do you know what I mean? (Z5213)*

Several interviewees referred to the inconsistent enforcement of the ban on smoking within undesignated ward areas, and certain patients disregarded the rule because they perceived that it was enforced unfairly ... *The ward rules are that you definitely cannot smoke, but you see people up and down the ward with cigarettes and no one reprimands them that I know for a fact. (Z52133)* However other patients observed that the staff was consistent and fair.

> *The thing that would be said to most of them from staff to the patient is you must go in the smoking room and smoke. That is the most common thing you will hear on this ward, and then what happens is, is like the goldfish syndrome. They walk in because they've been told, and the minute they get in it's forgotten, and they walk back out .So you have to stand there and say-go back inside, and they will go back inside. Then they will come straight back out. Go back inside. But that's the side of the illness just doesn't look as if that registered, if you tell them that and that registered why shouldn't everything else register. (Zp (4) 91317)*

Variable staff reactions towards patients who failed to return to the ward at the designated time was noted, and one interviewee recounted her observations ... *Normally about eleven, but I have seen people walking in through the door, three in the morning, four in the morning and depending on who is on whether they get a reprimand or not. There are times when they have agency staff at night and a free for all do what you like. There are times that music goes off at midnight that is that the telly goes off at midnight. (Z52119)* The inconsistent regulation of the use of the television set was a source of resentment for other patients, and led them to generalise about rule discrepancies.

> *If some nurses switch it off and some nurses the next day, will actually go and switch it on for another patient. There's no rules here. (Yp (7) 11153)*

Patients reported that nurses denied them access to bathrooms on the grounds that they had to be supervised. However one interviewee observed that certain patients bathed unsupervised at a very late hour, and she perceived a lack of a consistency between staff in relation to the rule, given that that these areas were left unattended during the day ... *no one ever supervises this ladies section during the day, so her argument to me was not rational, but I was in no mood for...she was in charge, and that is that with her. I read people as they are. I thought I am not going to get into this. I really needed to get into a bath,*

and a smoke. I thought not to worry I will just massage my feet with cream. I laid dirty, I had been sweating, and I had been gardening and things. I had to come back for a certain time. I was back for that time. (Z521393) This interviewee also reported an inconsistent rationale for another rule. She observed that staff refused to save food for patients who missed mealtimes, and some nurses quoted food hygiene regulations whilst others stated that it was a ward rule. The ward only provided refreshments for patients at designated intervals, and this rule might be breached if the ward was quiet, but one patient complained that the staff always refused to make her a cup of tea.

The interviewees referred to the inconsistent enforcement of treatment rules, and for example one patient felt trapped when a care plan that included daily amounts of escorted leave from the ward was implemented inconsistently. Another interviewee observed that staff treated patients differently when administering routine medication.

> *Yes on the same case of people telling me two different things. I said why the hell am I woken from my sleep at eight o'clock in the morning when I sleep till ten, to get my medication, because the last thing you should do with my illness is disturb my pattern of sleep. They said B and F rules. I checked the B and F that is ballocks! That is ballocks! That is another ward rule. I have seen that rule broken and have seen medication taken to patients. (Z2410)*

A few interviewees perceived that the rules were beneficial for the patient group as a whole, and advocated consistency on the grounds of equality. Moreover the position of being a patient in an acute psychiatric ward was associated with perceptions of helplessness, loss of self-control and unreliability, and these views led to the belief that staff should consistently impose restrictions on behaviour. Certain interviewees advocated the strict control of disorderly conduct, and one patient observed inconsistency between nurses in the management of conflict.

> *[Interviewer: Which patients would be breaking the rules?] There's usually a degree of harassment among patients. Depending on the nursing staff it'll be stopped. Some nurses are bone-idle and turn a blind eye. [Interviewer: But how would staff be getting patients to keep the rules?] As I said before it depends on the staff, some will stop it and some will turn a blind eye. Minor breaches just a word, major like refusing medication they'll call in the little hit squad of eight nurses. Very occasionally there will be the threat of removal to X ward, which is a locked ward. (Zp932061)*

However, patients also advocated a flexible approach, and perceived that staff responded humanely towards certain patients by overlooking breaches in the rules. Arguments for flexibility were put forward on the grounds of individual need, and one patient perceived a total ban on access to the ward kitchen as a denial of basic necessities.

> *[Interviewer: Do you think that every patient should be treated the same when it comes to what they can and can't do?] No, I don't because every patient has different needs. For a start you can't deny people water people that are on medication. There is no fountain. (Z521317)*

A few patients perceived that the rules were imposed fairly, and observed that nurses did not allow individual preferences to interfere with an egalitarian approach. However, others attributed minor discrepancies to the individual personality characteristics of staff that led them to form differing relationships with certain patients.

Well I've seen instances of what you might call favouritism or perhaps slanting things towards, but it's just one individual nurse or something. Perhaps likes a particular patient, but that's nice in a way if a nurse takes an interest in a patient. So it doesn't matter if they get a bit of extra treatment, so what. (Yp4nov205)

They associated inconsistency with differences in levels of engagement, and a patient described the effect of varying relations with nurses on her help seeking behaviour ... *Yes at the end of the day staff have their favourite patients, and patients have their favourite staff, and I am prepared sometimes to leave it a couple of days my issue, until I know that a member of staff I can relate to is on. It shouldn't be like that; you should be able to approach anybody. (Z52518)* Another patient identified arbitrary attitudes amongst staff, and observed that certain nurses were flexible as opposed to others that were extremely strict.

The nurses rule, the nurses make their own rules, some of them. (Yp (10) 248)

The development of inconsistency over time was observed, and a patient perceived that length of stay was associated with discrepancies in the rules ... *well it's hard to explain but the more patients are known the more they get away with smoking on the beds, in certain areas, but new patients are told not to smoke. It's as if the old ones they give up on. (Zwp14142)*

Patients did not seem to receive an induction when they were transferred from other wards in the hospital. This caused confusion and resentment, and lack of rule clarity also provided them with a loophole for breaches in safety rules. Several patients believed that all patients should be treated equally in relation to rule enforcement. Inconsistency between staff caused a rise in non-compliance because patients perceived that they were treated unfairly, and this supported the views of nurses who advocated consistency in terms of affirming equal treatment.

Contrary to staff fears patients did not object to different levels of engagement, but they disliked being subjected to the temperamental attitudes of certain staff when the rules were imposed. A small number of patients observed that disruptive patients were subjected to greater controls, but others advocated strictness because they were disquieted by inconsistency in relation to this group.

The achievement of consistency

Nurses perceived that consistency was very important for ward order, and the effective management of patients. They discussed various ways of achieving consistency, and perceived that a cohesive team approach towards the rules at an early stage in treatment led to constancy between staff for the duration of patients' stay in hospital. A nurse perceived that inconsistency took root at an early stage ... *That's the area that we sometimes fall down on and become a little bit inconsistent with whoever has had the first contact with that patient really. First impressions last, and already your role has been established with that patient. (Zwsn (1) 1358)*

The nursing teams made decisions about rules in different ways, and one group advocated a hierarchical approach whereby a core group of staff decreed the rules, and disseminated them throughout the ward community. A nurse described how staff decided whether to allow patients access to the office telephone. ... *and then we sometimes agree that OK if it's an emergency, if it's to their parents or whatever, we let them use it, but not use it like to make silly little calls to your friends. (Ywana291)* However, the other

staff group advocated the involvement of patients in rule formulation as a means of achieving compliance, but when they applied this approach, poor systems of communication and inconsistency between nurses caused discrepancies. Moreover, these failures resulted in an escalation of non-compliance with defined amounts of leave

> *That was a situation when we discussed, and we told our reasons why that was there, and everyone in the long for a while it worked, and patients took it on board, but again patients weren't returning at that time so the next person was going, why should I return on time? So it has sort of gone back again. So again in this package that is going to be included, and it is just about the staff having to keep up the consistency, and it gets so monotonous and naggy, but we have to because it is going to benefit everyone in the long run. (Zwsn261)*

Nurses argued that a reduction in the scope of rules might produce a clearly identifiable structure that could be easily followed by staff and patients, and it was perceived that an information booklet might incorporate research on which regulations were frequently breached, but this did not materialise. They advocated the use of a signing in and out book as a means of achieving compliance with leave regulations, and one ward used this method consistently, but the other allowed it to lapse. Several nurses stressed that breaches in the rules should never be overlooked because inconsistency perpetuated non-compliance. Others advocated constant clarification, and stressed that sanctions should be consistently imposed for non-compliance.

> *Yes. If they were overstaying their leave more than once and you could see it was becoming a pattern, then you would say you have to keep to this and even after the first time they were due back at seven and they come at eight or even if they come back at seven thirty, you still point out that you were due back at seven. You need to keep to this because if the doctor sees you are not coming back you will not get your leave increased, which sometimes happens. If they say they are coming back on time and they say no well they are about an hour late; we say we will leave it for a week then. (Ywsn11557)*

Nurses acknowledged that consistency might only be achieved when management objectives were clearly defined, and staff shared a rationale for the implementation of rules. One staff group identified the problems that underpinned inconsistency between nurses, and they had clear ideas about ways of addressing these issues; but they were unable to put them into practice.

Reasons for lack of rule clarity

Although they acknowledged that consistency was a problem, nurses perceived that patients complied with the regime as a matter of course, and this interviewee said ... *and you see people they all sort of do the same thing, and most of them sort of conform to that without really thinking about it. Cos we normally don't sit down with them and say look this behaviour is unacceptable this behaviour is acceptable. (Ys322)* They believed that patients copied one another's behaviour, and one nurse said ... *I suppose they are the main way by other patients. No role modelling as such, but seeing other people sticking to the rules that make it easier for everybody. (Zwa8138)* Examples of conformity were used to support the view that patients understood the rules, and one nurse elaborated on this ... *Yes they do, else we would have everybody smoking all over the place or carrying a plate down for dinner all over the place, I think they do understand and also people the people who are not on section, having to sign in and sign out, they come and tell you when they're back, they sign in and sign out. They understand yes. (Ysfgra291)*

A small number of patients maintained that information giving and reasoning was unnecessary. One patient defended the staff ... *they do if they ask, they can't always explain every time the reasons for their actions. So especially if you're new here you mustn't expect everything to be clear to you straight away. It takes a little time to get into the rhythm of the place.* (Ywp2214) Another patient observed that the staff clarified the rules inconsistently, but stated ... *they should understand why.* (Zwp14212) Another interviewee perceived that rule exposition was a waste of staff time.

> *Well depending on the level of intelligibility, the intelligence in a sense, they reason with them. [Interviewer: Do they?] Yes, but they don't always, but it usually occurs to the patient that they've been told in* some way. *[Interviewer: Right, and do they explain why they're not allowed to do something?] Sometimes they do, but again they're only human, and possibly it's not policy at the moment. (Yp (1) 4115)*

Several nurses appeared to take the rules for granted, and perceived that patients followed them as a matter of course. This finding conflicts with other aspects of the data in which they expressed the view that the rules needed to be reinforced constantly because patients were either irrational or deliberately non-compliant. The data showed that patients who were more aware of the regime looked down on others and aligned themselves with staff.

Information giving during the admission process

A few nurses said that they did give newly admitted patients information about the rules, but this was given indirectly, and they concentrated on settling patients into the ward environment. On reflection other nurses acknowledged that information giving was inadequate. Similarly, newly appointed nurses were not told about the rules during the induction process.

One interviewee described the approach that she adopted towards newly admitted patients.

> *Yes if the person comes straight away, you show them around you ask them if they want tea maybe sometimes they have been sitting at casualty for hours without even drinking or having a sandwich. So you ask them if they want tea or a sandwich. We always have bread rolls and biscuits so we give them something then we show them around the toilet area, bathroom area, non-smoking area. We tell the person your name. Like x I asked him his name and showed him my badge and said I am x (Yna6jan)*

Another nurse described a process of induction ... *then you go round with me. I point out things I tell you this is how we do it and this is how we don't do it' and things like that. (Ywna291)* Qualified staff emphasised treatment rules, and one nurse said ... *I mean the only real routine is medication I mean they can do what they want basically on the ward from when they get up to when they get to bed apart from the medication, and also I find it is the job of the primary nurse to sit down and go through any routine we have on the ward. What I do find is they say there isn't enough routine. (Ywsn111270)* One interviewee associated information giving with compliance ... *you are gradually increasing their compliance if you talk to them. Give them more information ask them what they want. (Ys322457)*

Two new members of staff had not been made aware of the rules during the induction process, and this interviewee said ... *I mean there probably are rules I don't even know about. It's not something when I came on to the ward I was told what rules were in existence. It's only sort of finding my own. (Ywsn4234)* The other nurse said...*I have to understand the thing first in order to explain it. (Zwsn319)* The use of written information was suggested, and one interviewee reflected that .. *sometimes they are not made*

clear in advance, and maybe they should be, and we are in the process of doing this patients' introductory, but it is taking forever. (Zwsn171I) One nurse stated that patients could not be expected to comply if they were not told about the rules, and another interviewee observed that staff took the rules for granted ... *think sometimes the nurses expect patients to know that's it's bad for them to smoke in the open area, and eating in their room they haven't really explained the reason why* (Yfcn212) One nurse referred to the procedure that was laid down for information giving ... *Yes we have to inform patients yes. We have a tick of checklist that the admitting nurse should go through so you know the patient's been informed (Zsn121) However* another interviewee reported that the procedure was followed inconsistently.

> *I would yes time permitting I would like to sit down and say what I have said to you, this is why I am telling you to do this, but all to often it is done, please don't do that, or can you go and do that there or you are not allowed in there and then later explain to them why they can't or if you have to say it four or five times then give them a reason why, but hopefully to stop all that we are going to get a pack together to be given to new admissions saying this is what you can't do and this is what we expect and this is why. (Zwsn261)*

The data showed that patients were initiated into the ward regimes, and nurses displayed an awareness of the impact of hospitalisation. Treatment rules were emphasised within one study area, and this suggested that nurses perceived that early compliance with medication was important. Nurses recognised that better systems of communication need to be developed for newly admitted patients.

Patients' perceptions of information giving and reasoning

A small group of patients reported that they had received information, but others said that they had not. Another group were aware of the rules, but did not know why they existed. A few compulsorily detained patients were unsure of their legal rights, and others were disconcerted by enforced confinement.

One interviewee reported that staff had clarified the rules ... *they did yes, and they expect you to do what they tell you to do really. Like not smoking here and smoking there. (Ywp2214)*

Other patients received information at a later stage, and this interviewee said ... *Yeah they do. They lay down the rules and if patients want to know why, then the staff are there to explain. They will tell us they are very good. (Yp (6) 51144)* Another patient elaborated on the type of interactions that occurred.

> *I suppose the main thing would be the smoking would be the one-the main thing. You have to smoke in this certain area, if we were to ask the nurses they'd say you have to smoke in this certain area because it's a fire hazard anywhere else. They may talk about the food as well what time we eat food and just keep us generally alert. (Ymp6 (51) 110)*

However, several patients maintained that they had not received any information about the rules, and one interviewee said ... *I've never been explained about the rules. (Yp 10) 1250)*

One patient felt that the rules were based on common sense principles ... *It's no good explaining to most of them what they can and can't do. It's the principal of when they are doing it wrong. You just have to tell no. It's no good explaining to them because it makes no difference. So it would be a waste of their time doing that. (Zp (4) 91431)*

Another interviewee felt that there were too many rules, and then said ... *but how can I say there are too many at the end of the day. when I don't know they really exist (yp12)* Other patients gave a similar

response, and this interviewee said ... *No, you just play it by ear. (Zp17a181)* Another patient expressed uncertainty ... *Yeah because there might be a lot more rules than I know, but because I'm not breaking any of them I never find out about them. (Zp (3) 9129)* One patient said that the rules were clarified after they were breached, or when patients made requests and observed ... *Sometimes the patients may ask a question, but the answer is not necessarily the answer they want to hear, or are expecting to hear. (Yp (6) 5124)*

Several patients were aware of the rules, but had not been told why they existed, and one interviewee responded:

> *[Interviewer: Are patients given the reason for why there are rules?] No I've never had them. (Ymp22ml)*

One patient described her experiences when she was transferred from another ward in the hospital.

> *I am so with it, the manager of the ward the senior nurse in charge, the staff nurses the ward Sister. Who is who please? I said that the first time I walked in. Everyone else hasn't got a clue they just ask anybody. That nurse will just say go and ask that person there. They don't even find out their named nurses' names. They are not shown around. Here is the bathroom, here is the toilet here is the linen cupboard, the washing facilities. I just made myself at home and found out myself. You are not told anything you are certainly not given. The rules are no food to be taken into your room and no smoking in your room in black and white that is not given. [Interviewer: Are patients given the reason for rules?] Never [Interviewer: Never?] (Z521371)*

Several patients reported a lack of rule clarity in relation to compulsory detention ... *It's only one thing I would say, is that when you are locked up and sectioned it goes on indefinitely you know and that's actually quite extreme. (Yp(7)1129)* Another interviewee responded passively to enforced confinement ... *No, I just presumed. I don't know where the shops are. I don't want to go out. Only when I am at home, If I want to go out for a walk or somewhere, I agree with what the hospital says if they sectioned you, that you can't go out. (zwp2241)* I attended a community meeting, and one patient said ... *I'm not sure about what your section means to you as a person the nurses give you a piece of paper, but that's not the whole story.* The occupational therapist told the patient to speak to his primary nurse, and he said ... *I was placed on a section for the love of God! I didn't know what it was about I'm only allowed out of this building to go to the smoking garden.* (Zwfn. 9.11.99)

On another occasion I listened to an interaction between a patient and a nurse during a community meeting. The patient questioned the reasons for enforced confinement, and asked why staff locked the ward door ... *locking the doors is it really necessary we don't run away. It's just a control mechanism I've had no fresh air for three days.* One nurse responded ... *if the consultant doesn't sign leave for you then we can't let you out. The ward doctor can't do it, but we can get in touch with the consultant for you.* Then other patients asked why they were locked in, and the nurse said ...*it can lock itself sometimes. It is locked at lunchtime and at times of short staffing and when patients are unwell or at risk.* (Ywfn. 5.11.99) I reflected that the patients might be responding to my presence, and that were taking the opportunity to highlight the practice of door locking. When the meeting finished the staff discussed the issues that patients had raised, and the senior nurse said ... *the door is locked from the outside so they seem to think it is locked from the inside. (*Ywfn. 5.11.99)

Two patients associated information giving and reasoning with enforced medication, and this interviewee said ... *I find that most of them they are very, they are tactful they don't just say do this and do that, they explain the situation. To try to talk to a sick mind it is very, very difficult, but they are tactful. (Zp17ja212)* Another interviewee observed the antecedents of a ward incident.

> *They talk to them. Yeah I must admit they are quite good and they talk to you, and say look, they explain to you, look come on, not everybody here smokes, and they don't want to, or come on, you've got to do this it's for your own good, and take your medication. Someone may not like to take their medication. They will come and they will try I mean like the first night I came some burly blokes came in they hold a man's arms out, and take him into his room because he wouldn't take his medication, and like they tried and they tried, and they tried to talk him into it. (Zp (4) 91492)*

A few patients were satisfied with the information they received, but others may have perceived that they were coerced during the admission process. There were indications that the ward door was locked routinely within one study area, and patients were not told why or when this occurred. This practice intensified patients' negative feelings about confinement. The data showed that nurses and ward doctors did not make independent judgements about leave, and patients were effectively imprisoned until consultants performed assessments.

Information giving following breaches in the rules

In the previous section some patients reported that they did not know about the rules. Nurses described how they informed patients about the regime when they broke the rules, and they rationalised this practice in various ways. They perceived that an indirect approach was less regimented, and that a gradual induction softened the impact of the regime. Others maintained that patients were not well enough to comprehend and retain information, or grasp hospital policies. Certain nurses observed or expressed a reluctance to give information to potentially aggressive patients.

One nurse argued that information giving during the admission stage might alter the relaxed nature of the ward environment ... *It's only when they do something that we think well this behaviour is unacceptable. Then you talk to them about it. You say do you think the way you've done it is unacceptable? And if they think it is acceptable you ask them why they think it is acceptable? (Ys322385)* Another nurse, felt that this method softened the impact of the regime. He conceded that there was a lack of written information, and that this was a weakness in comparison with other wards he had worked on.

> *I think its generally done during the admission it's a bit over the top for someone who come in on admission to start saying right you don't smoke, you don't do this, but you set ground rules, but informally you might say to someone, do you realise you don't smoke out in the corridor, rather than saying it as soon as they come in right you don't do this, you don't do that. I think it's a bit intimidating otherwise, it is spelt out to people but I think when they think the event might happen interventions come in and then it's explained why this is not allowed rather than sticking it in their face when they first come in. (ystn151123)*

One interviewee argued that all patients should be given reasons for the rules during enforcement . *I guess that even if a patient is in quite a psychotic state if you explain why as many times as necessary.* (Zstn2371) Another nurse perceived that therapeutic engagement formed the basis of information giving, but withheld this approach until she judged that patients mental states had improved ... *it's like building a*

relationship with them because you have been honest, and you are giving them a chance to ask questions, and then informing them (zwna214)

One interviewee admitted that patients were not given information about certain rules .. *I think, I think at times it is good to explain the rules. Other times it is difficult to explain the rules because they are laid down in hospital policies. They cannot understand why they can't, but of course generally it is good to explain. (Zwcn251371)* Another nurse stated that changes in treatment rules were not clarified.

> *Well on one day a patient may be told that they can do something. Then in the ward they can be reassessed and they can't, and sometimes the reason why isn't properly explained to the patient and that's frustrating for them. (Zms109)*

Information was deliberately withheld from certain patients, and nurses agreed that it should be given in a variety of ways. One interviewee said *...if someone comes in on a section, and they are not going to abide by the rules, so it is best to leave it for a few days, but if they had the information there. (Zs12)* They studied the patient's history before they breached the topic of ward rules, and this nurse said ... *Well first of all it's get to know the patients, their reactions how they react to, you know, when they are approached and everything, so you have to know which patient is how, you know what I am trying to say, how they are ill. So I do read the nursing notes to find out their history and see how they are, then from that I decide how to react, or how to communicate with them. (Ywna17116)* Other nurses felt that newly admitted patients could not understand or retain information, and this interviewee said .. *well if they come in and they are not very well, you don't discuss these things like that because they only have to take in what you are saying. But when they get better we go through each issue and well we have, these are the plans and but they break them sometimes so. (Ywna291397)*

Several nurses stated that they informed newly admitted patients about the rules, but this was a selective process.

> *I would be very frightened my first time on a psychiatric ward. I would introduce myself and introduce patients to each other. I would explain that the rules were for their own safety. For example you mustn't smoke in a no smoking area. If someone is sitting there very lonely you've got to make them feel at home, then introduce them and make them feel more at ease. Try to get them to make their hygiene; you can't say your hygiene is no good you have to encourage them. Never push them over the limit, tell them about their drugs and feedback to the staff how this patient is feeling Be very wary just listen. You have to make them safe, make them welcome, you don't want to bombard them when they are sick. (Ywfna109)*

Another nurse avoided potentially aggressive patients, and observed that a certain group remained non-compliant for the duration of stay. (Zwsn1142) One interviewee believed that patients were aware of the rules, and thought that they tested boundaries ... *Yes sometimes I think as long as you're quite clear as to the reasons why the rules are there then you can put those across so that the patient's know there's a reason behind it, not just the nurses being on a power trip. (zwsn3424)* Another interviewee perceived that nurses evoked patient aggression because they did not give them reasons for the rules.

> *Well you've got people here who have the potential to do a lot of harm, and also when you know one nurse might be consistently saying don't do that, give the reason why, that's dangerous etc another nurse might let them away with it so the nurses that don't would be the one who was targeted, so you know it's hard to be; you can't do it on your own. (Ywan4266)*

Another interviewee expected patient compliance to rise in accordance with duration of stay, and perceived that patients' understanding would increase in line with an improvement in symptoms. Patients

were not told about the rules or sanctions unless breaches occurred, but then certain consequences ensued.

> *Take the patient to a quiet area of the ward. Maybe a doctor's office nurse's office. Explain the behaviour that's expected of the patient on the ward. Explain the rationale behind those expectations. Try to come to an agreement between the ward staff and the patient in question would be the first line of method. Depending on the behaviour that's in question further action will be taken maybe by giving PRN medication if deemed necessary. (Ystn21210)*

Nurses perceived that they cushioned the impact of hospitalisation by not confronting patients with the rules. However they challenged patients when they judged that they were settled on the ward A few nurses described a therapeutic approach towards information giving, but others avoided broaching the topic of rules with potentially aggressive patients.

Comparison between wards

Eleven Y ward nurses, and fourteen Z ward staff referred to the topic of inconsistency during the interviews. Attitudes towards consistency varied between wards, and the views of Z ward staff were more conflicting than those of Y ward nurses. Z ward staff associated consistent rule enforcement with general social values, and perceived rules as remedial. They used them as a yardstick for right or wrong behaviour as well as a means of achieving compliance with safety or treatment rules, and the use of authority was legitimised in terms of the welfare of the patient group as a whole. Certain nurses referred to the irrationality of the patient group, and held that compliance with ward rules reflected successful treatment in terms of perceived normality. They linked diagnosis with incongruent behaviour, but attitudes towards non-compliance were split in that certain nurses believed that patients did not understand the rules. Other nurses held that cognition was unimpaired by illness. They blamed inconsistency between members of the nursing team, and the medical staff for failures in achieving compliance. See supporting examples from the transcripts on page 91 (zsn (1) 529) (zstn212264) (zsn (1) 1262) (zwsn261) (zwstn241); page 92 (zwan26128) (zwsn2619) (zwsn2514); page 92-93 (zwfn.9.11.99); page 93 (zwsn2615489) (zwcn251122) (zssn261270) (zsn1216); page 93-94 (zwsn261244) (zrn111416) (zwfn1250) (zwfn 26.10.99); page 95 (zwfn 17.1.00); page 95 (zstn21231) (zwsn261169); page 96 (zstn241) (zwsn261) (zsn261562); page 106 (zstn2371); page 107 (zwsn3424).

Concerns about the potential for risk amongst the patient group as a whole resulted in a policing approach towards patient care, but reinforcement was unsustainable with intractable individuals. Moreover a preoccupation with overall control resulted in low engagement, and various degrees of social incapacitation amongst the patient group were disregarded. All patients were subjected to the same degree of surveillance and reinforcement. Consistent strategic interventions were not employed to target severely disruptive behaviour. Consequently, pockets of resistance amongst the patient group continued, and generally compliant patients were subjected to unnecessary controls. Certain patients perceived that they were treated unfairly or harshly by staff and became non-compliant. See supporting examples from the transcripts on page 91 (zsn (1) 1262) (zwsn261); page 92 (zwsn2619) (zwsn2514); page 93(zwsn2615489) (zwsn171246); page 95 (zwfn.17.1.00) (zstn2121) (zwsn 241); page 97 (z821150) (z821150) (za8341); page 98 (z88226) (za8341); page 99 (z5213) (zp (4) 91317) (z52119); page 99-100 (z521393); page 100 (z2410) (zp932061) (z521317); page 101 (zwp14142) page 101 (z52518) (zwsn (1) 1358) (zwsn261); page 107 (zwsn1142)

Attitudes towards consistency between Y ward staff tended to cohere, and they were underpinned by a paternalistic philosophy of care. This perspective allayed discomforting aspects of rule enforcement, and the challenges to authority that occur in equal adult relationships. However, this perception of nurse patient relationships was infantilising because adults were regarded as children, and dehumanising because patients were not regarded as individuals in their own right. The risk of oppression was heightened because organisational requirements superseded the differing responses of patients towards rule enforcement, and they were all subjected to the same regime regardless of individual propensities for autonomy or compliance. See supporting examples from the transcripts on page 91; page 92 (ys322431) (ywsn111609) (ywna6jan347); page 101 (ywana291); page 102) ywsn11557).

However, Y ward staff seemed to be more confident about managing non-compliance than Z ward nurses because of family like relationships within the ward, and they stressed rule clarity, which suggests that they had more contact with patients during rule enforcement. They enforced treatment rules strictly, and a paternalistic perspective enabled them to rationalise the use of sanctions in terms of caring motivations, rather the mere exercise of authority. Disorder within Z ward, and lack of team cohesion had a detrimental effect on the consistent enforcement of changes to treatment rules. The nursing team were pre-occupied by the potential for risk amongst the patient group as a whole, and this suggests that patients were less thoroughly assessed or evaluated than within Y ward. See supporting examples from the transcripts on page 92 (ywsn11609) (ywsn111609); page 93 (ywan11) (ystn21323); page 96 (ywfn.22.10.99); page 97 (ywna6jan347); page 102 (ywsn11557).

Both nursing teams were concerned that disorder might be evoked by any display of preferential treatment towards patients, but they were unable to control the feelings that certain individuals engendered. The data contained more references to unreflective attitudes amongst Z ward staff, but inconsistency also occurred between Y ward nurses in relation to patients' needs. Nevertheless less rejection of demanding patients was exhibited, and with the exception of those who were classed as personality disordered Y ward patients received consistent attention when they approached staff. A lack of references to clinical supervision was highlighted in the data from both wards. See supporting examples from the transcripts on page 94 (ystn213323) (zrnnn416) (zwfn.14.10.99) (ywstn21302) (zwfn. 1.2.00) (zwfn.26.10.99) (zwfn.17.1.00).

Nurses on both wards referred to patient intimidation, and the Y ward examples contradicted a general impression of a consistent approach by a cohesive team. Despite assertions that all patients should be treated equally some rules were applied flexibly particularly during the admission phase. The Y ward team allowed the rules to lapse during this time in order to mask the reality of the ward regime, and both nursing teams avoided confrontation with acutely ill patients because they feared aggression. However, Z ward nurses displayed ongoing inconsistency to a greater degree, with alarming consequences for the nurses in charge of the ward. See supporting examples from the transcripts on page 97 (yfna32 (za8341) 97-98 (ywan179) (ywcn251230); page 101 (zwsn (1) 1358); page 107 (zwsn1142).

Staff from both wards advocated consistency between nurses as a means of affirming equal treatment, and in confirming an unyielding approach. Methods of surveillance and reinforcement were ineffective within Z ward, and frequent breaches in the rules intensified nurses' perceptions of loss of control over the patient group as a whole. References to rule breaking were fewer in the Y ward data, and this indicated that nurses targeted disruptive patients. The Z ward team did not target patients who continually

threatened order. See supporting examples from the transcripts on page 91 (ys322431) (zstn21264) (zsn (1) 1262) (zwsrn261) (ywsmn 111609) (zwan26128) (zwssn2619) (zwssn2514) (zwsn2615489) (zwsn171246) (ywan11) (zwsn241); page 96 (zsn261562); page 97 (za8341); page 98 (z8226) (za8341) (za417) (ywcn251230); page 107 (zwsn1142).

Strategic interventions depended on high levels of engagement with individual patients, and consistency between nurses during rule enforcement. The Z ward team experienced problems with general order, and higher levels of engagement implied a loosening of control over the patient group as a whole. Certain patients intimidated nurses, who attempted to manage dissension by avoiding confrontation. They assumed a rigid stance towards the group as a whole as means of allaying further disruption, but this evoked perceptions of unfairness amongst generally compliant patients. Consequently, greater numbers of patients disregarded the rules. See supporting examples form the transcripts on page 99 (zp (4) 91317); page 100 (zp932061); page 102 (zwsn261); page 107 (zwsn1142).

The data from both wards contained no references to the incorporation of rules into other therapeutic approaches. Nurses held that disorder might be evoked if patients were given differing amounts of attention, and they might have perceived that one to one interventions would be interpreted wrongly, or they may have avoided strategic interventions because this involved close contact with intimidating patients. Within both wards the lack of access to staff increased the potential for conflict because patients were forced to break the rule restricting entry to the ward office. Confidentiality was cited as a rationale for this rule, but the office was the focus for informal interactions with patients because this was where nurses who made decisions were usually located. Nurses responded inconsistently towards patients who were perceived to demand excess attention. Rigid attitudes towards certain patients contributed towards the dehumanising, and anti-therapeutic cultures particularly within Z ward. See supporting examples from the transcripts on page 91 (ys322431) (zstn21264) (zsn (1) 1262) (zwsn261); Page 92 (zwfn.26.10.99); page 94 (ystn21323) (ystn212302) (zrn111416) (zwfn1250) ('problems of the heart'); page 95 (zwfn.17.1.00); page 98 (za8341) page 99 (z5213) (zp (4) 91317); page 99-100 (z51393) (zp932061).

Nine Y ward and eight Z ward patients referred to inconsistency. Three Y ward patients strongly advocated consistency in rule enforcement, and the rest had no complaints about inconsistency. They did not express concern over the management of disruptive patients or about a lack of consistency amongst staff, and one interviewee observed that non-compliant patients were subjected to greater controls. However, three interviewees reported differences in levels of engagement between staff and patients. Two patients perceived arbitrary attitudes amongst staff, and held that certain nurses were very strict whilst others were relaxed. One patient was given no information about the regime following transfer from another ward.

Three Z ward patients felt that everyone was subjected to the same regime, and another observed that certain individuals were subjected to greater control. One patient observed constant reinforcement whilst another reflected that this method was ineffective. One patient reported receiving no induction into the ward regime following transfer from another ward, and perceived that the nurses were generally inconsistent. Another patient observed that the staff was lax about controlling conflict between patients, but that they were strict about enforcing medication. There were less references to different levels of

engagement with staff, and only one patient reported that certain nurses were easier to approach than others; but one interviewee reported that staff consistently refused to make her a cup of tea outside of the designated times for refreshments. One patient observed that duration of stay was associated with inconsistency.

The data suggests that consistency between staff was less of a problem within Y ward, and that Z ward nurses had problems in maintaining consistency. Y ward patients observed differences in levels of engagement, and arbitrary attitudes amongst staff rather than inconsistency per se. This indicated that Y ward staff relied less on methods of reinforcement, and interacted with patients to a greater degree than the Z ward team. The data also showed that Z ward staff was less consistent in managing disruption, and it appears that certain patients remained non-compliant for the duration of admission. See supporting examples from the transcripts on page 99 (ywp (7) 1153 (z5213) (z5213) (zp (4) 91317) (z52119) (yp (7) 11153); page 91-100 (z521393) (z2410) (zp932061) (z521317); page 101 (z52518) (yp (10) 248 (zwp14142)

Z ward staff talked at length about ways of achieving consistency, but they had not implemented any of their ideas effectively. This highlighted leadership difficulties, inadequate systems of communication, and a lack of clinical supervision. They tried to involve patients in the rules without addressing these problems, and this democratic step culminated in greater rule discrepancies. However, Y ward staff tended to describe the actual process of consistency, and had devised ways of achieving this, particularly with treatment rules. Examples of this appear in the previous chapter. The management systems within the ward seemed more effective, but certain patients verbalised negative reactions towards the methods of enforcement, and this suggested that methods of clinical supervision were absent or inadequate See supporting examples from the transcripts on page 99 (ywp (7) 1153) (yp (7) 11153); 101 (yp4nov205) (yp (10) 248) (zwsn (1) 1358) (ywan291); page 102 (zwsrn261) (ywssn11557).

The Y ward staff interviews contained twenty-seven references to information giving and reasoning, which indicated that these processes underpinned enforcement. However, nine nurses argued that patient acuity obstructed the comprehension and retention of information during the admission phase. The data also indicated that nurses did not confront patients with the regime in order to avoid adverse responses towards hospitalisation. An analysis of the remaining data indicated that most staff perceived that patients were socialised into conformity, and this suggested that the rules were embedded in the ward structure. These perceptions seemed to extend to new staff, given that one interviewee had not been made aware of the rules during induction to the ward. See supporting examples from the transcripts on page 102 9 YS322) (ysfgra291); Page 103 (yna6jan) (ywna291) (ys322457) (YWSN4234); page 104 (yfcn212); page 106 (ys3222385) (ystn151123); page 107 (ywna17116) (ywna291397) (ywfna109) (ywan4266).

The data suggested that qualified nurses imparted information about treatment rules, and lower grades of staff reinforced ward rules during the course of their duties, but is unclear when the information was given to patients. The data contained several examples of therapeutic interventions based on reflective processes, rather than bald informative statements, but these interactions usually occurred when patients breached the rules or asked for dispensations. Nurses assumed that awareness of the rules developed as acuity lessened, and they perceived that patients broke the rules deliberately when they reached this stage. This perspective enabled a cohesive approach towards enforcement, and the use of sanctions for breaches in the rules. See supporting examples from the transcripts on page 102 (ywsn11557) page 103;

(ys322457); page 106 (ys322385) (ystn151123); page 107 (ywna17116) (ywna291397) (ywfna109); page 108 (ystn21210).

A description of a rudimentary ward structure emerged from one of the interviews. The interviewee referred to routine rather than regime, and stated that staff had minimal expectations of patient compliance apart from rigid rules concerning medication and leave. This reflected an institutionalised environment that might be characterised as benign neglect. A general lack of stimulation with an emphasis on containment measures might have produced apathetic responses from patients. Therefore an oppressive ward atmosphere, rather than a process of adjustment to the regime, may account for the low rate of recorded ward incidents in Y ward during the data collection period. This ward environment may have lessened levels of high expressed emotion, induced feelings of security, and produced fewer opportunities for staff-patient conflict. However, the data indicated that infringements were dealt with summarily, and patients who were involved in these incidents or witnessed them may have been dissuaded from further acts of non compliance. See supporting examples from the transcripts on page 103 (ywsn111270); from chapter 4 page 59 under ward incidents; page 105 (ywfn.5.11.99) (ystn21210)

Y ward patients made fifteen references to information giving, and the data indicated that staff clarified the rules during enforcement, or in response to queries. Most patients could not remember if they were told about the rules during admission. One interviewee was told about expectations, but stated that staff did not give a rationale for the rules. Five interviewees stated that they were given complete explanations later, and I also observed information giving by an occupational therapist during a community meeting. The remainder of the patient group displayed uncertainty, and a degree of hyper vigilance. They assessed situations, and tried to anticipate staff expectations. Two interviewees' commented on inconsistency between staff. Another two patients were anxious and angry because they had not been told why they were confined to the ward. See supporting examples from the transcripts on page 103 (yp (1) 4115); page 104 (ywp2214) (yp (6) 51144) (ymp6 (51) 110) (yp (10) (1250) (yp12); page 105 (yp (6) 5124) (ymp22) (yp (7) 1129) (ywfn.5.11.99).

The data contained twenty references from Z ward staff. They placed less emphasis on patient socialisation, and this indicated that the rules were not embedded in the ward structure. In common with Y ward one member of staff had not been told about the rules during the induction process. Nurses tended to withhold information from patients during the admission process, and the reasons for this echoed those of Y ward staff. However, they also tended to be selective about giving reasons for potentially contentious rules for the duration of patient stay. Five staff had difficulty in sustaining a consistent approach to information giving during enforcement, and this problem seemed to stem from ambivalent attitudes towards the use of control. They avoided interactions with intimidating patients, and this suggested that senior nurses failed to provide adequate support for lower grades of staff. Conversely the Y ward data suggested that senior nurses were involved in the management of difficult situations, and acted as role models for lower grades of staff to a greater degree. See supporting examples from the transcripts on page 102 (zwa8138); 103 (ywsn4234) (Zwsn319); page 104(zwsn261) (zwna214); page 107(zwcn251371) (zms109) (zs12) (zwssn1142)

Another five Z ward staff stressed the need for written information to support verbal instruction, but this did not materialise despite much discussion during team meetings. They tended to intellectualise, whereas Y ward staff described actual interventions. Written information was also perceived as a means of avoiding

confrontations with patients, and this highlighted a lack of team cohesion and clinical supervision. Y ward staff placed greater emphasis on information giving during enforcement, but Z ward staff had difficulty in sustaining this, and gave way to uncontrolled emotional responses. See supporting examples from the transcripts on page 102 (zwsn261) (ywsn11557) (ys322457); 103-104 (zw3sn1711); page 104 (zsn121) (zwsn261); Page 107 (zs12) (ywfna109); page 108 (ystn21210).

Z ward patients made eleven references to the topic. Five patients had received no information, and they had become alienated or anxious as a result of being left to their own devices. One patient was concerned about approaching the office for rule clarification. Unstructured information processes produced various responses in patients who were uncertain of staff expectations, and one nurse observed that one group failed to comply for the duration of stay. Reactive methods of enforcement divorced the rules from any therapeutic context, and this evoked aversive or aggressive responses from patients. However two patients felt that information giving was a waste of time with most patients, and two patients perceived that the staff behaved in a therapeutic manner in relation to enforced medication. See supporting examples from the transcripts on page 98 (z8226) (za8341); page 99 (z5213); page 100 (z51393) (z2410); (zp932061); page 103 (zwp14212) 104 (zp (4) 913431) page 105 (zp17a181) (zp (3) 9129) (z521371) (zwp2241) (zwfn.9.11.99); page 106 (zp17ja2120 (ZP (4) 91492).

The Y ward team gently inducted patients into the regime, because they wished to avoid adverse responses to the rules, but then behaviour was expected to match apparent improvements in mental states, and the rules were rigidly enforced. This patient group were distressed by lack of information giving and reasoning particularly in relation to compulsory detention. They were disconcerted by the routine practice of locking the ward exit, and about not being told when this measure was taken. The other nursing team withheld information during the admission stage for similar reasons, but to a lesser extent, and anomalies stemmed from disorganised practices rather than deliberation. In some respects they were less coercive, but lack of team cohesion led to ongoing problems with rule clarity and enforcement. See supporting examples from the transcripts on page 102 (zwsn261) (zwsn (1) 1358); page 103 (yna6jan) (ywna291) 103 (zwsn319); Page 104 (zwsn261) (zwsn1711) page 105 (yp (7) 1129) (ywfn.5.11.99) page 106 (ys322385) (ystn151123); page 107 (ywna17116) (ywna291397) (ywfna 109) (ywstn21210)

Preliminary discussion

Conflicting attitudes towards care and control, and fear of patient aggression were sharply highlighted in nurses' perceptions of consistency. Nurses articulated differing concepts of mental illness, impairment and disordered behaviour. This appeared to influence their attitudes towards consistency. They advocated inflexibility because they feared that differential treatment might provoke disorder. Fear of patients influenced consistency between nurses, and this highlighted deficiencies in leadership, team cohesion and clinical supervision. This finding might be related to changes in patient turnover and acuity Thomas (1996). Transformations in the ward manager role might also be a factor (Cameron and Ogier 1994; Fagin et al 1996).

Nurses drew an analogy between ward rules and those that govern society, and this was appropriate in that organisational systems cannot function in the absence of order. Rules are instrumental in the delivery of safe therapeutic care within psychiatric hospitals. These comparisons highlighted dichotomous aspects of the roles and responsibilities of psychiatric nurses in that they have a dual loyalty towards the patients in their care, and the institutions to which they are responsible. Certain staff perceived that sanctions imposed on psychiatric patients should parallel the punishments imposed for social non-conformity, and this indicated that nursing embraces a punitive function. The findings reflect aspects of deviancy theory as presented by Becker (1963). Moral aspects of rules and sanctions are of primary importance because psychiatric nursing regimes contain an inherent propensity to veer towards authoritarianism when safety aspects of the role outweigh caring activities. The findings pointed to the influence of wider social processes on ward nursing regimes, such as those described by Berger (1963). Further Foucault's (1991) arguments about the dominance of systems of control within institutions seem to be of relevance in that he perceived that the construction of deviance is used as a rationale for actions that induce conformity with the norms of society (in Seidman 2004). The link made with punishment by certain nurses was divorced from the therapeutic aims of rules. Bowers (1998) points out that rule breaking by the mentally ill differs from deviance in that it arises from a different cause that is not easily understood. The generally low levels of engagement that were observed through non-participant observations suggested that nurses views about rule breaking were not informed by an understanding of the reasons behind non-compliance.

Nurses described how they dealt with the juxtaposition of conflicting aspects of the nursing role by reframing nursing in paternalistic terms, and this finding corresponded with aspects of social rule theory. However a family analogy was somewhat inappropriate because intimacy between members develops over time, and relationships within psychiatric units are fleeting. However, this perspective helped nurses because it embraced a rehabilitative purpose. This perspective may have helped them to manage relationships with large groups of acutely ill patients in that it legitimised control over adults. They described the feelings evoked by the position of certain patients, and how they overcame them by subjecting them all to the same regime. They perceived that conflict might arise if patients vied for equality, and this was associated with the need to maintain order. A paternalistic frame of reference might have enabled nurses to rationalise consistent rule enforcement, and this perspective could have helped them to override preferences for certain patients in the same way that 'good parents' regard their children with equanimity

Nurses advocated consistency in rule enforcement as a means of assessing responses to treatment, and compliance was perceived to reflect an increase in patients' internal controls over disordered impulses.

They articulated an association between diagnosis and societal reaction theory. They described the ways in which compliance was monitored through the use of surveillance and reinforcement, and this finding is reminiscent of Foucault (1991). Examples of the way that the rules were incorporated into other therapies were missing. For example the use of Cognitive Behavioural Therapy, social skills groups, counselling and anger management, and this suggested a lack of attention to evidence based practice that is cited as a requirement for the capable practitioner (Sainsbury Centre for Mental Health 2001). Complaints about the inconsistent application of treatment rules were mostly associated with arbitrary judgements on leave status, and the Z ward interviewees who also complained about disruptions in multi-disciplinary methods of patient care made them. Their descriptions of events highlighted deficiencies in the operation of multi-disciplinary teams, and this corresponded with Cohen's theory of disorganisation. He argued that if people do not view the rules in the same way, and choose to follow them disorganisation is inevitable within institutions (in Rubington and Weinberg 1971). The findings also correspond with the work of Thomas (1996) who observed that nurses were not coping effectively with changes in the in patient population.

Nurses described variable approaches towards information giving and reasoning. Most nurses did not appear to perceive that rule clarity was important. They tended to give patients information after they breached the rules, and they were inclined to avoid rule clarification during the admission process. One of the reasons they gave was that this might give patients a negative impression of the regime. They also admitted that they avoided information giving because they feared that patients might react aggressively. Most patients reported that they were not given information until they breached the rules, and they verbalised feelings of humiliation when they were reprimanded for breaches of which they were unaware. They articulated feelings that could be interpreted as hyper vigilance, anxiety and anger together with general fears about the unpredictability of the ward environment. These findings are indicative of a hierarchical system of care delivery, and a lack of service user involvement in the rules. The findings also echoed Goffman's (1961) observations in which he spoke about a betrayal funnel. He observed that at each stage of the admission process staff tried to give patients the impression that they would not lose any more of the rights that they enjoyed in the community.

Low levels of engagement were indirectly highlighted by patients' references to methods of reinforcement. References to restricted access to entertainment, refreshments and bathing facilities showed that Z ward patients were particularly deprived. Patients were given an inconsistent rationale for the rules, and they might have been less resentful if they had been told that organisational requirements took precedence over individual needs. These findings reflect aspects of symbolic interactionism in relation to the transmission of rules, and the way that Mead (in Haralambos and Holborn 2000) stressed the importance of role taking which involves prolonged rather than brief interactions about the reasons for restrictions. Patients expressed resentment, and described how they took pleasure in breaching safety rules, and it was evident from what they said that reliance on surveillance did not eliminate risk. These findings correspond with Goffman's (1961) concept of secondary adjustment. They also echoed what he defined as stripping, mortification and the differential treatment of patients who were trusted by staff. Certain patients were aware that staff allowed the rules to lapse according to length of stay.

The Z ward team described how they encouraged service user involvement but this democratic step was negated by inconsistency between staff in implementing agreements with patients. The other staff group were demonstrably more consistent because they had devised ways of achieving compliance, and they were less ambivalent about the imposition of control. However, they denied patients any involvement in

the rules, and this highlighted inherently patriarchal attitudes amongst members of the team. The data indicated that Y ward patients' feelings about compulsory detention in particular, had not been addressed sufficiently by staff. However both patient groups generally perceived confinement as imprisonment rather than treatment because the rules were not clarified in a therapeutic manner. Patients expressed feelings of anxiety because they did not know how to behave. Z ward nurses in particular admitted that they resorted to reprimands because they could not sustain information giving during enforcement. Consequently levels of high expressed emotion within the environment may have exacerbated patients' symptoms, and contributed to the high rates of ward incidents that emerged from the quantitative data.

Information may be given in a variety of ways. Problems of retention and the need for reinforcement might decrease if patients were given written material. The opportunity to question treatment is removed if patients are not given information, and nurses cannot mediate between them and the resources that are available. One of the requirements for nursing practice is that qualified practitioners act as advocates for patients NMC (2002). The data from both wards may be viewed from the perspective that power relations between patients and nurses were maintained because patients' did not possess the same information about the regime. This finding corresponds with Goffman's (1961) observations, in that he observed that staff excluded patients from discussions about the treatment that was planned for them.

Summary

The views of nurses converged in that they believed that patients should be subjected to the same regime in terms of consistent surveillance and reinforcement. Moreover, they espoused equality in treatment as a means of preventing disorder, and they feared confrontation with potentially aggressive patients, particularly during the early stages of admission to the wards. The views of nurses conflicted in that they perceived that patients were non-compliant because they were globally impaired, or emotionally arrested, and they blamed each other for lack of consistency. Several nurses believed that the feelings evoked by individual patients could not be contained, whereas others held that they should be overridden in the interests of ward stability and fairness. One group of nurses advocated user involvement in the rules as a means of gaining compliance, and others were in favour of a hierarchical approach.

Patients from both wards advocated consistency in the management of disruptive patients. One patient group did not object to variations in the intensity of relationships between nurses and patients, but they opposed the attitudes displayed by certain nurses during rule enforcement. The other patient group perceived unfairness in the enforcement of ward rules, particularly in relation to smoking, and they referred to rigidity in terms of access to personalised facilities.

Patients were expected to naturally adapt to the ward regimes, and the wards were generally regarded as the nurses' domains. This perception highlighted institutionalised attitudes towards ward management, and environments that were unresponsive to individual need. Lack of information giving might also have enabled overall control because non-compliant individuals were suddenly reprimanded, and other patients were made aware of the consequences of a failure to conform to ward norms.

The Z ward team identified the reasons for inconsistency in rule enforcement, but were unable to put their ideas into practice. The Y ward team described the process of consistency, and they were demonstrably constant in enforcing treatment rules. They were not as preoccupied with overall order, and less obsessed

with minor breaches in the rules. The Z ward team tended to perceive that patients' ability to adhere to ward rules demonstrated a breakthrough in terms of normality. Both teams failed to describe how consistency between nurses in rule enforcement was achieved when they were working with patients on a one to one basis, and this highlighted a focus on containment.

Attitudes towards consistency reflected a dichotomy between the caring and controlling functions of the psychiatric nursing role. Fear of insurrection and patient aggression underscored arguments for inflexibility. These fears were also associated with beliefs about mental disorder, irrationality and the treatment of social non-conformity. Nurses disregarded various degrees of social incapacitation, and strove to maintain overall control perceiving that the potential for risk existed within the patient group as a whole. They relied on containment measures rather than on therapeutic approaches as a means of enforcing rules associated with safety and treatment. Inevitably, these methods were ineffective with intractable patients who were not targeted, particularly within Z ward, and inconsistency between nurses in relation to this group invoked further disorder amongst generally compliant patients who were confused by the regime, or perceived that they were treated unfairly. Nurses blamed each other for lack of consistency or held that patients were incapable of understanding the rules. Both nursing teams did not describe how the rules were incorporated into other therapies that might have addressed patients' behavioural or coping difficulties.

Consequently, alterations in treatment rules were inconsistently implemented within Z ward against a background of general disorder, and lack of team cohesion. However inconsistency between nurses occurred within both wards in relation to the differing amounts of attention that patients received. The ward office was the focal point for nurse patient interaction within both wards, and nurses had particular difficulty in managing the feelings evoked by patients classed as personality disordered or with a dual diagnosis.

All of the factors so far outlined together with arbitrary changes in treatment rules by ward doctors contributed to disruptions in consistency within Z ward in particular. Both wards tended to allow the rules to lapse during the early stages of patient admission, and role ambivalence was sharply highlighted at this juncture. Fear of patient aggression and coercion emerged from the data, but a general lack of inconsistency between nurses particularly within Z ward was a major factor. However, the Y ward team appeared to contain patients at some stage, but inconsistency between Z ward staff resulted in loss of control over a small group of intimidating patients. Moreover, lack of team cohesion resulted in a backlash of patient aggression against nurses who were in charge of the ward.

Patients perceived inconsistency between staff, but variations in the regimes emerged from the data in that rule discrepancies within Z ward received greater attention. Their comments reflected the rigidity of the regime in terms of the use of constant reinforcement, and they highlighted the starkness of the environment in relation to lack of access to personal care or refreshment facilities. Patients reported differences in the personality characteristics of nurses within the Y ward team in terms of harshness or gentleness, and they observed differing levels of engagement between staff and patients.

The prevalence of references to inconsistency in the Z ward data augmented the WAS results in that this may have produced adverse responses from patients in terms of spontaneity, anger, aggression, and the higher rates of recorded ward incidents which were associated with higher levels of PRN medication

usage. Examples from the transcripts described inconsistency in the management of intimidating patients, which validated and clarified the diverse behaviours that were grouped under anger and aggression in the WAS results. The results also provided a social context for the antecedents and consequences of the high rates of ward incidents, and the use of containment measures in Z ward. The differential treatment of certain patient groups, particularly in Z ward, corresponded with aspects of deviancy theory.

The results further reinforced the concept of a paternalistic regime in Y ward, which enabled the consistent enforcement of treatment rules. This theme corresponded with the WAS and HPPP results in terms of higher scores on restrictions on activity and lower rates of spontaneity anger and aggression The results also showed that Y ward nurses tended to veil the regime during the admission process, but expectations of compliance rose after this phase had passed. Patients were infantilised and disconcerted by reprimands about rules of which they were unaware, and this system which was described by Goffman as a betrayal funnel may have contributed to differences in the quantitative results in this ward with the early control of intimidating patients.

However the results from both wards provided a context for a reinterpretation of Goffman's (1961) views in that a lack of rule clarity also arose from feelings of empathy for patients, and the concept that they naturally adapted to ward regimes, rather than just the motivation to avoid adverse reactions to rule enforcement which might interfere with the smooth operation of the admission process. The results showed that an inconstant approach towards information giving and rule enforcement had a detrimental effect on nurse patients relationships on both wards, and on ward order in Z ward particularly. Examples from the transcripts showed that nurses experienced role strain during rule enforcement, and the absence of references to supervision training and monitoring suggested that these factors had an impact on rule clarity and consistency.

This chapter has provided further insight into causative factors for differences in the quantitative results between the wards. The findings led to the conclusion that consistency was a factor in aggression, and that intimidating patients should be targeted during the early stages of admission. This section further highlighted the effects of restricted contact, and a lack of reasoning during rule enforcement on the therapeutic aims of the institution in terms of patients' responses to the nursing regimes. These factors also had an impact on compliance, and a detrimental influence on ward atmosphere. These conclusions led to questions about how these problems could be resolved, and conceptualised in a model that might generate changes in nursing practices. Consequently the model contains a synthesis of the findings from this chapter. The key elements of a therapeutic context for enforcement; supervision training and monitoring; the management of intimidating patients; rule clarity; team consistency; verbal and written information to patients in the early stages of admission to the ward were identified as interrelated themes in relationship to the key concept of ward stability.

CHAPTER 7

PATIENT'S FEELINGS ABOUT THE RULES AND INVOLVEMENT IN RULE CONSTRUCTION

PATIENT'S FEELINGS ABOUT THE RULES AND INVOLVEMENT IN RULE CONSTRUCTION

Material that discussed or highlighted views on service user involvement in rule construction was a prominent feature of the interviews, particularly those of staff. A text search for the following words generated material for this chapter. These included participate, participant, involve, involvement, share, join in, discuss, decision, take part, assistance, contribution, partnership, meet, community. The items that emerged from the search were read, and those not pertaining to the topic were discarded. The remaining material fell into three categories, and they are listed as follows:

- Community meetings
- The limitations on service user involvement in rule construction
- Levels of engagement and user involvement in rule construction

During the course of the analysis, it became apparent that there was a strongly related amount of material in the interviews that focused on patients' feelings about ward rules. A second text search was therefore conducted, using the following words: Coercion, compel, require, compulsory, make, hurtful, painful, distressing, saddening, disagreeable, distasteful, unpleasant, difficult, severe, bad, terrible, troublesome, acceptance, acknowledgement, agreement, assent, compliance, , consent, co-operation, accept, acquire, gain, obtain, receive, put up with, submit, bear, acknowledge, frustration, frustrate, frustrated, prevented, stopped, not-allowed, refused permission, banned, barred, grounded, anger annoyance, antagonism, displeasure, exasperation, fury, ill humour, aggression, indignation, irritability, irritation, outrage, humiliation, humiliate, shame, mortify, embarrass, degrading, shaming, condescension, disgrace, put down, submission, confinement, incarceration, trapped, locked, imprisoned, prison, confine, kept-in, limit, repress, restrain, restrict, bang-up, shut, jail, prisoner, shut up, grounds, stay in, stay on the ward, section 17, escort, escorts, go with, out with, accompany, guide, protect, guard, safeguard, safe, liberty, independence, freedom, autonomy, liberation, release, self-determination, authorization, carte blanche, dispensation, exempt. The items that emerged from the search were read, and those not pertaining to the topic were discarded. The remaining material fell into seven additional groups:

- Coercion.
- Distress.
- Confinement.
- Acceptance.
- Humiliation.
- Anger

These two related qualitative analyses are presented together in this chapter, and supplemented by material from the fieldwork notes taken during non-participant observation, where these were relevant.

Community meetings

Nurses identified community meetings as a means of service user involvement in rule construction. Community meetings are central to a therapeutic community approach, which predominated during the 1960's. Therapeutic communities are founded on basic psychodynamic principles in which individuals' difficulties are perceived to stem from relationships with each other. Regular group meetings are held to maximise the sharing of information, build cohesion, open decision-making and equality. Restrictions are imposed through the consensus of the community as a whole, rather than staff alone. Milieu therapy as it also known was not originally intended for acutely ill patients, as the fast rate of turnover, and levels of acuity may disrupt the programme. Consequently patients may not be able to fully participate or engage in collective decision-making. Kennard (1983)

The Z ward nursing team made most references to this topic, but the interviewees expressed differing views about the purpose and effectiveness of the meetings, and few patients from both wards made reference to this theme. A few nurses viewed community meetings as a democratic method of rule construction, and one interviewee said *... The clients have as much say as what we have. It is always discussed in a group, not just one person will set the rule. (Z8264)*

The meetings were perceived to reflect therapeutic community aims, and one nurse stated *... we like to think of the ward as a community that people are staying in with rules and regulations for everybody really, and I think that's where we can give patients a chance to talk about their feelings on the ward and why they don't feel safe, or why is this rule happening and what are the rules for. (Zsn (1) 1263)* The purpose of rules was discussed during the meetings, and this nurse said *... I always say to people we're not here to keep you in hospital any longer than you need to, we're not here to control you, or tell you what to do. We're here to help you, and to make your time productive, and a healthy time that you can get well and go home (Zsn (1) 11402)* Another interviewee stressed the service user led format of the meetings.

> *We have a meeting with the occupational therapist and a nurse member and the community meeting and that I where ward issues are discussed with the patients and they can ventilate any feelings that they have about how the ward is run. It is not a staff thing, it is directed by patients, and how they want things to change or what they want, or what they don't want, or what they think about something that has been introduced. That is where everything like that is discussed .. unfortunately attendance is very poor. (Zwsn261519)*

One interviewee supported the above statement, and said *... I am not sure I personally do not see much evidence of the patients getting involved.* However, another nurse asserted that the meetings had a significant impact on staff patient power relations, and then said *... I haven't attended a meeting so I don't know how much input is given to clients in changing the rules. (Zwsn1132)* Another interviewee linked inconsistent rule enforcement with poor staff and patient attendance at the meetings, and decisions were made without the full involvement of the ward community.

> *For patients there is this community meeting, but everything can be told there, but then we come to the question of who takes part in the community meeting usually the attendance is not 100%, not at all. When it comes to staff we cannot get staff together at the same place, and decisions have to be made so it is not 100%, so usually it can't be possible that also both patients and staff hear decisions have been made. (Zsrn171)*

One nurse described the events that ensued when a decision about a rule was made without the full involvement of the ward community ... *and for a while it worked, and patients took it on board, but again*

patients weren't returning at that time, so the next person was going, why should I return at that time, so it has sort of gone back again, so again this package that is going to be included, and it is just about the staff having to keep up the consistency, And it gets so monotonous, naggy but we have to because it is going to benefit everyone in the long run. (Zwsn261541)

Nurses devised rules at their own meetings, and one interviewee said *... and then whatever is said in that meeting then we carry it to the community meeting, and tell patients what's been decided. (Zwna22126)* Patients' requests were considered during staff meetings, and this interviewee said ... *they asked for the kitchen to be opened, and we did discuss it at the staff meeting, and came back and explained well we couldn't. (Z8381)* Another nurse described how staff discussed the rules between themselves, and then imposed them on patients. She gave an example of the construction of a rule that limited patients' access to the office telephone, and said *... and then sometimes we agree that, okay if it's an emergency, if it's to their parents or whoever we let them use it, but not to use it just to make silly little calls to your friends. [Interviewer]: Yes, and so would you all be involved in talking about that?] Yes, because we have got to let the other, we've got two shifts here, so therefore we have to let each shift know what's decided. (Ywna291303)*

Several staff said that they intended to compile a patient information leaflet, and one interviewee described how decisions were made about which rules should be included ... *Patients are not necessarily asked their opinion. Within the care package all the staff had input into what rules they wanted in there, that thought were important, and whatever they said, and however one felt about was included, but was looking at the patient group that we had what rules were consistently broken, which needed to be reinforced, which needed to be written down. (Zwsn261)* One nurse perceived that she had limited opportunities for involvement in rule construction, and said *... I mean new policies you get involved in a bit, well actually you don't really. Well you get shown the new ones, and you get an opportunity to comment but you don't really. (Yna3215)*

One patient said that the rules were negotiated during community meetings ... yes they are, yes indeed. *They are asked time and time again in meetings with nurses alongside with the O/T that we have on this ward. (Zp (2) 21655)* Another two patients referred to community meetings, and one person perceived that they were a forum for complaints ... *I haven't complained this time though I have in the past. (Yfp5994)* The other interviewee criticised the format ... *there should be a patients' council or even the ward councils. They should have a single individual who is responsible who can go to the manager, and say look this is a problem or whatever. It seems too amorphous. (Yp4nov336)* Another patient complained that staff did not clarify the rules or seek their opinion before they issued reprimands for breaches.

> *[Interviewer: Right, what do you think about when new rules come out on the ward, is everyone asked for their opinion?] They're not. [Interviewer: Can you give me an example of that?] Yes, like they've started to eat toast in the evening, but we don't know it, we don't know whether we can or we can't, and then we get into trouble if we burn the toast or something, and far more serious things than that, people aren't informed and they're not always asked. (Yp (1) 41372)*

Community meetings were undifferentiated from other methods of user involvement by certain nurses, and one interviewee elaborated on this *... the reason why we have a care programme approach now is to involve patients in their care plans, with their evaluation so that they can have some views about it, and also we have a patient's forum on the ward every Thursday. They have opportunities to say things as well like patient's meeting every Tuesday. They always want to say how they're feeling. (Yscn121452)* The same interviewee

stressed the importance of forming patient staff partnerships in care, and argued that this approach prevented ward incidents.

> *With advocacy as well, we've got advocacy on the ward as well, so they come around. I think we want patients to be informed really because they are influencing their care in certain ways, their involvement with the care plan, they come in a ward review, they've got patient's meetings, we've got advocacy, tribunal is coming and now we've got a commissioners' rating this month as well. I think they have, as I said if you treat people well then you have to involve them, you can't do it otherwise, you can't do it one way it has to be jointly done. If you have got less incidents and the same amount of people coming in. (yscn121475)*

Informal methods of service user involvement were also described. Patients were given unlimited access to refreshments within Y ward, but the supplies were used up too quickly, and this nurse said ... *actually we sit with them, and decided right, this is what's happening now, because after the supplies have all gone, you still have the problem after tomorrow, what do you want us to do? Do you want us to take it away now, or do you want us to take the machine away, or stop the machine, it finishes you know, you won't be getting anything. So they are being able to take responsibility, and that is talking to people instead of just doing things on their behalf. They have decided to take responsibility, and they now tend to be more responsible. (Ys3206)*

Certain Z ward nurses presented idealised views of community meetings that conflicted with other team members' perception of their contribution to service user involvement in rule construction. Several staff and patient accounts revealed that hardly anyone attended, and this belied the significance that certain interviewees attached to the therapeutic and democratic aims of community meetings. Nurses alleged that patients were involved in rule construction, but this view was contradicted by descriptions of how suggestions or requests were vetoed during staff meetings. The other team did not strongly endorse user involvement, and it appeared that staff constructed most rules. The data from both wards indicated that nurses did not always inform patients about new rules or changes to the regime.

The Y ward team viewed community meetings as an information-giving forum, and this exemplified a hierarchical process of rule construction. They made few references to meetings with patients, but one example demonstrated informal methods of user involvement. Conversely the other nursing team espoused therapeutic community ideals, but they held a staff meeting about a similar problem, and decided to lock the patients out of the kitchen. The patient data indicated that user involvement in rule construction was minimal within both wards.

The limitations on service user involvement in rule construction

Reasons for a lack of service user involvement in rule construction emerged from the staff interviews. Several staff perceived that compulsorily detained patients were either too ill or apathetic to engage in rule construction. They acknowledged that compulsorily detained patients' involvement in rule construction was severely limited, and one interviewee said ... *but as soon as someone gets well then we give the power back to them, and make decisions they want. (Z8332)* They recognised that they had the power to restrict patients' choice, and this interviewee said ... *there are things you can do and they can't. You are trying to build up rapports and get people involved in things. (Z821570)* Certain nurses associated levels of acuity with limitations on user involvement.

> *I don't know with a mental patient it is very, very difficult. There are times is not going to decide for themselves, and there are times when the patient can be very sensible. So again a patient that is very, very psychotic and deluded it means as a team they have to decide. (Zagenc1214)*

Another nurse believed that patients should be involved, but said *... the majority will say they're not interested in what we are saying. (Ywfna138)* Two patients associated acuity with global impairment, and one of them perceived that he was mentally competent in comparison with the rest of the group. However he felt that he was stigmatised by association, and said ... *if A had said to me well lets surmise then that he's going to say to me we want to put you on medication. Now if I'm mentally ill and I'm walking around a table tennis table all day not with it, who am I to argue? If I'm in my state now as I am-really, if I turn round and say. I don't need that then it's going to look like I'm ill and I do need it, because the fact that I am in here takes away my rights of opinion. (Zp (4) 91650)*

Nurses perceived that newly admitted patients should not be overloaded with information, and this interviewee said *... but when they get better we go through each issue, and well we have these are the plans, but they break them sometimes so. (Ywna2)* Excess paperwork was blamed for failures in this process, and one interviewee said *... we have to write a care plan when they are on section, and it should be part of that care plan that we are doing it on a regular basis, but you rarely see it. (Ywsn4218)*

However other patients thought that opportunities for service user involvement compared favourably with other wards in the same hospital ... *You actually discover you're suddenly on this, and then you suddenly discover a few weeks later you are suddenly on that, and that is that. The nurses on another ward will say that you have to listen to them, or we are going to inject you, you understand? Now on this ward last night, I refused medication, because I needed to speak to the Doctor first. So, they said okay. Well you see that's what I mean, the whole of this hospital works differently. (Yp (7) 11300)* On the other hand one interviewee witnessed an incident that involved enforced treatment, and concluded that service user involvement was not an option for acute psychiatric patients.

> *It takes away everybody's right, because if I say I don't need that ... Now if they turn round and say to me we want to put you on medication, I would say I don't want that. They say no, no, no you take this. I would say no, I'm not going to take it. Next minute I'm going to get into a fight with four guys, and they are going to give me an injection. My rights have gone because I am in here. My rights have gone whether I want medication or no it's deemed that they know best. (Zp (4) 91650)*

Patients tried to engage staff in discussions about prescribed medication with variable results, and this patient said *... they say that you've got to have that the doctor's said that you can't have your opinion on your tablets. It's up to the doctor. Cos they've all asked I've heard them. (Yp (10) 529)* She enlisted her partner's help during the ward round, and recounted his conversation with the consultant *... Well I tried to get him you know there's too many pills you know, I said I don't know where I am, I kept saying that. My husband said he had a row with the doctor he had a right go at him. He said too many pills for my poor little Mrs he said, she's very weak, with little legs, but the illness that's she's had, she's been through bloody hell with the operation you don't know what she's been through, you wouldn't give her pills like that. They wanted to give me shock treatment in hospital he stopped it. Yeah, he said what! She's been through a five-hour operation, and you want to give her shock treatment. No way! Pack it in, cos I fell out of bed and fell out of the chair. (Yp (10) 529)*

Another two patients complained about the side effects of medication, and this interviewee said ... *Well if they are on too much drugs, and they are suffering like from the effects of the drugs you know, they are*

better to lighten down on them, that's my opinion. When I was on a heavy dose, I was on a heavy dose a few weeks ago, and I nearly dies, it nearly killed me you know. (Ywp22168) However he formed a positive impression of user involvement because the dose was decreased, and a nurse described how these issues were resolved ... *You prescribe medication for the patient, he takes it and then he goes back to the doctor and says I don't think this is doing me any good it is making me feel ill, worse than I am. Then they go back to the wardroom, they discuss it, and sometimes they change the medication. (Yna4)* Another patient felt that she did not have the right to question her treatment because she had asked for help ... *I would take them because they are helping me. I don't think they should have the choice really. When you are ill you trust the doctors you let them. In some cases it affects patients but I don't think the doctors in a way listen. They do and they don't. As they said to me once if it gets into your blood stream you will be all right. So they do give you a reason. (Zp151202)*

Nurses referred to discussions with patients about medication issues, and one interviewee elaborated on this.

> *We are trying to in the discussions, especially with the group we have. We sit down with them, you know soon after a couple of days, couple of weeks after they have settled in, and it depends on their mental state-how they are when they come in what they think-whether they have got insight into the illness that they have, and you sit with them and it does encourage them to feel they are involved, and that they know a lot more about their treatment, and their response was heartening So they don't confuse the issue, we are not creating any confusion in them-you know you just give them the medication and they just take it. (Yas322440)*

Another nurse observed that qualified staff promoted user involvement in treatment rules, and recounted the type of interactions that occurred ... *do you feel this is helping, do you feel this is giving you side effects, do you feel that it's enough, and they do give prompts for people to display their feelings about their treatment they're getting. Yes they do, most definitely. (Ystn15130)* One nurse concentrated on explanations of side-effects, and said ... *when patients have got upset about their medication I've got out leaflets and showed them that the side-effects they are experiencing are normal, or that maybe a certain way of feelings is normal with that particular medication. I think after speaking with people like that then these people become more open and trust you more. (Zwna221)*

Other interviewees perceived that patients could only exercise choice if they were experiencing side effects, and this nurse said ... *No I don't think so because it depends if the patient's had a reaction against that medication then they have a choice not to have that medication or to have an alternative. But sometimes the patient doesn't really know much about the medication, but doctor does know maybe what can help then it can be changed. (Zsn21366)* One patient viewed ward rounds as an opportunity for service user involvement, and said...*sometimes it's a bit intimidating when you go into a room when you go into a room with ten or twelve different people. People you've never met before, but I suppose that's one way we do get a chance to air our views. (Yp (6) 51261)* One staff interviewee stated that although patients were allowed to express opinions about their treatment, this had no impact on the routine administration of medication ... *certain patients want to sleep very late in the morning, and we have to take them up for the morning medication, and some patients can bring it up in the ward round that they want to sleep very late. Okay they have said that all to the team. All the doctors nurses everybody, they have said their opinion but still the result is that they will be woken up early for their medication because if a certain one get medication four times a day it has to be given in a certain. There has to be a certain time between the medication intake. That has been explained to the patient. (Zwsn171286)*

One patient described how staff responded to a query about length of stay ... *if you have your medication and you go by the rules, you will be all right. (Yp291268)* Two patients refused to respond when asked about user involvement, and another interviewee complained about the attitudes of agency nurses *... they are just lazy I think they just sit around. They don't pass much remarks. They don't give you attention. (Zwp2541)* Another patient perceived that interactions with staff focused on compliance with medication rules, and stated *... I think they rely too much on medication to me. It isn't that to me, it's having someone to talk to. (Ywp2145)* A few nurses perceived that involvement in rule construction facilitated patient autonomy. One nurse felt that patients should make their own decisions in relation to activities of daily living ... *You really want people making the decisions for themselves, rather than you saying you know, you want somebody getting up and thinking oh I'll get dressed now rather than you going in and say look you better go in there and put some clothes on. (Ystn2)* Another nurse advocated voluntary participation in therapeutic activities, and said

> *The patients are not forced for example like O/T they are not really forced they are encouraged to do things. [Interviewer]: Right so you think that's better for them?] Yes because they can make their own decisions. (Zstn21277)*

Other nurses made generalisations about user involvement, and this interviewee said ... *if I wanted to tell people what to do I would have joined the police or the prison service. You are aiming towards people leaving here completely autonomous units and never coming back, or living up to them in the maximum level. (Ystn3)* Another interviewee perceived that the psychiatric system promoted dependence, and said ... *I think it needs to be thrown back to the patients so that they can have some input in their care. [Interviewer: yes so that they take more responsibility as well?] Yes I mean autonomy definitely. (Zstn241324)*

Another nurse felt that patients were not really involved in rule construction.

> *No, no I mean it is done in a way that choice is given, questions are sort of asked. What do you want, what do you want us to do for you now, where do you see yourself now? And at the end of the day they know this is what we think, this is what we are going to do, and this is best for you. I mean I appreciate the fact that people are disturbed, mentally, therefore they probably cannot make a rational choice because that's the reason why they are here in the first place, but I don't know, sometimes I think you know it's the reverse effect, probably if you give people that responsibility, they may recover when they realise they have that responsibility. (Zsn21396)*

Nurses and patients focused on medication management when they were asked about user involvement in rule construction, and this suggested that the regimes centred on a medical model of care delivery. Nurses perceived that service user involvement was obstructed by the legal status of patients because they had no choice but to accept treatment, or that they were too irrational or apathetic to fully participate in their care. Nurses carried out consultants' directives, but this hierarchical system of care delivery meant that fluctuations in patients' mental states or responses to medication were ineffectively managed in between ward rounds.

Levels of therapeutic engagement and service user involvement in rule construction

Service user involvement depends on interactions between patients and staff. Nurses gave various reasons for low levels of therapeutic engagement, and descriptions of actual opportunities for patients to participate in their care focused on ward rounds. The material from the patient interviews suggested that Consultant Psychiatrists displayed inconsistent attitudes towards patient participation in care planning.

High patient turnover, acuity, and bureaucratic demands emerged as reasons for low levels of staff patient engagement, and one nurse said *... I mean when the ward is busy and someone is coming up to you and saying I am bored, what can you do for me? But you have someone running around manic. It is really hard to say I am will come and see you in a while and we will discuss what we can do. You are trying to manage so many more patients.* Then the same interviewee said *... you have that much paper work. You haven't got time basically. If you structure the time rightly you will find time, and that is why I tend to plan it for a weekend. If someone comes up to me and says I really need to see you then they see me, but if it is just an evaluation then I will aim to do it at the weekend. Ywsn11322)* Another interviewee perceived that the therapeutic function of nursing had been eroded by various demands on staff time, and said *... we sort of lose that the real reason why we are here, for the client. Everything else seems to come first. Oh the audit is coming tomorrow, I can't see you about that now, this is important, I can't spend time with that client. The patient get anxious, you have to spend more time with them. (Zwstn21396)*

Nurses perceived that rule enforcement obstructed therapeutic engagement, and this interviewee said ... *the door being open is quite difficult because I feel like I'm a bouncer always sitting on the door watching, checking people, and then it takes away my time that I could be spending with the same people sat down and talking and discussing things or sorting out the housing or whatever. (Zwna21314)* Another nurse felt that she constantly criticised patients, and said ... *you feel you are constantly nagging. It shouldn't be like that. I want to be this person that you feel you can approach, and that you can identify with perhaps, or feel you can share things with me. (Zwsn261417)* Episodes of non-participant observation revealed that nurses could have talked to patients. Five members of staff were in the office, and they included two student nurses who did not seem to be deployed. An agency nurse and another student nurse were sitting on either side of a table outside the office door, and a female patient was wandering about aimlessly in front of them. The ward pharmacist came into the office and spoke to one of the staff ... *I've left you an industrial sized bottle of Droperidol. (zwfn25.2. 00)* I reflected that the use of major tranquillisers might decrease if the ward was more therapeutic.

During another period of non-participant observation one of the ward managers said to me ... *I keep a lean team I don't like to have too many staff no more gets done.* (Ywfn 5.11.99) During an interview another nurse made similar comments.

> *I think the ward is not strict enough on the staff.* [*Interviewer]: Really? The staff come in late, come in strolling in and you have to keep asking have you done your care plan today and things like that. [Interviewer]: So maybe you were trying to provide this home like atmosphere and that atmosphere is spilling over to the* staff*; it's hard to make the distinction isn't it? Then if you have two staff together they talk more than doing work, that's also happened, and I have to keep telling them not to stay in the office. (Ywsf125)*

Patients' engagement with the medical staff, and their involvement in the process of setting treatment rules, also varied. The nurses screened patients' requests in between ward rounds, and decided whether they

should be passed on to the consultant. This interviewee said ... *on certain issues they're not bearing in mind the type of illness that someone has, if they're deluded a request might be related to the delusion. (Zs 21447)* Patients could access the ward doctor in between ward rounds, and one nurse said ... *he's very good he'll discuss with any patient who wants to see him, maybe their medication or anything he can relay that. (Ystn21464)* The staff associated patient aggression with the Consultant Psychiatrists' inaccessibility, and this interviewee said ... *whether it's the amount of leave they can have, whether it's the medication that they have, they can be quite frustrated by us continually saying wait until you see your consultant. I think that's quite an understandable reason for the patients getting irate at the nursing staff.* (Ystn (21252)

Patients expressed various views on the extent of their involvement in ward rounds, and one interviewee said:

> *It is up to the doctors to give you the medication. [Interviewer: The doctor gives you the medication and he doesn't talk to you about it?] He just says this is what you are going to be on now. (Zp15d2400)*

Another interviewee held that the position of being a psychiatric patient negated service user involvement ... *if I turned around and said, I don't need medication, the doctor will actually say well you do. Now what he means is, he might give me medication that might keep me quiet. Now is that the answer? Just keeping me quiet is not the answer, you know? Last night I was going to throw a wobbly, and I was scared - I'm sure I worried two people here.* (Zp (4) 91650)

Another patient was distressed by the actions of a consultant.

> *I did not want my advocate to come into the ward round; he said that he ought to be present and I Got upset. I feel very bad about this because the consultant then banned all advocates from attending ward rounds, which isn't good for those patients who really need their advocate. They are on medication, which affects them very badly and they have to take it because they are on a section. (Yfp59121)*

Two patients stated that they had not attended a ward round for two weeks but they did not any express dissatisfaction. However one nurse felt that this was detrimental to patient care, and said ... *compulsory medication under section they don't have very much choice about. They don't get to see their consultants very often if they're having a bad time. Maybe once a week on the ward round that is it. (Zstn6213)* This patient appreciated the consultant's flexible attitude towards discharge planning ... *they would have discharged you within two weeks whether you felt you should be at home or not. I have noticed here they do leave it up to you. (Zp151202)*

A few nurses were impressed by the amount of involvement patients had in the construction of treatment rules during ward rounds, and this interviewee said ... *some obviously can't take in as much as others, but they all know what their drugs do what they're called when they need which drugs etc. (zsrn1604)* However, one patient complained about poor communication, and said... *and sectioned, it goes on indefinitely you know, and that's actually quite extreme. Well what I think you they should do is, they should give you an idea - they should communicate-there's no communication going on. Another thing - I know this is not - I might forget telling you this, if I don't tell you now, is that there's no such thing as a doctor explaining to you - you are going onto such a medication. (Yp (7) 11300)* One nurse supported this view ... *that's always an issue we can't give definite, not even the doctors can give a definite time. I think that's the hardest bit them not knowing. (Zsrn11604)*

During attendance at the Z ward round I observed that only one member of the nursing team was present. There was little communication between the nurse and the consultant. When the consultant enquired about the patients the nurse was hesitant, and the senior registrar interjected. She seemed to have more knowledge of the patients than the nurse. (Zwfn. 16.11.99) Conversely when I attended a ward round within the Y ward the ward manager was present, and he took a major role in the proceedings. The consultant constantly communicated with him, asked his opinion about alterations in treatment rules, and generally acted upon his recommendations. The ward manager was extremely knowledgeable about the patients' levels of functioning. (Ywfn. 17.11.99)

Nurses blamed lack of time for low levels of therapeutic engagement with patients, and for opportunities for service user involvement in rule construction. However aspects of the data showed that they did have time to talk to patients, but they tended to interact with each other instead. Patients tended to perceive ward rounds as the main opportunity for service user involvement. Ward rounds were very important to them because consultant psychiatrists made decisions about medication and leave from the wards. The consultants' status within the multidisciplinary team seemed to be magnified because they were present on the wards much less than nurses, and they made treatment decisions.

Coercion

The feelings that patients expressed about the rules conveyed an underlying sense that they were coerced during the admission process. One interviewee felt that nurses adopted a low-key approach during the admission phase, and said ... *they put their foot down in the first case. They tell them and comfort them and tuck them up almost in bed, but then they'd reason with them, and slowly as the patient starts to react on their own they can take it on the shoulder. No you're not and you're almost grounded if you do, and that sort of thing. (Yp (1) 4130)* Another interviewee claimed that the staff had not explained the reasons for admission.

> *Well it was again the story of them not telling us, they just told the doctors, and they don't tell you what's happening. You're considered like an object, a pawn to be moved around, you get a bit of that so I lost my temper about it, and I said, look I've been waiting here for three hours, and am I going to get a bed or aren't I? Because if I'm not I'm going to go home. Once I threatened to walk, I'm not sectioned. I said I would come voluntarily, and was being kept here unnecessarily. In my particular time now I think I'm a victim of a misdiagnosis, which is quite serious, but I've complained through the channels, but they don't seem to take it too seriously. I've been six weeks here for a misdiagnosis, so it's getting on my nerves. I'm pretty patient about it but you see it's a matter of opinion you know especially in psychiatry. If you've broken your leg you've broken your leg it's on the X ray but in psychiatry it's a matter of opinion. (Yp4nov364)*

Another patient had entered hospital voluntarily, and was compulsorily detained subsequently. She had been transferred from another ward in the same hospital, and in her eyes both nursing teams had not told her why she was detained.

> *I don't know where I stand here-psychologically it is extremely in the back of my mind its, its it permeates my being, this unsteady feeling of terror, because I never know what's to expect, or what's going to happen. They give you the impression that everything so fine and easygoing, but then they suddenly do such strange, and take such strange measures. (Yp (7) 011404)*

She blamed herself for her circumstances and said

> *Yes well you see I should have been speaking to them in a monotone voice permanently.*

[Interviewer: Did you get a bit upset?] I got a bit expressive. I suppose a little bit too expressive you see. (Yp (7) 11435)

The patient seemed traumatised and confused by her experiences, and elaborated on them during the course of the interview ... *I mean when I was on A, I took myself in there voluntarily, and then they said to me, no you can't leave. If you try and leave we will inject you, and section you. So why did they call it voluntary to begin with. Look all I really want to do to be honest with you is to go to B in C town as soon as possible, you know. They are going to keep me locked up in here indefinitely. (Yp (7) 11404)*

Another patient's previous experiences of admission had exacerbated her anxieties about treatment, and she had not been told about the duration of compulsory detention. She was hyper-vigilant, and said ... *basically I'm just sitting still trying to behave myself and not get into any trouble. (Yp (1) 4141)* Patients warned newly admitted members of the group about the threat of compulsory detention, and this interviewee said ... *you know when I first came in here, there was a little policy X you don't want to do that. You get sectioned and it's terrible, and you don't want that. But there's also too for those that are half with it, without being rude, a slight fear factor that goes around they don't want to be sectioned. (Zp (4) 91176)*

Another patient had presented himself for admission, but this was initially refused because he was inebriated, and he was told to return the next morning. However he attended a pre-arranged appointment with Alcoholics Anonymous, and was advised to return to the hospital, and he described the subsequent chain of events ... *So I was seen by five different doctors, assessments and the social worker I have got at the moment put me on the section. I thought oh no, a six month section! I will lose my flat, I will lose my benefits what am I going to do? (Zp17ja215)*

The data indicated a lack of rule clarity in relation to compulsory detention, and it appeared that nurses did not explore patients' feelings about confinement or their anxieties in relation to the duration of stay. This was particularly important for certain patients whose previous experiences of admission generated hyper vigilance, and a general distrust of the system. The data showed that patients perceived compulsory detention as punitive rather than therapeutic, and they shared these interpretations with each other rather than with nurses. They engaged newly admitted patients in a process of induction, but this sometimes fuelled their anxious responses to the environment.

Distress

Patients were distressed by reprimands from staff for example: ... *It makes me feel sad, and worried me a bit. (Z5450469)* Another patient felt victimised because nurses enforced the rules inconsistently and insensitively. He reflected that ... *Well when you are in a sick state of mind, and a poor state of mind it can be very hurtful. Like when I was told when I was on section that I couldn't smoke when I watched television, that I couldn't smoke next to that smoke thing. That one particular nurse, just the one nurse she says to me, do you understand why I am telling you this? I said no I don't, you are picking on me, you should pick on other patients for a change. They do it all the time; I don't do it all the time. She said you have to, she said. So I accepted that, I light a cigarette now, but I make sure I go into the smoke room. You can't have people smoking all over the place, but it was hurtful. (Zp17ja339)*

The following example illustrated the impact of a nursing response towards a patient who was suffering from depression. This interviewee warned that the staff risked an aggressive response from less passive patients.

> *Its-well when I say, there's ten nurses. Nine of them will talk to you instead of talking at you, and talking at somebody on this sort of ward, I would have thought you may get the wrong reaction from that patient, and I would just have thought that. [Interviewer: Has that happened to you personally?] Twice. [Interviewer: Can you give me an example of that?] I get-not such highs any more, because I go to terrible, terrible lows, but I really do feel that I want to go to sleep and not wake up ever again, and to have someone for no apparent reason, I hope I am quite a civil person, to just bark at you, it's wrong I think in any shape or manner, it is wrong. But to have it especially on a ward of this nature is and everybody else has been absolutely fine. [Interviewer. Did that upset you?] It greatly-I walked away and fumed for a while, and everyone else has been really nice, and I mean, I try not to bother them too much, I know they are busy and I know they've got paper work I understand that. But the only time I've seen any of the patients go up and want to talk to any of them-they always put their work down and talk to them, and I've sat back and observed it and thought, yeah that's very good. Except one, but there you go, you are always going to get one. (Zp (4) 91120)*

Nurses took control of certain patients' cigarettes, and this interviewee how he felt about this practice ... *being told, no, no, no, and it is a torment. [Interviewer: Can you give me an example of that?] Can I have a cigarette please, and it is no, no, no and it is up to them, and it is not up to them, but as soon as you come in here as a voluntary patient you give them responsibilities. (Zp11).*

Access to refreshments was restricted within one of the study areas. Another patient was distressed by inflexible staff attitudes, and said ... *if I want tea they say, you know the rules. The rules are that we are not going to make you tea. [Interviewer: And how does that make you feel?] It doesn't make me feel very good. [Interviewer: When you say not very good?] It makes me feel unhappy you know. (Zp15d2522)*

Specific examples showed that patients felt victimised by inconsistent rule enforcement. Certain patients were acutely aware of a loss of autonomy, and what they said suggested that low levels of therapeutic engagement exacerbated feelings of powerlessness. Poor facilities and lack of attention to patients' individual needs accentuated feelings of dehumanisation, and the starkness of the environment.

Confinement

The interviewees expressed various feelings about enforced confinement. They felt trapped, imprisoned dehumanised and claustrophobic. These feelings were intensified when nurses locked ward exits, as the following example illustrated.

> *I dislike the locked door; it stands symbolically to me that it's just possible you might never get out. That's what's worrying that chap isn't it? Because in that way if they don't behave themselves they won't get out. Then you think well how do I play this, do I yes sir, yes sir, three bags full sir, or do I start to kick against the rules. Me and those other two are the two extremes for me. (Yp (1) 41562)*

An informal patient maintained that the staff did not tell patients whether the door was locked or open. Enforced confinement reminded him of a previous admission, and he said ... *well I've been sectioned before, and it's a bit claustrophobic really.* The same interviewee reported that other patients had complained about this containment method, and went on to say ... *we feel it's a bit much because we don't know when the door's open really so for all practical purposes it may as well be locked all the time. It's tedious to go and ask to be let out, and they've got to find that person with the key and all the rest of it. (Yp4non72)*

When I attended a community meeting this patient said ... *locking the door is it really necessary? I've had no fresh air for four days.* The nurse replied ... *if the consultant doesn't sign leave for you then we can't let you*

out. The ward doctor can't do it, but we can get in touch with the consultant for you. Then several patients asked why the door was locked, and the nurse responded ... *it can lock itself sometimes. It's locked at lunchtimes, at times of short staffing or when patients are unwell or at risk.* Then the patient who had posed the original question said ... *it's terribly wrong to make someone feel imprisoned. I'm not sure if it's legal.* The nurse said ... *if you're not sectioned you can ask for leave. If we refuse that's illegal.* Then the patient said ... *who gives the consultant the right to tell you how you feel they take the job too far! The doctor doesn't know my background if you feel I'm at risk or not mentally stable I'll be willing to sit an aptitude test. The police are corrupt the doctors are corrupt and the system stinks. I feel completely safe but I also feel like cutting my wrists I feel as if I've had my hands chopped off because I can't see my children.* (Ywfn 4.11.99)

Another patient felt that door locking exacerbated environmental tensions, and observed that certain patients sought relief in alcohol ... *if you are locked up then what actually happens in some of them when they do finally go out you know they have to drink, to and then if they don't want to sit in a pub they will probably sneak one in on the ward, because well I suppose everyone has a different way because sometimes you need to relax a little back in the evening after being locked up with a band of flipping nutty people that should be screened off correctly into different wards, not squared off by area, by complaint or whatever you call it illness. (Yp971254)*

Several interviewees expressed various feelings about enforced confinement, and one patient felt that nurses were carrying out the directives of a punitive system. She had been confined to the ward for several days because her admission had not coincided with the consultant's ward round. She associated confinement with the penal system, and said ... *Ronnie and Reggie Kray one is in a mental institution and died there, and Reggie is still fighting fit trying to get out and live the rest of his life, and it's not getting done . . It is an imprisonment that's why I associate with Ronnie and Reggie Kray! (Yp (5) 89)*

The following Z ward interviewee's comments showed that he felt trapped, and this perception led him to imagine that he might crawl out of captivity like an animal from a cage.

> *[Interviewer: How do you feel about being in all the time? Most of the time?] I feel as if I am trapped. [Interviewer: So if you got home you haven't got the key so you couldn't get in?] Yes it is hard yes. (Inaudible) If I escape, if I don't escape I have to wait until my sister comes you see. I travel very fast, very fast on my hands and knees. (Z5831)*

The same interviewee described the impact of the ward regime on patients' autonomy.

> *That is all the patients after they have experienced all their hardships while they are in hospital they want to get out because all of them are trapped. They cannot go in and out as they used to when they had their own homes. They can't go and have a bath or shower. Some people only have a bath I have a bath at my home. I have no shower I go for a bath any time I feel like at my home. I can clean my teeth bath often. (Z5318)*

Another patient felt dehumanised by confinement, but found that rule breaking provided an outlet for these feelings, and said:

> *Just going off out of the smoking room and having a carefree attitude, and having a cigarette out of the smoking room. [Interviewer: You think that makes life better?] It makes life easy more bearable feeling incarcerated like an animal. (Zp18ja21)*

Another patient had been granted leave, and described feeling free:

> *Oh it was Doctor X who sort of gave it to me. I said I like to go shopping so he said well you can have eight hours a day now, you know and that was that. [Interviewer: And how does that make you feel now that you can go out for eight hours a day?] Relaxed it's just nice to be able to breathe clean air. Sort of get out of X ward or go to the park and feed the birds. (Yp (9) 11437)*

The open-ended nature of confinement evoked great anxiety. The data indicated that nurses had not helped patients to come to terms with detention. They did not always tell patients why or when the door was locked, and this indicated that the method was used routinely. Informal patients perceived that their informal status and autonomy was negated when the door was locked. The data showed that patients might be confined to the ward for several days because consultants had not signed the requisite form. This meant that nurses struggled to contain patients who were distressed by enforced confinement.

Acceptance

Several patients reacted to rule enforcement with unquestioning acceptance, and they were cautious about making requests that might be denied. These reactions may be viewed positively as a reflection of rule clarity and firm boundaries. Conversely they may indicate that patients were cautious about challenging or negotiating the treatment that was offered to them. This interviewee said ... *I don't ask for anything that will be refused. (Yp9)* When asked how it felt to be refused, another patient said ... *I've never been refused permission. I've never asked for something that I knew I wouldn't get. (Yp7))*

Other patients denied any emotional reaction towards restrictions, and this patient said ... *Oh I say well if I'm not allowed then it doesn't bother me. (Yp3)* Another interviewee said that she would apologise to staff for breaching the rules, and stop the behaviour. When asked how she felt about being reprimanded she said ... *it wouldn't make me feel rotten or bad or anything. (Ywp22m1335)* Another interviewee was philosophical, and said ... *I actually have learnt specifically not to be backward in coming forward, if you see what I mean. I ask because it doesn't matter to me how many doors are slammed in my face. In fact I can even make a pain of myself, and I don't care anymore, but I don't go to any extremes any more. I've started to calm down a little bit now, you know. (Yp (7) 11280)* Another patient said ... *I just think you get institutionalised, and you just accept what they tell you. you can and can't do.* I asked him for an example, and he said that he had neglected his personal hygiene prior to admission, and described his reactions when he was prevented from having a bath ... *To get into bed dirty is not me it's not my style. [How do you feel when you are refused permission to do something?] Just accepting. That's if you are mentally ill anyway, and you get told no you can't do that. If you let that get through to you and tense up inside you, you are going to be worse than you were beforehand. So if I get told something I just accept it. I just think well that's that. [Yeah you don't let yourself get?] No I try to remain calm all the time. (Zp (3) 91225)*

One patient became quite irate because he felt that I should not be asking questions about the regime, and said ... *I've just told you before you've got to obey the doctors, do activities and take medication. [Interviewer: How do you feel when you are told that something you are doing is not allowed?] No I don't mind because as I say again the doctors know better than us! I've had five breakdowns, and as I said to the doctors when I go mad I only go mad for a day, and they laughed their heads off. (Zmp5758)* Another interviewee did not question the rules, and seemed to have adapted to the regime ... *I know there are reasons why I was especially told to come to hospital but I found that out later when I was already here. So I*

have never resisted until I understood. I'm not one to complain. (Z21662) However one interviewee felt that tacit acceptance concealed underlying resistance towards the regime, and said ... *they accept the situation but that doesn't mean they like it. Or approve of it that's what I think, but a lot of people wouldn't voice their complaints. There must have been a big fuss when general smoking was stopped, and was confined to one room there must have been! People are more or less adjusted to that no, and we're told all the time that we're lucky to have a smoking room at all, and I think especially in a medical environment we are, because the medics see the results of smoking and they're very anti. So although our smoking room is a bit crowded I'm grateful for the smoking room. (Yp4nov113)*

A number of patients expressed acquiescence with the ward rules, although some responses suggested that this masked discontent or frustration, or was the product of previous rebellious behaviour that had failed.

Humiliation

Patients were humiliated by nurses' uncontrolled emotional responses towards rule enforcement. The data also highlighted a lack of rule clarity and inconsistency between nurses during enforcement. This patient was suddenly admitted to hospital and she described her experiences.

> *Like when you're rushed into hospital you just grab the first clothes you can, and everything's filthy if you haven't got round to washing it. I was going to wash my dressing gown that morning, and got bundled into hospital, and told it's dirty. I know that full well, but when you're without your detergent because you were just going shopping, and things like that, and then you know if you can't sleep at night. I eventually fell off to sleep at ten in the morning, and only slept to twelve, and got ticked off for that. What can you do? [Interviewer: How did that make you feel?] Very ridiculous in front of people, and very small. (Yp (1) 415)*

Several patients felt infantilised by nurses, and this interviewee said ... *it makes you feel stupid ... Naughty ... Like a schoolboy. (Yp3427)* One patient felt that he was subjected to public humiliation for sexually inappropriate behaviour, and described the experience:

> *I knew I shouldn't have done it but I was scared. [Interviewer: and you were told?] Go back in there and put your clothes on! [Interviewer: and how did that make you feel?] Small. [Interviewer: How do you feel if you are refused to do something?] It is their will against mine. [Interviewer: and How does that make you feel?] Smaller. (Zp18ja2365)*

Another patient complained about the attitudes of the night nurses.

> *Well you are obviously not allowed to go into any department that's right the compartments are the man's and the ladies I agree with that, but um what you are not allowed to do when they say lights off, and you've got to asleep, turn the telly off you've got to go to bed, and sometimes we're not children and I feel that at home sometimes you like to stay up, or get up and have a cup of tea if you can't sleep, but that's not possible here Well it makes me feel like a child, you know you're not allowed to do that is for children. (Ywp32397)*

Another patient described a response to a request for information ... *well if I feel it is in my own interest I don't mind if not I feel bad. I was humiliated yesterday by one of the staff, even though I'd been pestering her before she might have been fed up with me, and she told me to get out, and I'm sure if I look at her she is not up to my age. I wanted to know why I am here. (Zfp5895)*

The data showed that patients were stung by reprimands from staff, and the effect of infantilising nursing interventions were intensified when the rules are enforced inconsistently. One patient was publicly humiliated for sexually inappropriate behaviour, and this intensified his feelings of shame.

Anger

Several patients expressed feelings of anger during interview. They felt infantilised by nurses. They were frustrated because they felt that their psychosocial problems were ignored, and they were angered by inflexible responses to their requests. They were also angered by insensitive comments from nurses, and by restricted access to personal facilities. They expressed various views about the aggressive behaviour of other patients.

This patient felt infantilised by a nurse, and gave an example of a therapeutic approach that might have diffused her anger ... *I was on the phone to my ex partner and he was upsetting me. The nurse came and told me to stop shouting. It made me feel like a child, and I boiled up and told her that she had shouted herself when she told me to stop shouting on the phone. If she had put her hand on my shoulder, and said you're shouting please stop it, it would have been different. (Ywp212)* Another patient was missed her children, and a sense of powerless was exacerbated by the perception that nurses interpreted her distress as further proof of mental disorder.

> *To be honest, I haven't seen my children since last Friday. No last Saturday so it's nearly a week since I've seen my children, and I phoned today to speak to my ex husband, and he can't bring them down today because they are going to stay with their cousins and that, so it will be well over a week by the time I've seen my children. Who has the right to imprison me from seeing my children? That's another example because I won't allow my children to come up here, and sit on chairs and things like that. So why is that so wrong? [Interviewer: Yeah I understand that, I do.] The whole system is corrupt, the whole system just stinks, and if I have to scream it at the top of my voice to get something done about it I will. I will shout it from every bloody mountain, and every high-rise block I can. [Interviewer: and you don't what about giving your opinion?] You can give your opinion, but then if you get frustrated and angry because their opinions is the only opinion that counts when they are giving out medication. If you show any anger then they naturally say, well all right you're not too well, it's this, it's that, and try and tell you what you are thinking and feeling, yeah they do. Yeah they do. (Yp (5) 51164)*

This interviewee expressed anger about the attitudes of one of the staff and said ... *and they said to me she's been here for years I've known her years, and I wanted to get some orange juice, but because I couldn't get the water quick enough, I was so drowsy on medication I poured it in, and she said. Do you do that at home? I said no I don't do that at home, and I thought that was a rash way to speak to me and I was really annoyed. You know as if I come from, and I thought that was out of order what she said to me. but she's been nice ever since, but there's been some nasty comments made. (Ywp32353)*

The topic of restricted access to bathing facilities emerged again, and this interviewee's comments conveyed a sense of powerlessness ... *Well it is just outrageous. My history is certainly a PhD for somebody. I have been here for three months passed from ward to ward. I can't have a bath because there is nobody to supervise. It made me feel very angry, but I choose not to express my anger because I knew it would work against me, and that was that. (Z52124)* One patient had been transferred from another ward, and seemed to have a low threshold for frustration ... *when I was on the ITU ward I wanted to go out at a certain time. I asked the staff and they said in a minute, in a minute, and they kept saying in a minute, and they wouldn't let*

me go out for a walk. So I got very frustrated and blew my rag. (Yp (6) 51286) Another patient described his responses towards rule enforcement, using the words "irritated, angry, annoyed, irate!" *(Zp8ja365)*

One interviewee attributed aggression to behavioural causes.

> *They do it to get attention I should imagine. I mean some of them have messed about, and turned on the alarm. I've seen it in here, but I've heard that they ring the bells, and things like that, you know to cause attention, but some of them to get angry if they're spoken to in a way. I've seen a couple of boys hit the phone box, and smash the phone in or something like that. [Interviewer: Here?] Yes, and all of a sudden bang, and if you do something like that you've got to be careful or you get an injection. You have to be careful how you behave. (Ywp32382)*

Another interviewee perceived that patients broke the rules deliberately, and said ... *they're frustrated because they can't get their own way. (Zmp5778)* However another interviewee felt that aggression was produced by symptoms, and reflected ... *there's more sick patients in here than me. Most of the patients are abusive to the staff if they can't get their own way. They're not allowed out of the door if they want to get out. (Zmp5722)*

One interviewee was appreciative of the regime, and felt that the environment compared favourably with other ward systems that exacerbated patient staff conflict.

> *No as it is it's relaxed, so there's no big arguments, there's no big hassle, which is all right really. You find on some of the other wards, you find that you have arguments all the time. Doesn't with me especially but there's always somebody that's got a temper (inaudible) [Interviewer: and has that got anything to do with the rules? Is it stricter?] Well it's just the running of the wards. [Interviewer: Yeah?] Yeah they're always on top. They are always having a go. The staff are at it, it reflects on the patients, the patients then [Interviewer: Get worked up?] Get worked up and it causes arguments. [Interviewer: You mean that staff are always telling patients what to do, sort of thing?] Yeah basically. Whereas here they don't. Everything is really relaxed, and there is never any arguments as such, from what I have seen, so it's quite good. [Interviewer: It has got a very relaxed atmosphere; you don't feel tense in this.] It's easy, it's sort of like being at home, and they leave you to get on with your own devices. (Yp911305)*

During a period of non-participant observation I saw the behaviour of a recently admitted young male patient with a diagnosis of drug-induced psychosis. He was looking out of the window, and asserted that a man sitting on a bench in the hospital grounds was a government agent who was watching him. The patient was full of restless energy, but he had been left to his own devices. I perceived that he was spiralling out of control, and he constantly gesticulated at the staff through the office window. Then he began to hammer with his fists on the closed door, and shouted for attention. A member of staff opened the door spoke briefly, and then shut it in the patient's face. The patient turned to me, and asked me if I would let him go out into the grounds. Then he said ... *I hate that nurse he slams the door in my face. I promise I'll come back I've got a headache through no fresh air I can't stand it in here. (Zwfn25)*

He wanted to return to the ward where he was first admitted because he felt that the environment was therapeutic. During the course of a long interview it became apparent that he was struggling to retain a sense of identity and purpose. He was able to identify a need for education, housing and social activity. He tried to make sense of his mental state by comparing his fluctuating emotions to the English weather, and the use of this analogy suggested that he was in the throes of an adolescent crisis exacerbated by substance misuse.

The patient said that he refused visitors because he felt highly stigmatised by admission. He constantly reiterated that he would return to the ward if he was allowed out, and his anger against the staff had grown. This young man's comments revealed paranoid tendencies, and an increasingly hostile reaction towards rule enforcement.

> *I've been out yeah, more than one time yeah. I've been out and the nurses try and tell me you're not allowed to go out, you're not allowed to do this. Cos the one I call a blonde bimbo, she keep telling me, ah you buy drugs and bring it into the ward. And let everyone else smoke it, smoke what! I am somebody yeah, I will own up for my things, I'm not a thief, I'm not Robin Hood. I ain't nobodies nothing. I don't like being used as an arse wiper. Basically yeah, everywhere I go it's got a camera. Everywhere I go its got sound barriers. Every phone I hear ring I'm not, I can't hardly talk anymore really. Cos I'm angry right about now. Angry is the word for me yeah. (Zp (1) 21886)*

I asked him how he felt about the ward rules, and he said ... *that in itself makes me very angry, very angry because me I smoke cannabis yeah? From the age I started at thirteen yeah? It weren't really my fault to tell the truth it was someone who said to me yeah yeah come come cos I got kicked out of my house. Well not kicked out I wanted to stay out one night and my Mum said no, you're not allowed to go nowhere, bla, bla, bla. I was so angry I stormed out the door slammed it and I went to X's house. (Zp (1) 21886)*

At one point he became so agitated that he threatened to break my tape recorder, but when I offered to terminate the interview he chose to continue. The following extracts from the interview showed that the patient missed his freedom acutely, and that frustration was building into aggression. The patient said that he disliked the nurses, and this made him feel guilty ... *that makes me feel like I'm the most racist person in the whole wide world. But most of the white majority of them all saying to me yeah, you're not allowed to leave, you're not allowed to do this nah, no and then when I was ready I left it a little while, left it, left it and then when my anger starts burning it will burn all day long. (Zp (1) 21886)*

Then he talked about his perceptions of the environment, and his yearning for freedom ... *because cameras yeah, they've got cameras working everywhere. They've got sound barriers everywhere yeah. I prefer to be like a plant. See the plants over there? I prefer to be like that, that blows in the wind, just like that. I prefer to be like that, cos I use to be like that, and I use to enjoy my life. Free, as a bird. I used to enjoy my life. When I was broke I used to enjoy my life. When I get a little bit of clothes. I'm starting to hate everything about this whole hospital itself, and I didn't stop with nice day. [Interviewer: And so it upsets you when they say you can't do something like...] Yeah it really does. It makes me feel like wanting to punch all of them. (Zp (1) 21176)*

During a period of non-participant observation I observed another young male patient as he launched into a diatribe against the ward regime. He was speaking to a visitor, but he could be clearly heard from the ward office, and I perceived that his rage was directed against the nurses. The feelings that he expressed were similar to those of the previous patient, and the following was extracted from the field notes that I took at the time.

> *There's nothing wrong with me, everywhere you go they're looking for you. There's nothing wrong with me, everywhere you go they're looking for you. Where are you going, what are you doing. There's nothing to do, other people here they make me mad. What the fuck can I do, you tell me. Walking round and round they won't even let me out for any fresh air. Everywhere I go they're watching me, make me more mad. Four fucking weeks without any money, four fucking weeks. They try to make me take medicine, what am I supposed to do four fucking weeks without money? What am I supposed to do more burglaries, more crime? So many people suffering in hospital, there's nothing wrong with me. They lock the door you go mad, nothing to do but go round in*

circles. I'm going mad they're making me mad. I can't have no fresh air. They're following me around treating me like a fucking dog, a fucking dog. What am I supposed to do, four fucking weeks and no fucking money, what am I supposed to do? I feel sick no fresh air; I'm walking round and round in circles. They don't know nothing they make me mad. The things I've seen in my life I've seen little girls being raped in children's homes. I've lived on the streets like a rat. (Zwfn672)

The data showed that patients resented being treated like children. They perceived that staff interpreted anger as further proof of acuity instead of addressing the underlying reasons for their behaviour. Inflexible rule enforcement caused frustration, and this was intensified when patients felt that their requests were reasonable. Feelings of anger were induced by a sense of powerlessness, and the interviewees' comments showed that individual needs suffered as a result of pressures on resources, organisational deficiencies and inadequate facilities.

Comparison between wards

Z ward staff referred to the topic of service user involvement twenty- five times, and this theme emerged from the Y ward staff interviews on twenty-two occasions. Each group of patient interviewees referred to the subject ten times. Z ward staff made most references to community meetings. Certain nurses espoused democratic and therapeutic aims, but these ideals were not borne out by other aspects of the data. The interviews suggested a pseudo democratic process, whereby staff clarified pre-existing rules, and listened to patients' requests for changes in the regime. They discussed these requests during staff meetings, and the results indicate that patients were not always told why they had been vetoed. New rules were constructed during meetings despite the fact that most staff and patients failed to attend. The ineffective dissemination of the decisions that were made led to inconsistent enforcement, and breaches in the rules escalated. This exemplified deficiencies in the organisational structure of the ward.

Z ward nurses did not seem to agree beforehand, which rules should remain static, and they were not frank with patients about the reasons behind their construction. Certain staff defined the aims of community meetings, as a means of fostering therapeutic engagement as well as user involvement, but the data from non-participant observation and interviews showed that few patients attended. Other staff expressed doubts about the purpose of meetings because staff and patients so poorly attended them. The interviews showed that nurses regretted low levels of therapeutic contact with patients, and it might have been advisable to address this problem first before trying to bring patients together in a formal group. The group was led by occupational therapists, nursing assistants or students. This suggested that it was perceived as an adjunct to occupational therapy, and that the importance attached to it by certain nurses might not be realistic. See supporting examples from the transcripts on page 119 (z8264) (zsn (1) 1263) (zsn (1) 11402) (zwsn261519) (zwsn1132) (zsrn171); page 119-120 (zwsn261541) (zwna22126) (z8381).

Z ward nurses displayed an awareness of unequal power relations, and they were ambivalent about the use of control. The data showed that they wanted to create a more therapeutic service user-friendly environment. However they were obstructed by an unclear nursing philosophy that failed to reconcile structure and safety demands with therapeutic rule flexibility. All patients were subjected to the same regime regardless of individual levels of functioning, and this suggested that nurses lacked an in depth knowledge of patients on which to base a safe therapeutic regime. The existence of community meetings conveyed an impression of openness to service user involvement, but they seemed to be largely symbolic given that as demonstrated above hardly anyone attended. They appeared to act as a reservoir for the therapeutic ideals that nurses were unable to attain. See supporting examples from the transcripts on page 119 (z8264) (zsn (1) 11402);

Page 120(zwsn261); page 121 (z8332) (z821570); page 123 (zwsn171286); page 124 (zstn21277) zstn241324) (zsn21396); page 125 (zwstn 21396) (zwna 21314) (zwsn261417) (zwfn.25.2.00).

The lack of references to community meetings in the Y ward staff interviews may be because the rules were embedded in the ward structure, and therefore they were less open to negotiation. Discussions with patients took place informally as organisational problems arose, and community meetings were undifferentiated from formal methods of user involvement such as ward rounds. The nursing team expressed less ambivalence about social control and power relations in general. This indicated that they operated from a clear nursing philosophy that enabled a highly structured environment, but this care context may give patients little room for manoeuvre, and they may be prone to institutionalisation if the environment deters the development of autonomy. Nurses constructed rules at staff meetings, and disseminated them throughout the team, but the data showed that they did not inform patients prior to enforcement, which is indicative of a hierarchical system of rule construction. The patient group as a whole were kept in check when individuals received unexpected reprimands for breaching rules of which they were unaware. This approach intimidated them, and they described feelings of humiliation and hyper vigilance because they were unable to predict the environment. See supporting examples from the transcripts on page 120 (ywna291393) (yp4nov336) (yp (1) 41372) (yscn121452); page 121 (yscn121475) (ys3206); apge 122 (ywfna138) (ywna2) (ywsn4218) (yp (10) 529) (yp (10) 529); page 123 (yas322440) (ystn15130) (yp (6) 51261) (yp291268) (ywp2145); page 124 (ystn2).

A few staff from both wards associated a lack of service user involvement with restricted contact with patients. Y ward nurses identified barriers to therapeutic engagement, and these included screening out patients' demands on the consultant psychiatrist, and formalising channels for service user involvement. They perceived that they involved users in rule construction because they arranged reviews, tribunals and advocacy. This fitted with other aspects of the data that reflected a highly structured low therapy regime The Y ward team did not intervene when the consultant arbitrarily constructed a rule that removed patients' rights to advocacy during ward rounds. This reflected other aspects of the data in which nurses constructed rules without involving or informing patients, and supplied further evidence of a hierarchical system that might not lend itself easily to user involvement. See supporting examples from the transcripts on page 103 (ywsn111270) 120 (ywna291303) (yscn121452); page 121 (yscn121475); page 126 (yfp59121).

Z ward staff claimed that their responsibilities for rule enforcement and surveillance obstructed interactions that might encourage service user involvement in the regime. However aspects of the non-participant observation data showed that they did have time to talk to patients, but they tended to congregate in the office during quiet periods. A senior member of the Y ward team also complained about difficulties in persuading staff to leave the office, and enter patient areas. These findings highlighted managerial deficiencies in terms of effectively deploying and monitoring staff. See supporting examples from the transcripts on page 78 (zwfn.2.11.99) (zwfn.9.11.99) (zwfn14.10.99); page 125 (zwstn21396) (zwna21314) (2wsn261417) (zwfn.25.2.00) ywfn.5.11.99) (ywsf125); page 129 (zp (4) 91120); page 132 (zfp5895); page 134 (zwfn25) (zwfn672).

The data exemplified a hierarchical medical model of care delivery. Nurses focused on medication, surveillance and documentation. Aspects of the data from non-participant observation during ward rounds indicated that low levels of therapeutic engagement meant that they were unable to contribute effectively to the work of the multi-disciplinary team. One ward manager did adopt a high profile during ward rounds, and had a tight grasp

of clinical management issues, but this could have meant that the rest of the team did not have the opportunity to develop their skills. The other ward manager left ward rounds to lower grades of staff, and they did not appear to receive enough supervision and support.
The patient and staff data from both wards indicated that medication issues were the focus of ward rounds. Nurses and patients had little input into treatment rules apart from discussions about side effects. Examples of patients' psychosocial problems did not emerge from the interviews, but this was an area in which nurses might be expected to make a significant contribution to the proceedings. Strategic interventions for specific problems, and other therapies were not mentioned either. See supporting examples from the transcripts on page 121 (yscn121475) (zagenc1214); page 122 (ywsn4218) (zp (4) 91650) (yp (7) 11300) (zp (4) 91650 (yp (10) 529); page 122-123 (ywp22168) (yna4); page 123 zp151202) (yas322440) (ystn15130) (zwna221) (zsn21366) (zwsn171286) (yp291268) (yp2145); page 124 (zsn21396); page 126 (zs21447) (ystn21464) (ystn21252) (zp152400) (zp (4) 91650) (zstn6123) (zsrn1604); page 127 (zwfn.16.11.99) (ywfn.17.11.99)

Four Y ward and two Z ward patients spoke about feelings associated with admission. The Y ward interviews indicated that patients' perceptions of admission might be coloured by previous negative experiences of hospitalisation. Certain patients expressed feelings of fear anxiety and anger because they were unsure of the duration of admission, and confinement to the ward. Within both study areas, those patients who had agreed to enter hospital informally, and they expressed confusion about why they had been compulsorily detained later. See supporting examples from the transcripts on page 127 (yp (1) 4130) (yp4nov364) (yp (7) 11404); page 128 (yp (7) 11404) (yp (1) 4141) (zp (4) 91176) (zp17j1215).

Certain aspects of the regime distressed six Z ward patients. They were dehumanised by a lack of access to personal facilities. Better amenities within Y ward, for example unrestricted access to refreshments and a television set in the smoking room, reduced demands on nurses. Rule breaking associated with smoking was less, and this meant that patients received fewer reprimands from staff for breaches in the rules. However the intensity of emotion expressed by Z ward patients was striking, and when patients described their experiences feelings of dehumanisation, powerlessness, humiliation, isolation and rejection emerged as well as sadness. These findings indicated that Z ward nurses failed to provide a therapeutic and consistent context for rule enforcement. There was a sense of separation between staff and patients in the interviews. Rule enforcement could have been the primary reason for contact and this might account for the feelings of rejection that patients expressed. Feelings of victimisation were also accentuated by inconsistency between nurses during rule enforcement. See supporting examples form the transcripts on page 121 (ys3206); 128 (z5450469) (zp17ja339); page 128-129 (zp (4) 91120); page 128 (zp (4) 91120) (zp11) (zp15d2522)

Nine Y ward and seven Z ward patients expressed various feelings about confinement. However Y ward patients tended to focus on the psychological effects of being locked into the ward, and informal patients were particularly affected by this practice. They were not told why or when the door was locked, and this suggested that it was a routine measure. The locked door intensified feelings of claustrophobia, perceptions of coercive admission practices, resentment, and fears about permanent incarceration. There was no indication that therapeutic input increased as a result of this practice, and one interviewee perceived that the oppressive environment contributed to substance abuse amongst patients. An overview of the data indicated that substance misuse was not a major source of concern for Y ward staff, and liberal attitudes towards this behaviour may have contributed to a lower rate of ward incidents. See supporting examples on page 75 (ywfn.16.11.99) 126 (yp (7) 11300); page 129 (yp (1) 41562) (yp4nov72), page 129-130 (ywfn.4.11.99); page 130 (yp971254) (YP (5) 89).

The Z ward data contained fewer references to enforced confinement, and an open door policy may have led to patients to expect a therapeutic environment. However this symbolic representation of openness did not seem to be supported by others aspects of the regime, which focused on the use of containment measures. This may account for the greater intensity of feeling that was expressed by Z ward patients about confinement to the ward, who felt that the environment was dehumanising and punitive. See supporting examples from the transcripts on page 130 (z5831) (z58318) (zp18ja21; page 134 (zwfn25); page 135 (zp (1) 21176) (zwfn672)

Eight Y ward patients referred to acceptance, and this suggested that the rules were embedded in the ward structure. However their passive reactions towards the regime concealed feelings of fear, stigma, distrust and abandonment. Two Z ward patients accepted the rules unequivocally as well, and this patient group as a whole seemed to maintain a low profile. However even though passivity and withdrawal may mask psychosocial problems or proneness to institutionalisation there was no evidence that these reactions raised concerns amongst staff. Three other Z ward patients expressed feelings associated with stigma, dehumanisation, victimisation and powerlessness, which arose from their own experiences of the regime or through witnessing ward incidents involving enforced treatment. Although there were fewer references to the topic of acceptance in the Z ward data, certain patients graphically described underlying reasons for compliance that revealed a potential for aggressive responses against the regime and for absconding risk. Patients from both wards felt humiliated by staff attitudes during enforcement, and although no conclusions can be drawn from the small number of references they reflect other aspects of the data. Patients were stung by nurses' uncontrolled emotional responses towards rule enforcement. The Z ward data highlighted deficient rule clarity and consistency. Conversely the Y ward reflected institutionalised unreflective attitudes amongst the nursing team towards rule enforcement. See supporting examples from the transcripts on page 80 (yp (5) 5180) 9YP17111)(ywp3237) (ywp1123) (yp (10) 1617) (zp (4) 91246); page 81 (zp (4) 1776) (ywp32390) (zp521446) (zp (3) 91335); page 122 (zp (4) 91650) (zp (4) 91650); page 128 (zp (4) 91176) (zp17ja339); page 129 (zp (4) 91120) (zp11); page 129 (zp11) page 130 (ywfn. 4.11.99); page 131 (yp71) (yp3) (ywp22m1335) (yp (7) 11280) (zp (3) 91225) (zmp5758); page 131-132 (z21662); page 132 (yp4nov113). (yp3427) (yp (1) 415) (zp18ja2365) (ywp32397) (zfp5895).

The Y ward data contained eight references to anger and frustration as opposed to five examples from Z ward patients. However the rate of Y ward incidents that were reported was low, and this suggested that patients contained their feelings. A highly structured under stimulating environment may have lessened opportunities for conflict with nurses, and contributed to apathy or withdrawal. The interviews indicated that patients' psychosocial needs were neglected, and that the medical model was reinforced. Examples of aggressive incidents emerged from a few interviews, and from remarks made by staff during periods of non-participant observation. Patients observed that aggression was dealt with summarily, and controlled with enforced treatment. However I did not witness any incidents during the data collection period, and the ward records reports did not refer to these incidents. See supporting examples from the transcripts on page 73 (ywfn.11.11.99; page 74 (ywna291252); 133 (ywp212) (yp (5) 51164) (ywp32353) (z52124) (yp (6) 51286) (zp8ja365); page 134 (ywp32382) (zmp5722) (zp (1) 21886) (zwfn672).

Preliminary discussion

An analysis of the patient and staff interviews indicated that opportunity for service user involvement in rule construction was largely confined to ward rounds. If levels of therapeutic engagement were high nurses could further promote service user involvement during ward rounds. They could gather information on the antecedents to admission, and the strengths that aid recovery. This might enable them to become more effective patient advocates. Cogent arguments for service user involvement might be based on this information, and this might counterbalance the medical model with a psychosocial model of treatment. Nurses gave the impression that the nursing role was largely determined by rules constructed by consultant psychiatrists, and this may reflect institutional changes that are driven by intense public scrutiny of high profile cases, a process which has been observed by a number of authors (Crichton 1997; Pilgrim and Rogers 1999; Wilson and Rosenfield 1990).

Arguably effective risk management actively involves the service user in the process. Certain patients felt that their psychosocial problems were neglected, and this corresponds with other reports concerned with in patient care (The Sainsbury Centre for Mental Health 1998). The Z ward incident data revealed a high incidence of patient aggression and absconding. This reflects the differences between wards in levels of absconding that Bowers et al (1999) identified on which the selection for the two study wards was based. The feelings of dehumanisation expressed by patients may be viewed from Cohen's perspective in which he argued that the causes of deviance within organisations should be addressed, and viewed as an understandable reaction to specific circumstances (in Rubington and Weinberg 1971).

The patient interviews showed that lack of information giving by staff engendered anxiety, fear and confusion in newly admitted patients. Although few patients spoke about service user involvement, they expressed feelings of distress, alienation, and resentment because they perceived that nurses were emotionally inaccessible. Low levels of therapeutic engagement with staff intensified adverse reactions to rule enforcement. Certain patients were overtly compliant, but they expressed ideas about the use of aggression or intentions to abscond. The findings echo aspects of Goffman's (1961) work in which he observed a basic split between patients and staff together with restricted interactions between them. The feelings expressed by patients also mirror what he described as a 'betrayal funnel' in that patients did not seem to be kept fully informed, for whatever reason, about the rules connected with the admission process.

The feelings of confusion and fear expressed by patients indicate a lack of opportunity for service user involvement. These findings are suggestive of Williams views, in which he perceived that order does not just arise from rule following (in Stones 1998). Rules also give people the chance to participate in, and observe the process of order. Certain psychiatric ward rules cannot be individually negotiated for safety reasons, but others may be flexibly applied to reflect patients' different levels of functioning. Possibilities for genuine user involvement in rule construction may emerge if patients are engaged in care partnerships with nurses. This might facilitate autonomy, and help both parties confront an institutional duty of care. Improved communication might help patients to perceive that certain rules are imposed out of concern for their welfare.

The type of interactions with nurses that patients described, correspond with Gidden's views about the way that rules are often divorced from the social context. He perceived that this process is linked with the distribution of power and domination within society (in Elliott 1999). These perspectives could be applied to issues surrounding a lack of service user involvement, in that nurses retained the balance of power because they monopolised systems of rule construction and communication The findings may also be interpreted from

Mead's perspective (in Haralambos & Holborn 2000) in which he argued that people must understand one another's motives as well as the symbolic meaning of rules. Conceivably acutely ill patients need to engage in interaction process involving the transmission of rules, to a greater extent than those within the wider society, because their ability to share symbols may be impaired. Consequently the distress expressed by certain patients could have been alleviated if nurses had made greater efforts to set the rules within a therapeutic context.

The contrast between certain ideals expressed by Z ward staff in particular, and the actual extent of service user involvement in rule construction seemed to highlight underlying issues surrounding power and social control. Patients were given the opportunity to discuss rules during community meetings, but they were poorly attended. Interviews with staff showed that their requests might be vetoed during their own meetings, or agreements were reached, but inconsistent lines of communication and implementation led to increased disorder. These findings could be interpreted from the perspective of Cohen in which he associated normlessness or anomie with the absence of a set of procedures that correspond with agreed rules. (in Rubington and Steinberg 1971).

Nurses felt that patients scapegoated them, and that they were exposed to aggression because they carried most of the responsibility for the implementation of treatment rules. They perceived that they occupied a subordinate position within the hierarchy, but they were generally reluctant to act on their own risk assessments, and implement leave that had been granted by the consultant at the nurses' discretion. This finding highlights communication problems between members of the institution, which mirror a lack of effective interaction between nurses and patients involving rules. Mead held that the ability to share the meaning of symbols depends on a role taking process (in Haralambos & Holborn 2000). Arguably a lack of interdisciplinary the other's role contributed to the negative views that nurses expressed about consultants. These findings also correspond with social role strain, and Cotgrove's (1970) remarks about the conflicts experienced by employees in relation to differing interpretations of the role. The findings also reflect Merton's work on over conformity amongst the employees of bureaucracies in that certain staff felt that they could not exercise flexibility (in Cotgrove 1970).

Nurses used reprimands and denied patients requests. Acutely ill patients may be highly sensitive and perceive criticism even when none is intended. Hospitalisation may accentuate feelings of vulnerability, isolation and powerlessness. The data showed that nurses' uncontrolled emotional responses intensified patients' distress. Patients expressed distress about the denial of their requests, and they were confused about the reasons for restrictions. The locked ward door seemed to be symbolic for them, in that they associated a barred exit with compulsory detention, and fears of incarceration. When consultants decided to grant leave patients were allowed out for very long periods without escorts, and the descriptions they gave of this process suggested that they were not offered therapeutic activities that might improve coping strategies following discharge. This indicated that nurses felt that they were absolved from responsibility for the decisions that consultants' made on the patients' behalf. Patients valued the freedom, but arguably it was not a therapeutic aid to their recovery. Again these findings echo Merton's views about the way that social distance between managers and workers may lead to rigid interpretations of management directives (in Cotgove 1970).

Patients felt that they were incarcerated, trapped, dehumanised, stigmatised and treated punitively. This suggested that the rules governing confinement were not integrated into engagement or other therapies.

They expressed feelings of boredom, alienation and loneliness. They were concerned about a loss of autonomy and anxious about social arrangements. Certain patients described situations that could be interpreted as an inappropriate use of the medical model. This indicated that nursing interventions that might ameliorate the distress of separation anxiety for example, such as counselling, or controlled access to social networks were not used. These feelings could be interpreted as powerlessness that might have been eased within high therapy environments that addressed their psychosocial needs. The findings relate to Charon's (1979) concepts about the relationship between self-judgement and the judgement of others. He perceived that a sense of self is shaped by these interactions. He cited Goffman (1961) who described the way in which self-identity is eroded within institutions by mechanisms of control, in which patients are divorced from the social contexts from which they were admitted to hospital.

During the interviews certain patients indicated that they might attempt to abscond, and harm themselves or the staff. It is difficult to see how this risk might be recognised within low therapy environments that focus on external observations. The interviewees gave no indication that nurses used strategic interventions for their specific problems, and an over-reliance on methods of containment intensified the oppressive nature of ward environments. These findings mirror Goffman's (1961) work in that he also found that methods of overall surveillance were used as a means of control. Patients described how feelings of alienation and stigma found an outlet within the patient group, rather than through interactions with nurses, and they fuelled one another's anxieties about the ward environment. This corresponds with Goffman's observations about secondary adjustments in that they served as a means whereby patients distanced themselves from the institution in an effort to preserve a sense of self-identity.

Certain patients described a tacit acceptance of the rules, and others claimed that they were unaffected by restrictions or reprimands. They might be particularly susceptible to institutionalisation, and there were no references in the staff or patient interviews to nursing interventions that could ameliorate the negative symptoms of schizophrenia for example. Several patients felt angry and dehumanised, and wanted to escape from the environment, but they were able to control the impulse to abscond or react aggressively. This finding may also be viewed from Goffman's perspective in that he linked submission to authority with the imbalance of power between staff and patients, and systems of reward and punishment.

Patients described events that could be interpreted as institutionalised practices in which they felt that nurses stripped them of their dignity. These findings relate to Goffman's (1961) concept of mortification which includes descriptions of the way in which personal possessions, and activities that preserve a sense of self were removed from inmates or were unavailable. Patients expressed distress at the way they were spoken to by nurses, and this mirrored his observations about the particular tone of voice used by staff. Certain descriptions of interactions from the interviews, non-participant observation data and records of ward incidents involving rules could be interpreted from Goffman's concept of looping. He perceived that patients were not allowed to spontaneously express their own definition of the situation. Their reactions were construed as further evidence of illness because they did not act in prescribed ways, and the qualitative patient data from this study contained descriptions of these processes. Certain staff interpreted patients' responses to containment as further evidence of disorder rather than separation anxiety for example. The use of reflection and clinical supervision might have helped staff to perceive that this behaviour might be partly attributed to the environment, and their attitudes towards certain patient groups. These methods might have enabled nurses to exercise necessary controls, whilst responding humanely to patients' other equally important, psychological and social needs.

Certain patients indicated that they had endured a kind of social suffering because they were rejected by society. This suffering may intensify if nursing teams replicate the attitudes of the wider society, and also shun them. The findings correspond with societal reaction theory in that nurses seemed to view certain patients' reactions as deviant rather than symptomatic of illness. This echoed Becker's (1963) observations in relation to the collective social judgements of policemen, and their desire for respect, which he associated with their punitive responses towards certain social groups. These kinds of staff responses were particularly evident in the Z ward data because they were more conflicted than those of Y ward about the causes of mental illness and behaviour. The data showed that Z ward staff experienced particular difficulty in agreeing upon and applying decisions that were made at a macro level during micro level interactions with patients. Viewed from Mead's perspective a dynamic process of clarification was lacking during rule enforcement (in Haralambos & Holborn 2000). Relationships between staff and patients became polarised within a context of low therapeutic engagement, which obstructed the role taking process.

Summary

The Z ward nursing team stressed the importance of community meetings, and presented them as a means of user involvement in rule construction, but these ideals were not borne supported by the data. They vacillated between patient empowerment and authoritarianism and patients were confused by this approach. The Y ward team were less conflicted about the use of control, and tended to adopt hierarchical methods of rule construction. Patients became hyper-vigilant because they could not predict the environment. Nurses and patients perceived that the main thrust of user involvement centred on consultant's ward rounds.

The data showed that one nursing team vacillated between patient empowerment and authoritarianism. They were conflicted about the use of social control, and wanted to be more therapeutic, but deficiencies in the ward structure failed to provide them with a springboard for user involvement. They tried to introduce an unclear version of a therapeutic community as a means of redressing unequal relationships, and promoting patients' co-operation with ward rules, but the fragile structure could not support theses ideals. The unclear demarcation of staff roles, and poor lines of communication led to greater inconsistency between nurses. Breaches in the rules escalated, and nurses reverted to control in an effort to maintain stability.

The other nursing team were less conflicted about social control, and did not question their power over patients to the same degree. Methods of rule construction reflected a hierarchical ward system, and this was exemplified by the arbitrary manner in which a consultant psychiatrist banned patients' advocates from ward rounds. Nurses did not differentiate between formal and informal channels of user involvement in rule construction. This was indicative of a traditional ward system dominated by the medical model. The ward manager adopted a high profile during ward rounds, and this suggested that he was clinically orientated. Within the other ward nurses seemed ill equipped to deal with clinical management issues. The data suggested that management systems within both wards failed to strike an effective balance between staff and clinical responsibilities.

The Y ward patient group expressed more anxiety in relation to compulsory detention and enforced confinement. The high levels of surveillance within the environment, and the routine practice of locking the ward exit exacerbated these feelings. The Z ward patient group were dehumanised and angered by a lack of

access to personal facilities. They generally expressed a greater intensity of emotions because the weak ward structure resulted in constant reinforcement, and patients felt victimised because nurses imposed the rules inconsistently. Low levels of engagement and nurses' uncontrolled emotional responses towards rule enforcement adversely affected both groups of patients, but one nursing team engaged with patients to a certain extent when they assisted them with activities of daily living. This may have ameliorated feelings of abandonment, and provided an outlet for disclosure.

This final results chapter provided further insight into the content of ward rules; patients' responses to them; the impact of rules and rule implementation on nurse patient relationships and on ward events; and the relationship between ward rules, ward atmosphere and ward design. The findings sharpened the construct that team inconsistency was a major factor in the high rate of ward incidents in Z ward, and this validated the quantitative results. The lack of references to community meetings in the Y ward data augmented the quantitative results, which revealed higher restrictions on activities in the HHPP subscale, and lower perceptions of spontaneity, anger and aggression in the WAS subscales.

The qualitative data provided a social context for the quantitative results in that Z ward staff wished to promote service user involvement, and a therapeutic community approach. Consequently these factors might have accounted for the higher rates of spontaneity, anger and aggression in Z ward because patients were encouraged to express their feelings. However these factors had a negative impact on ward order, because decisions on rule construction were communicated inadequately and inconsistently enforced. Nurses resorted to rigidity, and the use of containment measures when rule breaking escalated because of these factors. Descriptions of events in Z ward augment the quantitative results on the high rates of ward incidents and PRN medication usage, and reveal the antecedents and consequences of situations.

Y ward patients descriptions of their feelings in relation to confinement reinforce the HHPP results on higher restrictions on activity, in that there were recurrent references to door locking. This finding was related to a lack of rule clarity in that patients were unsure about the reasons or length of compulsory detention. The concentration on hierarchical methods of service user involvement in the data may also account for lower rates of spontaneity, anger and aggression in the WAS subscales because service user involvement was linked with formal methods of participation in rule construction in the data. The results from both wards exemplified the impact of a general lack of therapeutic engagement in that patients' psychosocial needs were neglected, and this gave rise to the process known as looping as described by Goffman (1961). This meant that patients' responses were redefined by the staff in terms of further evidence of mental disorder. This phenomenon was particularly evident in the Z ward data, and the examples from patient transcripts augment the quantitative results in that they contain descriptions of the antecedents and consequence of ward incidents. Examples of the type of situations that occurred included separation anxiety, responses to witnessing ward incidents, together with restricted access to facilities and activities. These findings are supported by the quantitative results.

The results of this chapter sharpened the concept that service user involved might be achieved through the closer participation and support of the multi-disciplinary team in rule construction. This might give rise to a system of tiered flexibility, as previously described, through negotiation with patients so that changes in individual treatment rules could be matched with changes in particularised ward rules, such as access to unsupervised bathing. Consequently other interrelated elements of the conceptual model on page 188 which recommendations for changes in clinical practice were conceived. They are represented in the rectangles as

negotiation with patients; flexibility and tiered flexibility, and were conceived to have a positive impact on ward stability. This innovation was interlinked with the overarching themes in the model of a therapeutic context for enforcement, and supervision, training and monitoring. The final chapter attempts to clarify the conclusions of the preceding chapters, and describe their wider application to clinical practice. The final recommendations centre on a conceptual model, which is based on a synthesis of the key findings in the preceding chapters. The table overleaf summarises the key findings on each ward from both the qualitative and quantitative data.

Table 5: summary of qualitative differences between wards

Themes	Ward z	Ward y
Role ambivalence	Higher	Variable
General methods of enforcement	Authoritarian	Paternalistic
Intimidation by patients and rule enforcement	Avoidance	Early control
Punishment	Higher	Lower
Paternalism	Lower	Higher
Reflective practice	Lower	Variable
Nurses' perceptions of authoritarian enforcement	Highly ambivalent	Variable
Patients feelings re authoritarian enforcement	Dehumanised	Humiliated
Nurses' rationales for consistency	Fairness /ward order	Fairness /ward order
Inconsistency and patients' care plans	Highly inconsistent	Highly consistent
Strategies to achieve consistency	Lower	Higher re treatment rules
Nurse patient relationships and consistency	Inconsistent	Less inconsistent
Disruptions to consistency	Higher	Lower
Consistency over time	Highly inconsistent	Consistent
Fear of intimidation and inconsistency	Prolonged avoidance	Early control
Patients' perceptions of consistency	Highly inconsistent	Variable on ward rules
The achievement of consistency	Highly disorganised	Cohesive re treatment
Reasons for lack of rule clarity	Disorganisation / resistance	Adaptation / resistance
Information giving during admission	Lower	Variable
Patients' perceptions of information giving	Lower	Variable
Information giving following breaches in rules	Lower	Variable
Community meetings	Higher emphasis	Lower emphasis
Limitations on service user involvement	Variable	Variable
Levels of engagement & service user involvement	Lower	Higher re treatment
Patients' feelings re rules	Linked to ward incidents	Linked to detention
Coercion	Higher	Variable
Distress	Higher	High re locked door
Confinement	Variable	Variable
Acceptance	Variable	Higher
Humiliation		
Anger	Higher	Lower

Table 6: summary of differences between wards in the WAS subscales

Was subscales wards y and z compared	**Ward z**	**Ward y**
Involvement	No significant difference	No significant difference
Support	No significant difference	No significant difference
Spontaneity	Higher	Lower
Autonomy	No significant difference	No significant difference
Practical orientation	No significant difference	No significant difference
Personal problem orientation	No significant difference	No significant difference
Anger and aggression	Higher	Lower
Order and organisation	Lower	Higher
Programme clarity	No significant difference	No significant difference
Staff control	No significant difference	No significant difference
Was subscales staff and patients Compared	**Staff**	**Patients**
Involvement	No significant difference	No significant difference
Support	No significant difference	No significant difference
Spontaneity	Higher	Lower
Autonomy	No significant difference	No significant difference
Practical orientation	Higher	Lower
Personal problem orientation	No significant difference	No significant difference
Anger and aggression	Higher	Lower
Order and organisation	Lower	Higher
Programme clarity	Higher	Lower
Staff control	No significant difference	No significant difference

Table 7: summary of differences in wards in the HHPP subscales

Hospital hostel practices profile Ward y and ward z compared	**Ward z**	**Ward y**
Restrictions on activity	Lower	Higher
Possessions	No significant difference	No significant difference
Meals	Higher	Lower
Health and hygiene	No significant difference	No significant difference
Residents' rooms	No significant difference	No significant difference
Services	No significant difference	No significant difference
Hospital hostel practices profile, staff and patients compared	**Staff**	**Patients**
Restrictions on activity	No significant difference	No significant difference
Possessions	No significant difference	No significant difference
Meals	No significant difference	No significant difference
Health and hygiene	No significant difference	No significant difference
Residents' rooms	No significant difference	No significant difference
Services	No significant difference	No significant difference

Table 8: Summary of differences between wards in ward incident and PRN medication levels

Ward incidents rates	**Ward z**	**Ward y**
Differences in incidents	Higher	Lower
PRN medication levels	**Ward z**	**Ward y**
	Higher	Lower

CHAPTER 8

DISCUSSION

DISCUSSION

The sociological context of ward rules

The results showed that psychiatric ward rules reflected the norms of the wider society, but they were also context specific in that they fulfilled institutional functions of therapy and control. Psychiatric nurses created rules and routines in relation to the implementation of treatment orders devised by Consultant Psychiatrists. They also implemented hospital safety policies, and constructed other rules associated with risk. Other rules were associated with expectations of socially appropriate behaviour. Brown's (1965) concept of explicit rules corresponds with written policies associated with institutional safety, and rules associated with patients' legal status under the Mental Health Act (1983). His definition of implicit rules matches unwritten ward rules associated with social mores and expectations of appropriate behaviour.

The ward structures replicated the wider social system, which depends on the consistent performance of learned behaviour (Brown 1965). Patients were generally subjected to the same regime, regardless of differing levels of functioning. These practices were associated with a pre-occupation with overall order. Rigidity was also influenced by nurses' beliefs about mental illness causation, behaviour and treatment. In general Z ward staff were more concerned with the reinforcement of appropriate behaviour than Y ward staff. Their attitudes towards rule enforcement reflected aspects of societal reaction theory in that certain nurses perceived that rule enforcement served a corrective function. Conversely others felt that the rules acted as markers to reality, and that constant reinforcement stemmed irrational impulses that might threaten overall order. Differing views about the aims of ward rules amongst the team coalesced in an inflexible approach, towards for example, rules associated with smoking; access to refreshments; the use of banned substances; and inappropriate behaviour. The Department of Health (2002) recommended that service users should have access to drinks and refreshments at all times.

An organic model of mental illness was widely held by the Y ward team, and they tended to enforce certain rules less stringently. For example rules on smoking, access to refreshments and the use of banned substances, but they enforced treatment rules rigidly. Expectations of appropriate behaviour rose as compliance with treatment was achieved because they perceived that patients' should be able to control their responses as their mental states improved. Differing attitudes towards rule enforcement between the wards exemplify the influence of theories about mental illness causation, and rule breaking on nurses' attitudes. Aspects of the results also reflect Bowers (1998) arguments that rule breaking by the mentally ill should not be defined as deviance because it arises from an irrational basis. The results revealed the impact of conflicting sociological theories on the aims of ward rules, and the way in which this produced differences in the flexibility/ inflexibility of the ward nursing regimes.

Social rule theory and rule enforcement

Given that psychiatric hospitals perform functions of social control they may be defined as rule enforcement agencies. Consequently nurses may be regarded as agents of social control, or *rule enforcers* as defined by

Becker (1963). The ward may be perceived as a microcosm of society, in which nurses and patients perform assigned roles. This perspective corresponds with Gehlen's (1980) wider definition of the institution as a programming mechanism in Berger (1963), and with social rule theory, which describes how the family initiates the internalisation of norms. The results showed that the Y ward team approach relied to a marked degree on the socialisation function of the family. Nurses adopted parental roles, and this was strongly associated with an organic view of mental illness. They were more inclined than Z ward staff to perceive that mental impairment affected patients' cognitive abilities, and that they were in a regressed state during the early stages of admission to hospital. Aspects of the results correspond with Bowers (2002) work on nurses' attitudes towards patients in the special hospitals in which nurses identified the therapeutic purpose of rules. He found that staff that adopted a parental perspective had more positive attitudes towards patients with personality disorder.

From a symbolic interactionist perspective disordered internal processes may impair the ability to share the meaning of symbols, and this may include ward rules. A parental approach might assist in resocialisation, but Y ward nurses tended to assume that all patients were similarly impaired, particularly during the early stages of admission to hospital. The results showed that several patients were aware of the rules, and compliant with the regime. They expressed strongly negative feelings in relation to the assignment of a childlike role, and for example, they resented being subjected to the same levels of confinement as patients who did require greater restrictions on their activities. Thus from a symbolic interactionist perspective nurses did not take into account patients' individual capacities to share the meaning of ward rules, and this had an impact on the development of autonomy. The requirement to foster patient autonomy is an important element of the National Nursing and Midwifery Council's (2002) guidelines for nursing practice.

These attitudes could be viewed from Giddens (1976) perspective in which he states that rules are often viewed in isolation as if they are linked with specific activities or behaviour. However he refutes this view, and states that rules cannot be divorced from the structural means through which they are incorporated and changed into social practices. In his opinion this process is closely related to the diffusion of domination and power throughout society. He perceives that rules embrace two functions in that they establish meaning, and authorise forms of social behaviour. He perceives the rules of social life as methods, which are used in the performance of social practices. He argues that an awareness of social rules is a distinguishing feature of human beings. Knowledge of the rules helps us to react to and influence various social situations. Giddens views the most important aspects of structure as the rules and resources that are repeatedly used by organisations, and that characterise them. Acutely ill psychiatric patients may lack awareness of rules, and part of the admission process may involve resocialisation. However if rule enforcement is divorced from engagement this process could be perceived as a means of power rather than therapy, and as such one of the dual functions of the institution is negated. The Department of Health (2001) identified deficiencies in the reception of service users to inpatient units, and recommended clearer systems of communication that included rule clarity.

> *"Service users report that the admission process itself can be a distressing and demeaning experience. Too often the first days of inpatient stay are particularly confusing and boring with the service user and their family not knowing what is available or what is expected of them".* p.12

Both wards relied heavily on surveillance as a means of monitoring risk, and rule following. The results showed how difficult it might be for acute psychiatric units to shift towards engagement and away from a reliance of custodial care. Nurses disliked surveillance duties, but they did not feel that they could manage large numbers of acutely ill patients in other ways. Pilgrim and Rogers (1999) identified similar anxieties amongst professionals who felt that risk assessment is linked with control. They perceived that it was irreconcilable with a caring and therapeutic role.

> *"They resent and resist becoming society's police officers for informal rule rather than law infringement".* p.182.

Goffman (1961) identified a reliance on surveillance in his study for similar reasons. This system according to Foucault (in Elliott 1999) is closely linked with the rise in institutions during the industrial revolution. He perceives that discipline rests on methods of observation, which are closely linked with power and coercion. He draws an analogy between the construction of factories, military camps, and other structures such as asylums and prisons. He maintains that these structures facilitate the control of individuals.

> *"To render visible those who are inside it; in more general terms, an architecture that would operate to transform individuals to act on those it shelters, to provide a hold on their conduct, to carry the effects of power right to them, to make it possible to know them, to alter them".* p.98.

According to Foucault the rise of surveillance emerged during the industrial revolution when the supervision of workers was needed because large numbers were employed in complex tasks. Under this system the division of labour increased as supervisors undertook a discrete function that separated them from the workforce. In Foucault's view this hierarchal system incorporated the power to discipline people. Individuals were responsible for surveillance, but they were also surveilled through what Foucault describes as a piece of machinery or hierarchy. Although the hierarchy has a head the system as a whole is powerful, because the organisation of relationships within it ensure that all the members are surveilled, including those who act as supervisors. Foucault perceived that a particular system of punishment evolved with the rise of disciplinary institutions. In addition to corporal and other forms of punishment disciplinary regimes have a corrective function, which relies on training together with a system of rewards and sanctions. Within this system individual actions are measured against an overall rule, and the level of conformity to be attained. Foucault refers to this process as normalisation.

> "*The perpetual penalty that traverses all points and supervises every instant in the disciplinary institutions, compares, differentiates, hierarchizes, homogenizes, excludes. In short it normalises".* p.102

Foucault perceives that this normalising mechanism together with surveillance is one of the most important instruments of power. This process regulates behaviour whilst permitting a degree of individual difference. Foucault also refers to disciplinary writing and the examination system. He perceives that individual behaviour is demarcated and documented through observations gleaned through the examination system, and the documentation that accompanies it. This results in the construction of cases, which incorporate knowledge of the individual, and power over him or her.

"It is the individual as he may be described, judged, measured, compared with others, in his veryindividuality; and it is also the individual who has to be trained or corrected, classified, normaliseexcluded, etc". p. 105

Foucault perceived that examinations and written descriptions of people are an integral part of the disciplinary mechanism within institutions, which dehumanise and disempower individuals. The social status of individuals is defined in terms of a standard measurement of normality, and those who fall short of this constitute a case. In this way the individual becomes both the cause and object of power. He perceived that systems of hierarchical surveillance and normalising judgement are formalised channels for the expression of power.

Dandeker (1990) linked Foucault's ideas about the development of disciplinary power with Weberian theory. Weber argued that this system lessened material costs. Additionally it made political control less obvious and stifled resistance so that social power became constant and strong throughout society. Disciplinary power within organisations increased the effectiveness and compliance of the population. Dandeker stated that Foucault maintained that the use of modern surveillance techniques is unavoidable because they are the most efficient means of controlling the masses. Dandeker cited Giddens who argued that surveillance has an information gathering function, as well as a supervisory one. He talked about *power containers,* which are created under certain conditions. He argued that surveillance must be able to be carried out within different social contexts, which utilise specialisation, sanctions and specific aims. Dandeker states that surveillance activities are evident within all social relationships. Surveillance involves the collection and storage of information, and the supervision of people through orders, or through the natural or constructed environment. The use of information gathering activities is used to monitor the conduct of those under supervision, and in the case of people who are subject to official control, their compliance with orders.

When these activities are lasting they can be said to comprise the organisational basis of a relationship of domination between rulers and ruled. In this context surveillance is not simply an aspect of all social relationships but an organisational means of reproducing a social system of rule. Consequently surveillance is not just an aspect of social interaction it is an organisational means of replicating a social system of rule. Dandeker observes that the use of surveillance for supervisory and monitoring purposes is a predominant feature of formal organisations. They have explicit aims and a formal organisational structure for carrying them out. He links the concept of rule with the elements of surveillance, and discusses how the people in command reproduce the system of rule. The system of rule requires that people obey commands routinely, and for this to be effective relationships between those involved need to be strong. Dandeker argues that rule is differentiated from surveillance systems, and the exercise of control. Control is involved with the actual management of behaviour through punishment or exclusion. However both activities reinforce the other in the reproduction of rule, because the act of gathering information usually involves the supervision and control of behaviour.

Macro level social rule theory assists in the understanding of the results of this small-scale study in that wider systems of surveillance and discipline within society could be perceived as operational within the micro social system of the wards. However psychiatric hospitals must balance these functions with their stated therapeutic aims. Arguably psychiatric units fulfil the criteria of *power containers* as defined by Giddens

(1985). However in order to fulfil the purported aims of psychiatry this power must be acknowledged, and utilised flexibly or inflexibly through the ward rule system, in accordance with patients' individual therapeutic needs. The work of Bowles and Dodds (2002) demonstrates that it is possible to move away from surveillance towards therapeutic engagement without a significant increase in risk.

Ward management systems and ward rules: Z ward

The management problems within Z ward echo Cohen's (1971) work in which he stated that a failure to follow procedures based on agreed rules inevitably results in disorganisation. The Z ward team did not operate from a clear nursing philosophy, and they vacillated between rigidity and flexibility. In symbolic interactionist terms they did not share the same interpretation of the rule enforcement role, and this led to inconsistency between nurses. Consequently lack of rule clarity caused disorganisation, and this reflected Cohen's (1971) concepts on in that the staff had no clear guidelines about how to proceed when patients broke the rules.

The regime failed to contain patients because a duty of care was blurred by conflicting concepts of the nursing role. The ward manager adopted a low profile within patient areas, and left the clinical management of the ward largely in the hands of the rest of the team. The team was closely knit, and the ward manager was staff rather than patient centred. The roles and responsibilities of nurses were less clearly defined than those of the Y ward team where qualified staff took primary responsibility for the enforcement of treatment rules. The structure was underpinned by a distorted vision of a therapeutic community approach that resulted in a confused version of a flattened hierarchy. Nurses, patients and other members of the multi-disciplinary team made arbitrary decisions about rules. They were not agreed or clarified prior to implementation, and higher grades of staff did not monitor inconsistency between nurses who were working in communal areas or individually with patients. Breaches in the rules escalated and nurses blamed patients or each other. The Department of Health (2002) highlighted problems with the leadership of inpatient wards.

> "*There needs to be investment in the development of managerial and leadership competencies of ward managers or sisters/charge nurses*". p.17

The results showed that certain Z ward nurses perceived that they constantly criticised patients. These perceptions were reflected in the feelings that patients expressed about interactions with staff involving rules, and in their adverse responses towards enforcement. The quantitative results support the qualitative evidence in that the WAS showed that Z ward patients displayed more anger; the HHPPS results showed that restrictions on meals were greater within this ward; also the number of recorded ward incidents, and the use of PRN medication for the control of aggression was much higher. They tried to promote user involvement in rule construction as a means of engaging with patients, and enlisting their co-operation with the regime. The decisions that were made during meetings with patients were followed through inconsistently, and this caused an increase in non-compliance. Nurses reverted to rigidity because they perceived that patient empowerment was detrimental to order, and they were afraid of losing control of the ward.

Arguably the Z ward team were misguided in trying to create a version of a therapeutic community approach within an acute psychiatric setting. Nurses wanted to create a therapeutic regime, but these ideals were dashed because patients did not make expected progress. Within the current climate it may not be possible to attain ideals that remotely match a therapeutic community approach because of the constant fluctuations in levels of patient acuity and turnover. These communities were not originally intended for acutely ill patients precisely because short admissions obstruct the development of a collective ward atmosphere. This approach depends on highly structured roles and expectations for patients and staff. Moreover the general quality of support for patients and staff was poor, but if these structures were firmly in place then a version of a therapeutic community approach might evolve. Since the time of data collection several papers have emerged, and they show that organisational problems in acute psychiatric wards remain severe (Shaw 2001; Muijen 2002 and Griffiths 2002). However Mistral and McKee (2002) demonstrated that structural and relationship changes within acute psychiatric wards could provide a basis for the introduction of therapeutic community principles

The Z ward team tried to transform institutional practices for the benefit of patients. They seemed to be more aware of the current emphasis on service user involvement, and were more inclined to adopt a social model of mental illness than the Y ward team. As such this corresponds with Gidden's views (in Seidman 2004). He argued that individual behaviour is not dependent on organisational systems within society. He perceived that people are able to reflect on the circumstances in which actions are performed, and they do not simply conform to social norms. Rather they are able to reflect on their actions, and incorporate this knowledge into their behaviour. Giddens perceived individual action as a dynamic process of social awareness. He argued that traditional social practices have been overtaken by a constant process in which the effect of social action are integrated into institutional practices. He maintained that institutions such as psychiatry generate information about personal life. However the fragile Z ward structure was not strong enough to support innovation, and role ambivalence increased when the staff resorted to traditional methods. In Dandeker's (1999) terms the basic essential systems of rule or structure were not reproduced, and the results correspond with his arguments in that the conditions that he described were not met.

Ward management systems and ward rules: Y ward

The Y ward manager was patient centred. A clear vision of his clinical management role underpinned the ward structure, the role of the team, and the interpretation of a duty of care. Y ward staff followed clear procedures. For example they used a signing in and out book and patients were usually confined to the ward pending a review if they returned late. Qualified nurses focused on this, and they helped patients to see that the rule was enforced out of concern for their welfare. Patients were left in no doubt about the consequences of non-compliance, and the reasons for the use of the step system. From a symbolic interactionist perspective they helped patients to share the meaning of the rule or symbol, and there is evidence that they did this through effective communication.

However the care context was perhaps over protective and some patients found the environment intensely oppressive. The results showed that nurses were influenced by a blame culture as well as their care philosophy, and they laid great emphasis on the prevention of absconding. Patients were largely left to their

own devices as long as they complied with treatment rules, and they were consistently enforced. The Y ward team stressed the homelike nature of the ward environment, but aspects of the results contradicted this perspective. Certain patients reported that they were infantilised or treated with disrespectful insensitivity. This approach pinpointed managerial deficiencies in monitoring the work of individual members of the team, and in clinical supervision. The high levels restriction and the emphasis on compliance with treatment rules were combined with a general lack of stimulation, and this structure resulted in an apathetic acceptance of the regime by most patients. They expressed strong feelings about enforced confinement because they were frequently locked into the ward as well as being subjected to surveillance. Although the regime physically contained them, they experienced psychological distress that manifested in feelings of oppression, hyper-vigilance and fears of permanent incarceration. The results showed that sudden isolated acts of violence against objects did occur despite the high levels of containment within this ostensibly peaceful ward environment, and these incidents were dealt with firmly. The Department of Health (2002) identified inpatient wards that provide appropriate stimulation and structure as a core element of individual care plans as safer more therapeutic environments.

Aspects of the results reflect Merton's views (in Giddens 2001). He showed how inflexibility developed from a tendency to view rules as ends rather than means, and this reflects the results given that all patients were generally subjected to the same rules regardless of individual levels of functioning. Merton maintained that institutional pressures induced over conformity, apprehension, and rigidity amongst employees. He perceived that strict adherence to the rules protected them from criticism, but also obstructed organisational goals. Given that psychiatric hospitals perform a dual function of therapy and control from Merton's perspective the rigid enforcement of rules obstructed the therapeutic aims of the organisation. Patients were not treated therapeutically according to their varying and changing needs for control, and this meant that the dual aims of the organisation were not achieved. The results suggested that organisational pressures influenced the Y ward team to a greater extent than Z ward staff. The Z ward team attempted a therapeutic interpretation of the rules, but as previously outlined the fragile structure made this unviable.

Giddens (2001) discussed Weber's theory of an ideal type of bureaucracy. He cited Merton concluded that certain aspects of this type of organisation could result in dysfunction. He observed that bureaucrats are trained to adhere rigidly to written rules and procedures. Flexibility and autonomy in decision making are discouraged as is creative problem solving. The bureaucratic function entails the management of cases, which are measured against impartial criteria. Merton argued that this rigid system could produce *bureaucratic ritualism.* Within this context the rules are followed, despite the fact that another course of action might be in the best interests of the organisation overall. He also held that strict observance of the bureaucratic rules could ultimately subvert organisational aims. Merton predicted that conflict between the public and bureaucracies might arise, when the needs of the individual were overridden by the rigid application of rules. Giddens argues that difficulties in dealing with specific cases highlight the inherent faults of bureaucracies because they are not designed to manage cases that require a flexible approach. Aspects of the results bear this theory out when applied to the micro social context of the wards in that Z ward patients reacted particularly adversely towards the regime.

> *"High therapeutic intervention and interaction environments diminish disturbance, violence and boredom. Poor amenities and lack of structured activities and individual attention promote*

untoward incidents and create risks". Department of Health (2002) p.13

Role strain

The results indicated that nurses' were uncomfortable with aspects of control. The interview descriptives showed that rule enforcement involved interactions with adult patients who were generally older than they were, and most nurses coped with this difficulty by adopting an impersonal approach. The Y ward nursing philosophy engendered less conflict and stress amongst nurses about the use of control, but certain nurses overstepped social boundaries, and patients were infantilised by a parental approach that intensified unequal relationships. For example nurses told patients that they were naughty and criticised their levels of hygiene in a highly personal manner. Patients were demeaned and angered by nurses' attitudes, but they were not dehumanised to the same extent as the Z ward group because they did engage with patients to a certain extent during enforcement. In a study of nurses attitudes towards personality disordered patients residing in the special hospitals Bowers (2002) found that nurses who were motivated by parental attitudes were able to maintain a positive perspective towards the role. The results of this study pinpointed the negative effects of this approach when it is taken to an extreme, and systems of clinical supervision are inadequate.

The views of Merton (1957) and Cohen (1971) about organisational pressures and role strain correspond with the emotional dilemmas confronted by nurses in relation to rule enforcement. Within both wards a rigid interpretation of the rules resulted in adverse reactions from patients, and ward crises that culminated in the increased use of containment measures. Merton perceived that a rigid approach might arise within institutions because they attract the type of employee who avoids autonomous decision-making. Emerson and Pollner (1975) analysed professionals' perceptions of their work (in Pilgrim and Rogers 1999). Duties such as the compulsory detention of patients in an emergency were regarded as 'dirty work' as opposed to therapeutic aspects of the role. They also cite Hughes (1971) who identified this concept in relation to the shame experienced by professionals when they were involved in the involuntary detention of patients. They distanced themselves from the role, emphasised caring aspects, and claimed that rule enforcement was forced upon them.

These studies correspond with the results of this study in that patients were dehumanised by rigidity, and the impersonal manner in which most nurses enforced the rules. Low levels of engagement during rule enforcement intensified patients' perceptions of powerlessness and alienation. They felt dehumanised by a lack of emotional warmth, and nurses generally failed to convey that the rules were enforced out of concern for their welfare. Patients experienced a range of distressing emotions, and these feelings were particularly intense within Z ward where deficiencies in structure resulted in the use of constant criticism against patients who breached the rules. The nurses in this study experienced similar feelings of role ambivalence in relation to rule enforcement, and they also may have distanced themselves from the role in a similar fashion, which gave patients the impression of a lack of warmth.

Nurses felt overwhelmed by responsibilities for the enforcement of treatment rules that were constructed by consultant psychiatrists. They were distressed by dilemmas in relation to enforced confinement. The lack of structured activity within both wards was mirrored in generally low levels of staff patient engagement. The

high patient turnover resulted in a rise in bureaucracy as nurses strove to document multifarious aspects of patient care, and they restricted informal contact with patients. This corresponds with Foucault's observations about disciplinary writing. The results showed that patients tried to access nurses in ward offices when they were distressed or in need of rule clarification, but they were frequently ejected, and both ward teams rationalised this by citing patient confidentiality. The interactions that did occur were bounded by judgements about which categories of patients should receive attention. For example individuals classified as personality disordered were ejected but psychotic patients were sometimes allowed to sit with staff.

The results correspond Bond & Bond's (1994) observations on bureaucratic organisations in which they argue that the training of staff members includes an enculturation into the adoption of objective attitudes towards patients. This assumes that patients will be dealt with according to the rules of the organisation. This means that staff must ignore their own feelings and those of patients. The results of this study showed that the role strain experienced by nurses was influenced the conflicting demands of the hierarchy and the emotional dilemmas that they confronted associated with rule enforcement.

The results revealed how the operational aims of the institution were carried out at ward level. As previously stated in the introduction this depended on the way that staff implemented rules associated with therapy and safety. From a symbolic interactionist perspective the results revealed how macro level initiatives were translated into micro-level interactions between staff and patients. The results from patient interviews and field notes from non-participant observations showed that nurses generally divorced rule enforcement from engagement. Goffman (1961) also observed restricted interaction between staff and patients, and contemporary studies on acute psychiatric wards such as Quirk and Lelliott (2001) also observed this. Goffman's findings echoed the remarks made by nurses and patients about the manner in which the rules were enforced. Patients in particular referred to the tone of voice used by staff, and he also remarked on this. However he viewed the institution from the patients' perspective, and this study incorporated the staff's views. The results showed that in general terms nurses did not enjoy the rule enforcement role, and they were aware of power relations. These reactions were particularly evident in the Z ward results.

Nurses experienced role strain when organisational demands for safety and control outweighed therapeutic aspects of the role. This behaviour reflected Wilson's findings (in Cotgrove 1970) in which teachers experienced similar role strain because of the caring and disciplinary demands of the post. The results showed that Z ward nurses were particularly conflicted about responsibilities for control, and they expressed more resentment about this aspect of the role. They perceived that rule enforcement obstructed engagement, and damaged relationships with patients. Conversely the results showed that Y ward nurses were less ambivalent about control particularly in relation to enforced confinement, compulsory medication and aggression. They also married control with engagement to a certain extent in that they assisted patients with activities of daily living. They also used psycho education techniques, which involved a pre-discharge group, and information giving about medication.

The interviewees' argued that they did not have sufficient resources to spend as much time with patients as they would have liked. The wards were constantly destabilised by new admissions. The staff was involved in close observations of high-risk patients, and this depleted their strength. They perceived that surveillance,

rule enforcement and bureaucratic duties obstructed opportunities for engagement. The role of inpatient staff was analysed by the Department of Health (2002). They found that qualified nurses were overburdened with office duties, and less experienced or non-qualified staff was in contact with the patients. However certain aspects of the results suggested that they could have spent more time with patients. Whittington and McLaughlin (2000) found that nurses spent about half of the working day in contact with patients. However the amount of psychotherapeutic one to one contact was minimal.

The nurses in this study may have restricted formal or informal contact with patients because they were constantly exposed to acuity. They expressed feelings of ambivalence because they perceived that they were not fulfilling the therapeutic aspect of the role, and they dealt with this by maintaining an emotionally detached stance during rule enforcement. In a review of the evidence about life on psychiatric wards in the 1990's Quirk and Lelliott (2001) identified similar pressures on staff. They also found evidence of violence, sexual harassment, and a rising number of difficult young patients with schizophrenia. They highlighted low staff morale and high turnover together with deterioration in nurse patient relationships. Their findings correspond with the results of in that patients complained about ward conditions. They also viewed the environment as boring and unsafe.

Inherent conflicts were manifested in uncontrolled emotional responses towards patients, and these attitudes were particularly noticeable within the Z ward nursing team. They were more at variance with the role of psychiatry, and they operated without a clear vision of a duty of care. These conflicts were managed through group alliance, and they maintained a low presence in patient areas. Patients' feelings of anger, abandonment, insecurity and victimisation were intensified because rule enforcement was divorced from other forms of interactions with nurses. These feelings were less intense amongst the Y ward patient group because nurses engaged with patients to a degree during pre discharge groups. They also incorporated the rules into basic self-care activities, and assisted patients with these functions. The results showed that limited forms of engagement reduced the dehumanising impact of hospitalisation. However the ward environment was oppressive because levels of containment were extremely high, and this was borne out by the quantitative results from the HHPP scale.

Patients may not just be influenced by internal disorder they may also be distressed by psychosocial difficulties that manifest in resistance or acting out behaviour. At this point the ability of psychiatric nurses to combine the dual aspects of the role becomes essential. They must help patients to understand not only the rules, but also the rationale for their existence. If they get through to patients that the rules are imposed out of concern for their welfare, then they may follow them with less resistance. From an interactionist perspective if patients are helped to understand the meaning of nurses' behaviour then they may learn to take on the role of the other. This facility may have been disrupted by illness, and when patients display resistance or unawareness nurses need to access patients feelings and thoughts. In other words they take on the role of the other, and this may help them to understand patients' behaviour and predict their responses

The concept of role taking bears a similarity to empathy, which can only be expressed through contact with patients. Jacobs (1988) gives this definition of empathy.

"Empathy or identification means the ability to put oneself into someone's shoes, to get into their skin to experience what they might be experiencing". p.30

Rule enforcement should not be divorced from other forms of therapy such as counselling or help with activities of daily living. Ward rules should form an integral part of patients' care plans, and their responses should be continually assessed. Y ward nurses appeared to have greater contact with patients. For example they worked to gain compliance with medication and leave, and they assisted patients with activities of daily living. At times the results showed that they did take on the role of the other, and for example they were distressed when a patient was unable to see her children, but the results showed that the nurse did not let these feelings interfere with organisational demands for safety. However these feelings were not communicated to the patient, and medication was offered in an effort to calm her, which she interpreted this as a punitive act. Another patient was humiliated when a nurse reprimanded her for a lack of personal hygiene, and in this case the nurse had totally disregarded the circumstances of the patient's emergency admission. In symbolic interactionist terms the nurse failed to conceptualise or read the symbolic meaning of the patient's self neglect.

Multidisciplinary teams and rule construction

The nurses in this study expressed resentment against Consultant Psychiatrists when patients reacted adversely towards rule enforcement. Conceivably from a symbolic interactionist perspective nurses may not developed a shared understanding of the pressures on Consultant's that are primarily accountable for the safety of patients, and the protection of the public. Nurses undertake twenty four hour responsibility for inpatient care, and the results showed that the advent of multi-disciplinary teams, which may be viewed as a modification of the organisational hierarchy, did not have a significant impact on the role strain they experienced in relation to the rule enforcement role. This suggested that they felt isolated, and that role strain might have been ameliorated if other members of the multi-disciplinary teams had played a greater part in decision making with regard to the flexible or inflexible enforcement of rules. The system of weekly ward rounds interfered with the consistent input of the multidisciplinary team in decisions that were made about patient management. From a symbolic interactionist perspective limited contact between members of the team inhibited the development of a shared perspective on the management of individual patients. The Department of Health (2002) identified the significant influence that Consultant Psychiatrist and Medical staff exert over the organisation of inpatient services. They highlight a crucial need for an improvement in collaborative working between nurses and medical staff for the co-ordination and development of inpatient services, and the management of risk. They recommended that Consultant's should set aside specific times for a regular contribution to the ward team, and other meetings.

Nurses followed consultants' directives but although they were in most contact with patients they did not act on their own assessments, and for example as a general rule they refused to even take patients out into the grounds without the consultants' consent. This meant that patients were confined to the ward for several days pending ward rounds, and nurses bore the brunt of their hostile or distressed reactions. Patients were given extended day leave by consultants, but they were not allowed to bathe unsupervised on their return,

and this suggested that the nursing role was strongly associated with institutional safety. These sorts of complaints did not emerge in the Y ward results, but patients complained that nurses frequently locked them in. O'Rourke and Bird (2001) point out that risk cannot be eradicated it can only be minimised, and the aim of risk management is the prevention of harm. They point out that risk can be general, specific or both and that comprehensive assessments should identify all the risks. They argue that risk assessments cannot be performed by one agency, but nurses are constantly confronted by situations involving risk because they are in most contact with patients. O'Rourke and Bird (2001) point out that working closely with individuals decreases risk, and it could be argued that low levels of therapeutic engagement increased risk. The authors point out that risk is dynamic, and that patients' mental states can fluctuate rapidly. Patients' perceived that ward rounds were the primary mode of user involvement, and attached great importance to medication. O'Rourke and Bird (2001) argue for greater service user involvement in their care.

> *"Effective risk assessment and management, which actively involves the user in the process can, and should be, empowering".* p.2

Nurses were preoccupied with the enforcement of treatment and safety rules. The results highlighted the need for a redefinition of the role of multi-disciplinary teams in relation to rule construction. The separation of roles meant that responsibilities for order and safety were not diffused throughout the team. Nurses were educated in various therapies as well as the medical model, and numerous post registration courses were widely available, but the results showed that they perceived their role as largely custodial. Low levels of engagement within the wards perpetuated this role because nurses' contributions to ward rounds were based on patients' responses to medication and leave. The results correspond with Riley's arguments in Bond and Bond 1994)

> *"Institutions, which depend on rigidly, maintained d hierarchy and strict division of labour amongst their personnel cannot fail to transfer the results in some form to the treatment of patients. The difficulties of acquiring a theoretical appreciation are as nothing compared with the difficulties of enacting flexibly within an inflexibly organised system".* p.69

The results showed that the Z ward team was exposed to more conflict and aggression than that of Y ward. Their reactions towards certain patients mirrored Whittington and Wykes (1994) study in which they tested a cyclical model of violence against psychiatric nurses. The model suggested that violent incidents cause stress, and this results in deterioration in nurses' levels of functioning which causes them to perform in ways that exacerbate the risk of violence. In another study Whittington and Wykes (1992) also found that certain staff reported high levels of stress, which continued for a considerable time after the incident. The support that staff received was usually informal in nature, and strongest in the immediate aftermath of the incident. The results of this study suggested that a lack of social support in the form of clinical supervision, and role modelling from more experienced staff for those working with patients was lacking. In another study Whittington and Wykes (2002) found that experienced staff were more tolerant of patient aggression. High tolerance was linked with low emotional exhaustion, low depersonalisation, and high personal accomplishment. The results of this study showed that less highly trained and experienced staff tended to avoid rule enforcement with intimidating patients, or that they confronted them, and experienced high level of stress. Another consequence of this was that the nurse in charge of the ward became the target of aggression because they were forced into a position where they had to confront patients with the rules.

This kind of situation could be countered by increased support from the multi-disciplinary team. More support for the nursing staff might ameliorate rigidity with a consequent decrease in aggression. Additionally the increased involvement of the multi-disciplinary team in rule construction and enforcement could help nurses to set boundaries consistently. Multi-disciplinary teams represent a flattened hierarchy with equality between members, but the results showed that nurses still tended to be consigned to a custodial role. Low levels of engagement with patients, and an emphasis on surveillance tended to reinforce this because this affected the therapeutic input that they were able to offer during ward rounds. The Department of Health (2002) pinpointed the disproportionate amount of time that staff skills are utilised in the organisation of inpatient wards.

> *"Such activities as record keeping, ward rounds/ reviews, observation can inappropriately monopolise staff time, when compared with therapeutic engagement. It is important that adequate priority and resources are given to a structured regime of activity and service user engagement and that staff skills and time allotted to such work is protected in the face of competing demands".* p.15

This situation corresponds with Gidden's structuration theory (in Stones 1998). Giddens investigated how collectivities are formed and structured through social practices. He perceived that most groups contain two main features. They exhibit lasting patterns of positions and relationships. They have a specific structure in terms of moral codes, types of domination and class structures. This serves as a context for the repetition of routines and rituals over time, which becomes a fixture of social life. Giddens gave an example of the structured subordination of women to men in business organisations. However he points out that all social practices change with time, and so do structure. According to Giddens (2001) Weber was concerned that a rise in the power of bureaucrats might decrease democracy. he held that the hierarchical nature of bureaucracies together with increased specialisation meant that the work of those operating near the floor of the organisation is routine fundamentally, and that the workforce is relatively powerless in comparison with other members of the hierarchy. Weber predicted that they might become alienated, and resigned to the role in the absence of any opportunity to exercise their own initiative. Consequently they might become defensive and rigid in an effort to protect themselves from any further inroads into their positions within the hierarchy.

Multi-disciplinary teams represent an opportunity for nurses to break out of subordination to the medical and other professions, but in order to do this they must embrace change. Although staff resources were an issue as identified in several reports (Department of Health 2002; The Sainsbury Centre for Mental Health 2003) the results showed that nurses were reluctant to act on their own assessments. Nurses who violate institutional rules may be disciplined, and may ultimately lose their registration. The results showed the extent to which the kind of ward regimes that nurses created were influenced by the institutions that employed them, and that regulated their activities. Further the results revealed how the threat or use of containment measures for rule breaking influenced patients' attitudes towards control. Although containment methods were employed more intensively within Z ward, both groups of patients tended to perceive them as punitive rather than therapeutic. This provided further evidence that rule enforcement was divorced from engagement. Although they would not act flexibly without the Consultant Psychiatrist's consent they also resented rule enforcement duties, and felt that they bore the brunt of patients' adverse reactions. However Consultant Psychiatrists also shoulder responsibility for patients, and both sides might

benefit from a closer alliance, which might result in mutually supportive relationships in which responsibilities for the management of risk in relation to rules is diffused.

> *"While inpatient care needs a multidisciplinary partnership approach, development of joint medical and nursing practice is particularly crucial to staff deployment and managing risk on each ward, and to overall inpatient service development and coordination".* Department of Health (2002) p.17

Service user involvement in rule construction

The Mind Organisation (2003) states that full service user involvement means that they should be treated as equal citizens with dignity and respect in mental health services. They should be given complete information about their treatment and rights. They should be involved in their care and treatment. They should have access to advocacy, and be involved in the planning, operation and evaluation of services. Other aspects of the recommendations include the training of workers by service users. Service user involvement could be perceived as a change in the hierarchical system in which care is delivered. Cotgrove (1970) argued that ways should be found to decrease the demands made on employees, and solutions that increase staff autonomy throughout the organisation. Within the system in which the wards in this study operated an increase in staff autonomy was difficult to achieve, and without this it would be even more difficult to promote service user involvement in rule construction. Nurses and patients associated user involvement in rule construction with consultants' ward rounds. The results demonstrated the dehumanising effects of communal facilities and stark environments that were unresponsive to individual needs. Improved facilities for patients may alleviate the distress of enforced confinement, but these embellishments may only serve as a veneer within a system in which containment dominates ward-nursing regimes.

Service user involvement is related to autonomy, but this could not occur within a system where all patients regardless of individual levels of functioning were subjected to the same rules. Risk assessments were largely based on patients' responses to rules in combination with surveillance. Yet the results showed that certain patients circumvented the rules or managed to remain compliant whilst harbouring ideas of aggression or absconding. This suggested that these methods should not be divorced from therapeutic engagement, and that safer risk assessments together with a decrease in aggression or absconding might result from increased nurse patient contact. Consultant psychiatrists altered treatment rules but a gradual increase in patients' autonomy in this area was not reflected in ward rule flexibility. These anomalies may only be resolved when ward and treatment rules are constructed in consultation with patients, carers and all members of multidisciplinary teams as recommended by the Department of Health (2002)

> "*There must be a regular means and forums for encouraging service user involvement in determining how the ward is run, what rules of conduct apply and what activities are available. Each ward should have regular timetabled user/staff meeting with advocacy input as requested*". p.13.

Service user involvement in the ward regimes also jeopardised overall control. High levels of occupancy and turnover made it difficult for nurses to acquire an in depth knowledge of patients strengths and weaknesses, and low levels of engagement compounded this problem. Z ward nurses were more conflicted about power relations, and discordant views within the team manifested in uncoordinated efforts to involve patients in

rule construction. Patients were given the impression of power sharing, but nurses were unable to take the risk, and they resorted to authoritarianism.

A lack of commitment to service user involvement could be viewed from the perspective of theories related to stigma. The results showed that certain staff viewed patients as inherently irrational and unpredictable. Further particular patients such as those who were intimidating or who had been categorised as personality disordered tended to be avoided by staff. An analogy could be drawn between staff patient relationships and Blumer and Duster's race relations' theory in Stones 1998). They suggested this issue should be approached as a symbolic activity, and studied within the social context in which it occurs. They perceive that race relations emerge during human interaction, and develop through shared activity. They argue that racism does not arise from the feelings that one racial group have towards other groups. They perceive it an attitude towards other groups that have been categorised and represented in a certain way. Racism arises through a collective process whereby differing social groups construct images of themselves and others. This process is fundamental to the development of racial prejudice, labelling, and the concept of others or outsiders. The powerful group exhibit four types of collective behaviour. They feel superior, and perceive the other racial group as fundamentally different and strange. They perceive that they possess certain rights and advantages. They fear that the subordinate race has designs on these privileges, and this is one of the basic sources of racial prejudice. The authors argue that this conflict arises from group rather than individual conflict.

These concepts could be applied to the issue of service user involvement if it is combined with Giddens (2001) analysis of Weber's work. Giddens stated that Weber was concerned that a rise in the power of bureaucrats might cause a decrease democracy. He held that the hierarchical nature of bureaucracies together with specialisation meant that the work of those operating near the floor of the organisation is routine fundamentally, and they are relatively powerless in comparison with the higher members of the hierarchy. Weber predicted that they might become alienated, and resigned to the role in the absence of any opportunity to exercise their own initiative. Consequently they might become defensive, and rigid in an effort to protect themselves from any further inroads into their positions within the hierarchy. However the development of service user involvement could represent an opportunity for nurses and patients to form an alliance. This together with a shift towards therapeutic engagement could improve the position of both parties in relation to other members of the hierarchy, and might reduce the risk of aggression against nurses. Whittington and Wykes (1996) found that nurses were subjected to more violence than other staff in a general hospital.

Rule clarity and power relations

The Department of Health (2002) recommended that patients should be given clear guidelines including information about the rules when they are admitted to the ward. Both nursing teams did not generally give newly admitted patients information about the rules. The Z ward nursing team constantly analysed the structure, and tried to involve patients, but poor lines of communication resulted in a lack of rule clarity. Consequently they were unable to give patients, newly appointed staff and students information about the

rules. The Y ward nursing team stressed that the ward was the patients' home, and they felt that an emphasis on rule clarity would convey a negative first impression of the environment. The rules were embedded in the ward structure, and nurses did not perceive that they should review the rules or impart them to patients, newly appointed staff or students.

The interviewees gave various reasons for a lack of rule clarity, but the overriding theme was that they assumed that patients naturally adapted to ward norms. This assumption was contradictory because nurses associated mental illness with social impairment, and this was likely to exert a negative influence on adaptation. Both nursing teams perceived that there was no need to tell patients about the rules unless they breached them, but patients felt humiliated, victimised, frightened, distressed and angry when they were criticised or reprimanded for breaching rules of which they were unaware. Nurses used the threat of sanctions to control disruptive behaviour, and the results showed that patients made negative interpretations of containment measures when they witnessed ward incidents. The results showed the detrimental effect of lack of rule clarity in that it was associated with absconding risk and aggression, particularly within Z ward. Williams states that human beings are expected to be capable of understanding the meaning of rules, and of shaping them the context in which they arise (in Stones 1998). Order does not just result from rule following. Rules give people the opportunity to take part in the process of order, and to observe what is taking place. Consequently a study of rules also involves an analysis of the context in which they arise. Poor communication in relation to rules did not give acutely ill patients the opportunity to take part in this process. A successful trial that significantly reduced levels of absconding in acute psychiatric wards incorporated rule clarity as an element in the prevention of absconding (Bowers et al 2003)

Aspects of the results relate to sociological theories of power and control within medicine. Bond & Bond (1994) observed that professionals frequently restrict information because they assume that patients would rather not be informed, or do not possess the capacity to make informed choices, and retain self-control. They cite Waitzkin & Stoeckle.

> *"A physician's ability to preserve his own power over the patient in the doctor-patient relationship depends largely on his ability to control the patient's uncertainty".* p187.

The results of this study showed that when nurses withheld information about the rules they induced a state of uncertainty and fear amongst certain patients. Bond & Bond (1994) cite Davis (1963) who referred to clinical and functional uncertainty. The concept of functional uncertainty could be applied to the practice of withholding information about ward rules in that it is defined as a means of managing interactions in order to stop patients questioning treatment, and to prevent adverse responses to unpalatable information. The results of this study also showed that lack of rule clarity maintained uncertainty amongst the patient group. This enabled overall control because patients, who were suddenly reprimanded, threatened with containment measures or transferred to a locked ward for rule breaking served as an example for the rest of the group about the consequences of non-compliance.

Intimidating patients, rule clarity and enforcement

Lack of rule clarity led to problems in the management of aggression within Z ward. The results showed that both nursing teams avoided information giving and rule enforcement because they feared intimidating patients. The Y ward teams' nursing philosophy encompassed aggression as a symptom of disorder, and this enabled a cohesive approach towards containment during the early stages of admission. The low rate of ward incidents may have been associated with this approach because patients may have felt psychologically and physically contained when they were acutely ill. They may have retrospectively perceived containment measures as an expression of nursing care or concern for their welfare. The Z ward nursing team continued to avoid intimidating patients because they were operating from an unclear duty of care, and certain individuals remained non-compliant for the duration of stay. Senior nurses bore the brunt of aggression when they were forced to confront patients. Agency nurses tended to be excluded from this ward team, and they were mainly deployed in surveillance. A few patients made comments about their lazy disinterested attitudes. Agency staff enlisted the assistance of permanent staff during rule enforcement because they were unsure of patients' reactions, and certain patients responded by testing boundaries.

The results cast further light on the antecedents of aggression in that the staff perceived that patients sensed a lack of team cohesion, and they also felt that patients knew that they were afraid of them. The results showed that lower grades of staff were exposed to unacceptable levels of stress within both study areas because they came into most contact with intimidating patients. Most nurses avoided close contact with this patient group, but they had to overcome their anxieties when rule enforcement became unavoidable, and certain staff became inured to abuse. Although the Y ward team were more cohesive they also encountered problems with intimidating patients. Whittington and Wykes (1997) used a theory of coping in an analysis of the psychological mechanisms that staff used to cope with stress associated with violence. They found that avoidance and confrontation were used by over a third of staff. This resulted in an increase or decrease in levels of staff patient interaction. Confrontative coping was associated with a short-term increase in anxiety. This study could be linked with the Z ward results in that nurses in most contact with intimidating patients tended to use avoidance. This meant that the nurses in charge of the ward were forced into confrontations with patients when rule enforcement became unavoidable which meant that they experienced frequent episodes of anxiety.

The results from both wards highlighted a lack of clinical supervision and support from higher grades of staff for nurses working in communal areas, or individually with patients. The nurses were aware that certain Z ward patients were out of control, but they did not target them, and they rigidly imposed the rules on the rest of the group because they feared that general disorder might break out. They perceived that they constantly criticised patients who in turn regarded the regime as punitive. Submissive patients internalised rebukes, and those who were less quiescent externalised feelings of resentment in behaviours ranging from verbal aggression through to absconding.

The results showed that patients from both wards were acutely aware of inconsistent rule enforcement, but they overlooked these anomalies to a degree, and perceived that differential treatment demonstrated nurses' humanity and fallibility. They objected when nurses subjected them to harsh enforcement, and ignored other patients who blatantly breached the rules. The extent of inconsistency between within the Z ward regime produced a lack of respect for nurses from intimidating patients, and they frequently challenged the regime.

However nurses continued to focus on overall control in an effort to create stability, and the patient group as a whole became less compliant.

One group of Z ward nurses assumed that acuity did not obstruct compliance, and they believed that patients broke the rules deliberately. They blamed inconsistency, and perceived that certain nurses ignored rule breaking because it was so rife amongst the patient group. Although views were split in terms of the causes of non-compliance the end result was the same in that the team became more authoritarian, and nurse patient relationships became polarised within a heightened atmosphere of threat. Certain staff displayed judgemental attitudes towards patients, and the use of containment measures increased. The WAS results confirmed that patients in this ward expressed a higher degree of anger. The number of ward incidents was also much greater than those of Y ward, this could be linked with Whittington & Patterson's (1996) findings in which they reported that aggressive patients tended to exhibit certain behaviours some time before an assault on staff, and they were dissimilar to non-aggressive controls in that they displayed the same type of behaviour three days before the assault. The results show that the Y ward team nipped aggression in the bud, but intimidating patients were not managed well within Z ward, and aggression escalated.

Rates of absconding and non-compliance with leave rose, and nurses responded inconsistently to these incidents. This was in marked contrast to the Y ward staff approach. They monitored leave strictly, and imposed consistent sanctions for non-compliance. Patients within both wards witnessed ward incidents involving enforced medication or transfer to a locked ward, and they regarded these measures as punitive rather than therapeutic. Patients' reactions to containment measures showed that control was usually divorced from a therapeutic context, and consequently they did not perceive that staff employed these methods out concern for their welfare. A review of policies for the management of violence by the Royal College of Psychiatrists (1995) found that a small number of patients tended to be repeatedly secluded. They argue that it should not be regarded as a form of treatment, and that it is usually hard for the patient to view this unpleasant experience as therapeutic rather than punitive.

Deviance

The results showed that nurses differentiated rule breaking by those patients with a discrete diagnosis of mental illness from other groups with co-morbidity, such as dual diagnosis or personality disorder. This mirrored Bowers (1998) views about deviancy theory in relation to mental illness. In general Z ward staff's attitudes towards rule breaking were influenced by deviancy theory to a greater extent than Y ward nurses, and certain Z ward staff perceived that all patients broke the rules deliberately.

However both teams adopted similar attitudes towards people classed as personality disordered, and this reflected aspects of Becker's (1963) work in that these patients could be perceived in similar terms as the sub-groups or outsiders that he identified. The Z ward team's reactions towards these patients echoed Becker's observations about the collective social judgements of policemen towards certain groups of people, and their punitive responses towards challenges to their authority. This reflected the influence of wider

social processes on micro level interactions, and suggests that nurses had internalised societal reactions towards certain groups. These patients tended to be isolated, and were most likely to be feared or rejected by the Z ward staff. Non-compliant patients were subjected to various containment measures that included time out, enforced medication, seclusion or transfer to a locked ward. The Personality Disorder Capabilities Framework (NIMHE 2001) recommends that training for the care of these patients should be founded on respect for their human rights, and reflects their views and experiences. The training should aim to break the chain of rejection at every level of society and within services accessed by individuals. Other aspects of the recommendation include the integration of research evidence into practice, and work on the promotion of patient autonomy, responsibility and self-rejection. The time out procedure was used routinely within both wards, and this measure was also used as a threat. The Royal College of Psychiatrists (1995) commented on its extensive use, and argued that it is open to abuse. They point out that this procedure should form part of a planned and documented therapeutic behavioural modification program. However the results from this study showed that it tended to be used reactively, and was divorced from a therapeutic context.

Haghighat (2001) considered the topic of stigma, and perceived that this process involves self-protection and self-centred behaviour. The stigmatiser by shunning the stigmatised decreases his/her anxiety, and this strengthens the attitude. Certain aspects of Hagighat's work seem particularly appropriate for psychiatric nursing in that he also theorises that other aspects of stigmatisation involve the avoidance of danger and victimisation. He perceives that people that experience threat, failure and frustration and who have low self-esteem are more inclined to stigmatise others. He points out that the presence of these attitudes is an obstacle to patient treatment. These ideas seem to be a particularly appropriate means of understanding the behaviour of certain staff, particularly within the Z ward team in relation to particular patients. The inadequate structure resulted in anxiety and an increase in ward incidents. Haghighat's ideas bear a relationship to Whittington and Wykes (1992) cyclical model of aggression, and both studies provide an insight into the reasons for nurses' attitudes towards certain patients. Wykes and Whittington's (1999) paper also showed that psychiatric nurses who had been assaulted by a patient reported worse mental health than controls and less command over anger.

The results showed that Y ward staff viewed treatment rules as vitally important because they operated from an organic view of mental illness, and they expected compliance to be coterminous with improvements in patients' mental states, which they attributed to the efficacy of pharmacological methods of treatment. The Z ward team tended to adopt a societal reaction view of mental illness, and they tended to view rule breaking as deviant rather than from the standpoint of disorder. Mental illness may induce thought disorder. As previously stated in symbolic interactionist terms this may mean that patients may be unable to read common symbols, or they may misinterpret them. Essentially they may be incapable of taking on the role of the other. Similarly internal processes may disrupt interactions with others, and produce behaviour that appears irrational, threatening or deliberately deviant to staff. However the clinical management of large numbers of acutely ill patients must be underpinned by an adequate structure otherwise chaos might ensue. This depends on the ability of nurses to clarify the rules, and facilitate compliance.

Bowers (1998) maintained that labelling theorists made the mistake of divorcing mental illness from the inner processes of deviant individuals. He pointed out that these views are reductionist in that human

actions are perceived in moralistic terms. Labelling theory is difficult to apply to mental disorder because concepts of self-responsibility for actions are considered in an extremely complex way within psychiatry, and rule breaking cannot be reduced to simple concepts of right or wrong, or good and bad. The methodology employed cast a light on the processes involved in rule breaking behaviour within an acute psychiatric setting, and staff's reactions towards it. The results showed that in particular Z ward nurses responses towards rule breaking did take on a moralistic, judgemental tone, and certain rules were used as a yardstick for right and wrong behaviour rather than for therapeutic or safety reasons

Cohen argued that certain types of deviance are an understandable reaction to specific circumstances (in Haralambos & Holborn 2000) He maintained that if the causes of deviance are tackled the use of stronger controls and sanctions might be avoided. He claimed that acts of absconding from institutions for example could highlight causes of frustration, and result in organisational changes that address dysfunctional issues. From a symbolic interactionist perspective patients' behaviour, and their attitudes towards control might only be changed at a micro level of interaction in which those involved attempt to understand the meaning of deviance. Further as previously stated patients may not be able to grasp the motives behind enforcement, and they may not perceive that the rules are enforced out of concern for their welfare. Greater involvement by the members of multidisciplinary teams with patients on a daily basis might provide support for nurses, and promote a shared understanding of the reasons for deviance and restrictions. This might also produce greater flexibility for individual patients because responsibilities for safety would be diffused amongst the team.

Disorganisation

Psychiatric patients may be preoccupied by internal concerns, and in symbolic interactionist terms they may be temporarily unable to conceptualise or respond to the meaning of rules. Frequent rule breaking produced disorganisation within Z ward, and the team could not fulfil therapeutic functions in the absence of order. As previously mentioned in the introduction acutely mentally ill persons might not be motivated to adopt an institutional perspective of the rules, because they are preoccupied by internal concerns. They may also resist enforcement because they resent hospitalisation, or because they feel that the rules are too rigid (Cohen 1971 in Charon 1979). Viewed from Cohen's perspective Z ward nurses experienced a sense of anomie or hopelessness because they were constantly confronted with rule breaking behaviour.

Both teams of nurses were presented with emotional dilemmas that conflicted with the therapeutic aims of the institution. Cohen argued that in certain situations the choice of an option that transgresses institutional rules could prevent organisational breakdown. Viewed from the perspective of ward nursing regimes a flexible approach may avert disorganisation in appropriate situations that do not compromise the safety of patients or the public. The results of this study showed that senior Y ward staff did use a flexible approach when this was appropriate, but nurses from both wards usually adhered to the rules rigidly, and resorted to the use of containment measures when patients reacted adversely.

Inconsistencies within the Z ward team led to the inconsistent enforcement of rules involving leave from the ward, and they tended to enforce other rules, such as those associated with illegal substances or smoking, rigidly. Consequently they frequently criticised patients, and their adverse responses were further compounded by the tendency to allow the rules to lapse with intimidating patients. Understandably other patients perceived unfairness, and they responded with increased rule breaking.

Containment measures

Aspects of the results echo Cohen's work on disorganisation (1971) in which he observed that people from outside might be brought in to take charge of unstable situations. For example rapid response teams composed of nurses from other wards were called upon to restrain unmanageable patients. The results showed that patients perceived containment measures as punitive rather than therapeutic. Both teams used the threat of enforced medication, time out and transfer to locked wards to deter unwanted behaviour, and this enhanced the tendency for patients to regard these measures as punitive. These feelings were exacerbated when they witnessed ward incidents, and they made their own interpretations of events because staff did not use debriefing techniques. This would have involved one to one or group sessions with patients to give them the opportunity to talk about the event and to offer them reassurance. The Z ward group witnessed more ward incidents and this was borne out by the ward records. New arrivals were warned about the consequences of non-compliance by other patients. This increased feelings of threat within the environment and certain patients became hyper-vigilant. The results showed that they were prepared to respond aggressively or abscond if they disagreed with the rules that were imposed, and this demonstrated the negative effects of the use of threats. Bonner et al (2002) found that patients felt distressed and ignored before they were restrained and ashamed and isolated afterwards. They found that post-incident debriefing was infrequent for staff, and particularly for patients. Patients were frightened of being restrained, and certain staff and patients stated that the incidents had provoked upsetting memories of previous trauma. One of the components of a successful trial to reduce absconding in five acute psychiatric units Bowers et al (2003) incorporated post incident debriefing. Previous research by Bowers (1999) identified lack of debriefing as a significant factor in absconding.

The use of sanctions within each ward exemplified a confused approach towards disordered behaviour in that certain patients were held responsible and others were not chastised. Those classified as personality disordered were timed out in their rooms, and within Z ward psychotic patients were not targeted because nurses were particularly conflicted about the extent to which they were responsible for their actions. Conversely Y ward staff dealt summarily with disruptive behaviour, but Z ward staff allowed disordered behaviour to escalate, and then patients were compulsorily sedated or transferred to locked wards. The quantitative results showed that the use of PRN sedation was minimal within Y ward, and extensive within the other study area. This reflected differences in the rate of ward incidents, and showed that this containment measure replaced an adequate ward structure. The results also suggest that staff required further training in the psychological management of aggression (Whittington and Wykes 1996).

A comparison with the work of Goffman (1961)

Control issues

The results showed that nurses were influenced by the norms that they had internalised, and that rule enforcement was associated with the wider social processes that they had been subjected to, rather than the treatment or safety function of the institution alone. Goffman did not study staff, but the results suggested that the psychiatric nurses of today experience greater conflicts in relation to the control aspect of the role. This corresponds with Gidden's observations (2001) in which he predicted that all social practices change over time as information is fed back organisations through interactions with service users. Disorganisation within Z ward led to frequent criticism of patients, and the staff were aware of this. They expressed a desire to be more therapeutic, and to involve patients in rule construction. In general Y ward staff were less conflicted about the enforcement of rules, but certain nurses expressed distress about confining patients to the ward. Goffman's findings suggest that the staff were complacent about the use of control, and that service user involvement was not an issue. There is evidence in the results of this study that longer stay or patients who were known to staff received more concessions than others, and this reflects aspects of his findings in relation to the privileges that certain patients received in return for helping with domestic duties for example.

Generally the total imbalance of power between patients and staff that Goffman observed was far less evident in the results of this study. Prison like conditions still pertained particularly within Y ward where the door was locked habitually, and patients perceived this practice as imprisonment. Although contact with the outside world was much less restricted, patients were still effectively imprisoned until a Consultant Psychiatrist had assessed them. The results showed that nurses experienced frequent emotional dilemmas in relation to this practice. Arguably, had they been asked, the staff in Goffman's study might have expressed similar feelings. The results of this study shows that despite the advent of multi-disciplinary teams nurses still bear twenty four hour responsibility for the safety of patients on behalf of the institution, and this influenced a rigid approach towards rule enforcement particularly amongst less experienced staff.

Goffman observed that patients were consigned routinely to the sick role upon admission to hospital, and he viewed this as fundamental to the rationalisation of control. The results showed that Y ward team operated from this perspective, and this did help them to reconcile care with control. They appeared to have more in common with the staff in Goffman's study in that they were more aligned with institutional values. Conversely Z ward staff were more inclined to adopt a societal reaction view of mental illness, and to question the role of psychiatry. The system of privileges to which Goffman referred was still in evidence in the form of a gradual increase in defined amounts of leave from the ward in return for compliance with treatment, and appropriate behaviour. Goffman perceived this system as punitive, and the results of this study showed that the step system still embraces a disciplinary function, but it also served a therapeutic purpose in that patients were not exposed to the stresses of the external environment before they were well enough to cope. The containment measure of transfer to a locked ward corresponds with Goffman's observations of a system of rewards and sanctions. However in his study patients were given or denied access to improved facilities according to their levels of compliance with the regime, and in general this was

not the case in this study. A few references from the data showed that a small number of long stay patients, and those with repeated admissions got special treatment in relation to rules or facilities.

Regimentation

The results of this study showed that the ward regimes were less regimented than those in Goffman's time. However the they suggested that ward nursing regimes have veered towards what might be described as benign neglect, in that patients were expected to do little more than comply with medication, and take meals. The results showed a much greater awareness of patients' rights, and reluctance particularly amongst Z ward staff to contravene them, even when this meant that patients suffered self-neglect in terms of personal hygiene. The patients in this study were not forced to perform all of their activities with the same group of people in the same place. Occupational therapy was optional, and they were not forced to bath, wash, dress or shave at the same time. However the same system that Goffman observed for the management of large numbers of people was still in evidence. Methods of overall surveillance were still used as a means of control so that non-compliant patients could be identified easily.

Goffman did not interview nurses, but the nurses in this study acknowledged that patients functioned at different levels. However they argued that they all should be subjected to the same regime in the interests of fairness and overall order. They perceived that disorder might break out if patients were not treated exactly the same. This perspective was influenced by the high turnover of patients in that nurses were preoccupied by the unknown proclivities of the group, because they did not have time to acquire an in depth knowledge of individuals. Rigidity provided a means of managing large numbers of acutely ill patients, and as previously stated non-compliant patients stood out from the rest of the group. The individualisation of rules would have involved a shift from overall surveillance towards engagement so that nurses could assess fluctuations in patients' individual levels of functioning.

Communication processes

The results of this study also corresponded with the restricted interaction that Goffman observed between patients and staff. The patients in this study also reported that the staff addressed them in a particular tone of voice during interactions involving control, and aspects of the non-participant observation field notes also supported this. The staff also acted as intermediaries between patients and other members of the hierarchy. Goffman perceived that the staff deliberately restricted patients' access to other members of the hierarchy, but the results of this study suggests that patients became frustrated because Consultant Psychiatrists were difficult to access, and they projected this on to nurses. Both teams in this study promoted advocacy, and informed patients of their rights of appeal against enforced confinement.

Nurses have a statutory obligation to inform patients of their mental health status during the admission process, and of associated rules, such as enforced confinement or compulsory medication. During this time patients should also be made aware of ward rules, and expected standards of behaviour. Viewed from the

perspective of Goffman's study, the results showed that although current communication processes on the wards in this study had improved, nevertheless they were still inadequate. For example the Y ward results showed that certain patients were extremely anxious because they did not understand why they were detained, and these reactions were exacerbated by previous negative experiences of hospitalisation. Nurses stressed the importance of settling patients into the ward, and gaining early compliance with medication. They tended to veil the regime during the early stages of admission in order to contain patients. Goffman observed that the staff concealed treatment plans from patients. Certain patients in this study also perceived that this was the case, but the results did not reveal deliberate intent on the part of staff in this regard. They suggested that acuity obstructed retention, and that nurses needed pay greater attention to communication processes.

However there was evidence that both teams of nurses, and Y ward staff in particular withheld information about ward rules during the admission process. Goffman referred to this practice as a betrayal funnel, and perceived that staff did this so that the smooth operation of the admission process would not be disrupted. Whilst this was a factor within Y ward particularly, nurses also gave other reasons this practice, they did not want to swamp patients with rules, cause them additional distress, and give them a bad impression of the regime. In symbolic interactionist terms they took on the role of the other, and viewed the admission process from the patients perspective. However the results showed that both teams tended to allow the rules to lapse in relation to intimidating or aggressive patients, and a major factor was that they feared their responses. If the staff in Goffman's study had been interviewed they too might have expressed similar fears.

Mortification

Goffman's concept of mortification serves as a useful point of comparison in an analysis of the way that ward rules were enforced in the wards in this study, and patients' responses towards them. Poorer facilities within Z ward exacerbated discontent, and resulted in conflict between nurses and patients. Patients were forced to smoke in a stark room facing each other in rows of chairs lined up against the wall in one of the wards. Certain patients could not stand the claustrophobic atmosphere of the smoking room or being in close proximity to each other for any length of time. This led to friction with staff because patients constantly breached the rule. There was no television set in the smoking room, and this was another source of conflict with staff because patients wanted to smoke cigarettes whilst watching television in the day area. They could not make their own hot drinks or snacks, and this contributed to the general starkness of the environment. The HHPP results showed that restrictions on meals were greater. And this was another source of friction and distress. The level of noise and excitation within the ward was exacerbated by the design that incorporated large empty spaces, and the bleak décor intensified the dehumanising effect of the environment. The inadequate facilities provided for patients correspond with Goffman's theory of mortification, in that patients could not perform the usual social activities that preserve a sense of self. Certain Z ward patients described feelings of dehumanisation in relation to the environment, and the enforcement of rules, which obstructed a sense of autonomy.

Y ward was cosier in some respects in that the rooms split off from a central corridor, and facilities for refreshments and relaxation were better. Patients appreciated this, and the ward design played a part in decreasing conflict with staff over smoking rules. However the intimate surroundings intensified feelings of claustrophobia particularly as the exit was locked routinely and levels of surveillance were high. This was borne out by the HHPP results, which showed that Y ward was more restrictive than Z ward. However even though the décor was sparse the environment also felt safer and less bleak. Nurses tended to assume that the environment played a major part the low rate of ward incidents within this ward, but the results showed that few structured activities were offered, and patients were left to their own devices as long as they remained compliant with treatment. Low levels of excitation, high restriction and lack of stimulation within the environment produced a soporific oppressive atmosphere

The results of this study reflected other aspects of Goffman's findings in terms of what he described as mortification. There was evidence that respect for patients' feelings was lacking. Within Y ward this was associated with a parental approach. Patients were infantilised and humiliated by certain nurses attitudes towards rule enforcement. Z ward staff discouraged displays of certain types of emotion, and evidence of disrespectful attitudes towards patients emerged from the results. However the quantitative results showed that Z ward patients were more inclined to express anger. This may have sprung from the ward philosophy, which tended to embrace societal reaction views towards mental illness to a greater extent than Y ward staff. Consequently patients were subjected to greater levels of criticism because staff constantly reinforced rules because they perceived that patients broke them deliberately. The disorganised and inconsistent system also frustrated patients who perceived that they were treated unfairly.

The results of this study paralleled other aspects of Goffman's theory of mortification, in that patients were thrown into contact with those whom they might wish to avoid in the world outside the institution. Like the patients in Asylums (1961) they also had to share personal hygiene facilities, and they were generally treated as a group rather than as individuals. They also had to ask permission to perform activities that they could do spontaneously at home. However the interviews with staff in this study showed that they subjected all patients to the same regime for various reasons. The research context differed in that Goffman's study took place within a large long stay institution. Arguably the staff in Goffman's study had less reason for rigidity because they had a longer time to get to know patients, and to access their individual levels of functioning. The results of this study showed that the staff acknowledged that patients functioned at different levels, but they argued that they all should be treated the same in the interests of overall order. They perceived that they might be overwhelmed by patients' individual demands, and that if they met them they would encourage conflict between patients in relation to perceived unfairness. Goffman observed that personal possessions and clothing were removed from the patients in Asylums, and the results showed that these practices were much less in evidence in the contemporary psychiatric wards in this study. The sort of personal possessions that were removed were variable, but certain staff and patients advocated much greater restrictions in the interests of safety.

The results showed that the same system of surveillance and recording of patients' activities that Goffman observed was still in place. There was evidence that certain nurses perceived patients' emotional or behavioural responses as evidence of dysfunction. However others were distressed by emotional dilemmas in

relation to enforced confinement for example, but they resorted to the medical model because they perceived that this was the only option available to them. The Z ward data showed that nurses tended to reject patients classed as personality disordered or those with a dual diagnosis. The results showed that patients reacted in various ways, and this reflected aspects of mortification theory in that they expressed feelings of dehumanisation and humiliation. The results of this study evidenced a similar use of secondary adjustments amongst patients that Goffman observed. For example patients described how they circumvented the rules, or took pleasure in breaking them because this gave them a sense of freedom and autonomy. Acts of absconding, refusal of medication and aggression could also be perceived as secondary adjustments. The high rate of ward incidents within Z ward could be interpreted as acts of secondary adjustment. Patients within this ward expressed more anger and feelings of dehumanisation than Y ward patients, and this may have stemmed from the high levels of criticism they experienced from the staff as they struggled to maintain order.

Aspects of the results of this study support Goffman's findings. The use of external observations, and the rigid enforcement of rules were still in evidence. The system of recording patients' responses to the rules, and observations based on the use of surveillance remained the main focus of nursing interventions. The restricted interaction between patients and staff that Goffman observed in his study was still in evidence Several patients reported that nurses used a particular tone of voice when they addressed them, and this paralleled Goffman's findings. The step system was still operational within the wards in this study, but generally patients were subjected to fewer restrictions on their activities than those in Asylums. However the literature that has emerged since the data was collected for this study suggests that improvements in psychiatric care have tended to occur ion community provision, and that conditions in acute psychiatric units still leave much to be desired (Shaw 2001; Muijen 2002; Quirk and Lelliott 2002).

The relationship between the results of the study and the literature review

The nurses in Z ward expressed greater conflicts about institutional values and concepts of mental illness. Certain nurses perceived the need for rigidity because they regarded all patients as inherently irrational, and they argued that ward rules grounded patients in reality. Other nurses argued that they were upholding the values of the wider society, and that the use of sanctions against patients who breached ward rules reflected those that were imposed on the general public. They perceived that patients broke the rules deliberately, and these attitudes support Morrison's (1998) findings. She also found that staff who were more controlling perceived greater organisational emphasis on maintaining the system. They believed in restricting the mentally ill, and perceived more aggression and violence.

However an underlying lack of agreement within the team about the aims of ward rules resulted in a fragmented fragile structure. The rules were unclear and imposed inconsistently. The results relate to Jungman and Bucher's (1967) study in which they argued that different management systems within wards were associated with differing levels of breaches in the rules. They identified a lack of clear goals, structure, team cohesion and consistency within one ward. The high rates of breaches in the rules within Z ward were produced by similar deficiencies in structure. The results showed that Z ward staff also employed the same

rigid measures as the nurses in Jungman and Bucher's study in an attempt to gain control of the patient group.

Differing interpretations of non-compliance amongst Z ward nurses' echoed Crichton's (1997) findings in terms of the attribution of blame. However in this study a more censorious view of rule breaking and aggression on the part of the Z ward team sprung from a social view of mental illness. The results reflected the same censorious element within both ward teams that Crichton (1997) identified in his study in that nurses generally perceived that personality disordered patients acted out of free choice and lack of self-control. Richardson (1995) and Crichton (1997) argued that fair and appropriate responses towards patients' who breach the rules should be supported by institutional structures. Both studies made an important point about the need to regulate staffs' responses because arbitrary or subjective judgements may lead to the unreasonable use of sanctions and containment methods. The results from this study showed that nurses needed more support from within the hierarchy together with further training and clinical supervision in the management of aggression in order to avoid a slide into authoritarianism.

The results also relate to Flaherty et al's (1981) study. The authors postulated that certain ethnic groups perceived psychiatric wards negatively because they did not expect them to be so restrictive. Young male patients from ethnic minorities reacted particularly adversely to the Z ward environment. Although conflicts with staff were associated with breaches in the rules on substance misuse they also perceived the ward as highly restrictive. Flaherty et al argued that negative reactions from patients might increase staff rigidity, and this emerged in the Z ward data. Nurses adopted a social policing approach towards breaches in the rules, which contributed to the high rate of ward incidents including absconding

The Y ward regime bore a relationship to the benevolent authoritarian system with clearly demarcated staff roles as described by Jungman and Bucher (1967), but it differed in that nurses did not clarify the rules. Certain aspects of the regime reflected Alden's (1978) study in that Y ward patients' reacted similarly to high levels of restriction in that they were withdrawn and passive. Both wards operated a formal step system, which was rigidly applied within Y ward, and nurses consistently withdrew patients' privileges for non-compliance. However the low rate of absconding within this ward may also have been associated with high levels of surveillance and door locking. The results confirmed Bursten and Geach's (1980) findings in that the operation of a formal step system produced better patient outcomes. However this was a follow up study and unlike Y ward patients the subjects had been engaged in therapeutic activities during hospitalisation. Aspects of the results related to Alden's (1978) findings in that patients responded similarly to an emphasis on compliance and a lack of attention to psychosocial needs by becoming withdrawn. Arguably the Y ward team produced better patient outcomes than Z ward staff in terms of ward incident rates. However the regime was unlikely to produce long- term improvements in levels of functioning because patients were discharged without increased levels of coping skills for life in the community.

Both teams of nurses generally failed to clarify the rules until they were breached by patients and this was borne out by the WAS results. This practice bore a relationship to Hewison's (1995) study in that lack of rule clarification may be interpreted as a means of exercising power over patients. The results reflected aspects of Johansen's (1983) study in which he also found that reactive ward policies produced rigidity, and that

rules instituted in response to ward events may continue to be imposed long after the incident has passed. Reactive methods of rule construction were more prevalent within Z ward because the rules were not embedded in the ward structure.

An element of aversive stimulation as described by Whittington and Wykes (1996) was absent within the Y ward environment, and nurses did not frustrate patients by demanding that they engaged in activities. Patients were left to their own devices as long as they complied with treatment rules, and under stimulation may be associated with the low rate of ward incidents. Nurses tended to overlook minor breaches in the rules because the underlying ward structure was strong. Deficiencies in the ward structure within Z ward resulted in frequent non-compliance, and nurses constantly criticised patients. The team displayed more uncontrolled emotional responses towards patients during rule enforcement, and this could be interpreted as aversive stimulation, which could be associated with the high rate of ward incidents.

Both groups of patients reacted adversely to the manner in which nurses enforced the rules. Y ward patients expressed feelings of humiliation, hyper vigilance and withdrawal. The feelings expressed by Z ward patients were much more intense in terms of alienation, powerlessness and anger. Alden (1978) found that patients became more communicative when staff allowed them to express anger, but they also tended to exhibit greater hostility and independence. The WAS results showed that Z ward patients were allowed to express more anger than the Y ward patient group. The Z ward team, nurses vacillated between laissez faire attitudes and authoritarianism. They became rigid in response to a perceived threat of loss of overall control. This evoked confusion and hostility amongst patients, and the Z ward incident data related to Bowers et al's (1999) study in which a large group of absconders left the ward because they were annoyed with the staff.

The Z ward findings supported Bensley at al's (1995) findings in which patients associated a lack of rule clarity with aggression. However although Y ward patients also complained that they were not informed about the rules, the rates of aggression were low. Lack of rule clarity within both wards was borne out by the WAS results which showed significant differences between nurses and patients perceptions of rule clarity. This finding related to Caplan's (1993) study in which patients perceived an emphasis on compliance with the ward routine, but they were unclear about ward rules and staff expectations of behaviour. Caplan attributed a low rate of ward incidents to an emphasis on compliance by nursing staff, and hypothesised that patients might perceive this as an expression of care and concern rather than control. An emphasis on compliance within Y ward may have had a similar effect. However Caplan's study was carried out in a maximum security ward where patients might expect a high level of restriction. Y ward patients perceived the environment as intensely claustrophobic and oppressive. Staff combined surveillance with the routine practice of locking patients into the wards. Patients' comments showed that they were not psychologically contained, and they expressed fears about permanent incarceration. They also felt that nurses were unapproachable, and laid to much emphasis on compliance with medication.

The results reflected aspects of Lanza's (1988) study in that certain Z ward patients reacted aggressively to limit setting. The results cast further light on the antecedents of aggression in that Z ward nurses displayed a lack of confidence and fear when they enforced the rules. Morrison (1994) argued that consistency might not be vitally important, and argued that aggression sometimes occurred when nurses were consistent. The

results from this study highlighted the antecedents of aggressive incidents within one extremely inconsistent nursing team. Patient staff conflict was produced by consistency in that the nurses in charge of the ward were forced into confrontations with patients. Lower grades of staff avoided intimidating patients and they did not clarify or enforce the rules. Inevitably enforcement became unavoidable and nurses in charge of the ward bore the brunt of patients' adverse responses to restrictions.

This situation bore a relationship to Kologjera et al's (1989) study in that patients may have provoked nurses because boundaries were unclear. Z ward nurses' uncontrolled responses towards provocation fitted Kologjera et al's hypothesis in that this may have mirrored patients' earlier experiences. Arguably nurses were drawn into a repetition of the same punitive responses towards limit testing experienced by patients at the hands of former carers. Kologjera et al argued that containment measures could provide patients with a corrective emotional experience if sanctions are set within a caring context. However the results from this study showed that patients who witnessed ward incidents perceived containment measures as punitive rather than therapeutic. These reactions were more intense within Z ward, and certain patients intimated that they might respond aggressively or abscond if staff imposed containment measures. There was no indication that patients were debriefed. They made their own interpretations of ward events, and warned each other about the dire consequences of non-compliance. Both teams of nurses threatened patients with containment measures as a means of control. The results related to Bowers et al's (1999) study in which patients absconded when they witnessed ward incidents.

The results related to Lutzen's (1990) findings in that nurses expressed role ambivalence in relation to the dominant psychiatric ideology. Both nursing teams were distressed by frequent dilemmas associated with enforced confinement. They felt that they were pulled between responsibilities for the implementation of Consultant Psychiatrists' directives, and the emotional reactions of the patients. This finding echoed Lutzen's results in which nurses also perceived that they were not free to give authentic psychiatric nursing care. Like the nurses in this study they dealt with role ambivalence by maintaining an emotionally detached stance, restricting informal contact and emphasising the ward rules. Z ward nurses were more conflicted about the role of psychiatry, and like the nurses in Lutzen's study they managed ideological conflict through group alliance. However Y ward nurses expressed more resentment against the medical hierarchy, and this reflected the generally hierarchical nature of the ward system. The results showed that Y ward nurses focused on compliance and they also assisted patients with activities of daily living to a certain extent. This might have produced more opportunities for disclosure, and contributed to the low rate of absconding. The results related to Bowers (1999) study in that certain patients who absconded harboured social concerns. The conflicting ethos within the Z ward team resulted in disorder, and even lower levels of engagement. This meant that patients had less opportunity for disclosure, and the risk of absconding or aggression intensified.

Further research

The results could be utilised to promote evidence based nursing practice as part of a research utilisation project. Burns & Grove (2001) cite the CURN Project that used research findings to implement and evaluate change in practice. The use of this method might be particularly appropriate for the implementation and evaluation of changes in the communication of rules. The results revealed that patients were not always

aware of the rules, and when they were reprimanded for breaches they reacted adversely. The effect of further training in interpersonal skills, particularly in assertiveness skills, could be tested (Burnard 1988; Nelson-Jones 1991).

The study could also form the basis of randomised controlled trials. For example nurses studying for an MSc could test the effects of improvements in rule clarity as part of the research module of their course. The components of the trial could include interviews with patients to assess their baseline knowledge of ward rules. Ward incidents and atmosphere could be monitored as a means of measuring the impact of improved rule clarity. The impact of clinical supervision, and multi-disciplinary team support for rule construction and enforcement could be similarly tested. Service user involvement in rule construction might be incorporated into the work of multi-disciplinary teams, and individual programmes of care. A follow up study could investigate the impact of differing ward nursing regimes on long-term outcomes, which could monitor patient re-admission rates and levels of functioning.

Thomas (1996) states that patient care plans frequently lack clinical focus. The results of this study suggested indicated similar problems. Thomas recommended greater stress on the reasons for admission so that strategic interventions could be introduced in line with patients' individual needs. This process might also highlight patients' previous levels of functioning prior to admission, and result in a less rigid approach to the rules. The effect of this kind of intervention could be tested, but might be difficult to achieve given that many patients are admitted in an emergency, and high bed occupancy levels make focused interventions difficult to sustain.

Muijen (2002) argues that few studies have compared the therapeutic value of hospital care with other services. He argues that few answers have materialised from research or practice to deal with problems of acute care, and that there is no agreement on ways to proceed. He recommends that in-patient care be planned according to the wishes of patients. A follow up study could interview patients following discharge with the aim of discovering what they found useful, and what should be discarded in relation to rules that could be flexible within acute psychiatric wards.

Synthesis of the findings and the development of a Conceptual Model

The final stage of the analysis involved a progression from the empirical findings to a conceptual overview of the data on which the model on page is based. The findings were integrated to form broader constructs from patterns in the analysis of the quantitative and qualitative data. The data analysis methods are detailed in Chapter 2. As stated on page 45 the qualitative analysis was assisted by QSR*NUDIST. The conceptual model was derived from the referential coding facility in the database. As the categories were refined they were clustered with the aim of initiating associations between them. This process often took me back to the basic coding in order to maintain a thorough analysis of the data. A narrative account was constructed across groups of topics across transcripts. Examples from the transcripts were used to support the themes that developed (Riley, J. 1996; Miles & Huberman 1994). The number of references that pertained to each topic was counted to aid the comparison between wards, and they appear in the results chapter under the comparison between wards sections.

Concurrent with the above process notes were written on the underlying reasons for particular codes. The text searches were printed, and the extracts were read a number of times. Comments were made in the margins. These included summaries, associations and preliminary interpretations. The themes that emerged were listed separately, and were then clustered. Then they were categorised into overall themes while checking back with the original transcripts to make sure that the themes actually were related. This enabled a theoretical understanding of the categories, which was used as a link between the categorisation of the data and the writing up of the results. Inferences were made from the clustered themes. The essence of the interviewees' descriptive answers were extracted from the data that made up the themes. The findings were described from the perspective of the participants rather than being subjected to a theoretical interpretation. The phenomenological interpretations of the participants' responses were joined to form overarching concepts.

> *"A synthesised structure is a statement conceptualised by the researcher joining the core concepts. The structure as evolved answers the research question, 'what is the structure of this lived experience".* (Parse 2001) p.172

Then the results of this analysis were moved up to another conceptual level to represent the meaning of the lived experience at the level of theory. For example nurses descriptions of their feelings in relation to rule enforcement were merged as role ambivalence. This concept was supported by examples from the transcripts. Other possible explanations for the data and the connections between them were checked by returning to each text unit in the cluster and ensuring that it fitted with the emergent theory. (Burns and Grove 2001; Smith, Jarman and Osborn 1999).

The development of a tentatative conceptual model on which to base implications for clinical practice involved a further stage of subsuming particulars into the general, and decisions about whether the concepts described above belonged to a more general class. This method placed the data into a more abstractly defined category. Glaser (1978) used the approach of searching for basic social processes in the data into which specific concepts could be subsumed. Glaser described this process as a conceptual and theoretical activity in which the researcher moves backwards and forwards between first level data, and the more general categories that

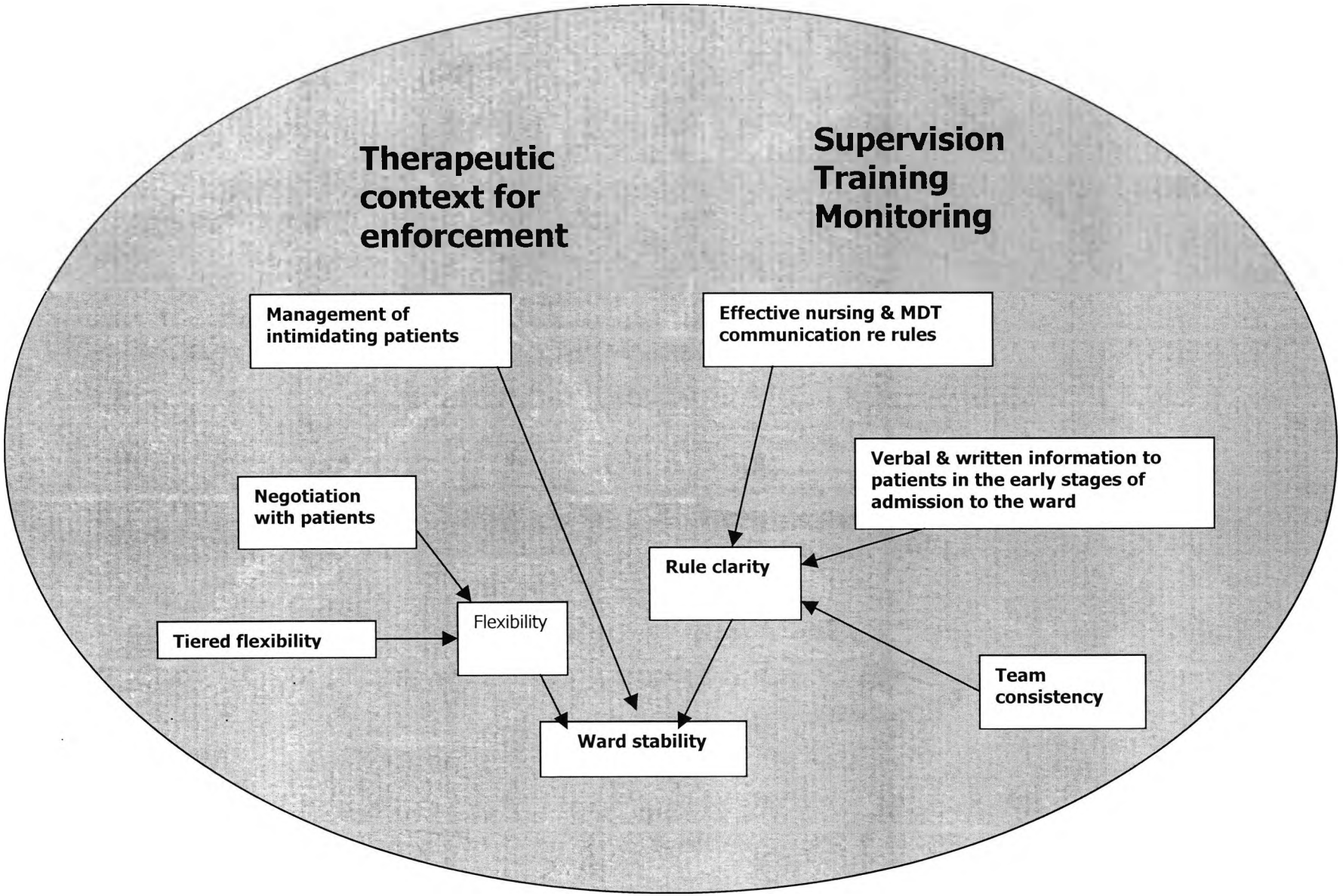
develop through a repetition of the process until saturation is reached. Saturation of the category means that new data does not enhance the meaning of the general category.

The qualitative data analysis provided an insight into the causative factors of differences in the quantitative results between the wards. For example the integration of the quantitative results, and the qualitative data in Chapter 6 led to the conclusion that consistency was a factor in aggression, and that intimidating patients should be targeted during the early stages of admission to the ward. This chapter further highlighted the effect of restricted contact on the therapeutic aims of the institution in terms of patients' adverse responses to the nursing regimes. Particularly in Z ward these factors had an impact on compliance, and a detrimental influence on ward atmosphere. Conclusion drawing led to questions about how these problems could be resolved, and give rise to recommendations for changes in clinical practice. Consequently a synthesis of the findings from this chapter appears in the conceptual model on page. The key elements of a therapeutic context for rule enforcement; supervision training and monitoring; the management of intimidating patients; rule clarity; team consistency; verbal and written information to patients in the early stages of admission to the ward were identified as interrelated themes in relationship to the key concept of ward stability.

This process involved the maintenance of a strong link with the study's conceptual framework, and the research questions. For example sociological theory informed the development of the model in that it provided a context for the negative consequences of rigidity on the therapeutic aims of the institution, and a basis for the development of ideas about how flexibility might be introduced. Symbolic interactionism focused on the importance of shared meaning in rule transmission on which the concept of therapeutic engagement in rule enforcement evolved as an overarching theme. The conceptual model was influenced by the project aims, and the research questions, but the process, which led to a higher level of abstraction in the analysis of the data as described above, augmented initial coding. The model emerged from interrelationships between the general categories. This process involved decisions about which variables were most important for ward stability. The conceptual model explains the general classes that emerged from a synthesis of the clustered data, and the relationships among them. The general concepts in the model act as a bridge between the general constructs or classes that incorporate the themes that emerged from the qualitative and quantitative data results, and the study recommendations.

Conceptual Model

The diagram overleaf is a graphic representation of the key findings on which the following recommendations are based. The rectangles contain a synthesis of the main themes from the data analysis, and display their relationship to the key concept of 'ward stability'. A stable ward is one where there is minimal conflict between patients and staff about the rules and their application, and maximal cooperation between both groups. The arrows represent interrelationships between the themes that have a positive effect on ward stability. This conceptual model is used to illustrate new knowledge that resulted from the data analysis. The commentary and description of concepts that go with the model explicate the evidence base for this knowledge. There are four key elements that have an impact upon the production of ward stability.


Therapeutic context for enforcement
Supervision
Training
Monitoring
Management of intimidating patients
Effective nursing & MDT communication re rules
Verbal & written information to patients in the early stages of admission to the ward
Negotiation with patients
Rule clarity
Flexibility
Tiered flexibility
Team consistency
Ward stability

Flexibility: An overly rigid approach to rule enforcement was identified as impossible, given the differing acuity and conditions from which patients suffered. Nurses were concerned that flexibility would have a detrimental effect on ward order because of an increase in demands made by patients. These views were also linked with ideas about mental illness causation and behaviour, and concerns about the maintenance of overall order. A flexible approach represented a move away from surveillance towards engagement, which they perceived might have an impact on the maintenance of ward stability. The study findings demonstrated that flexibility could be introduced in two ways. Firstly, through **negotiation with patients** about the content of rules and the rationale for their existence, leading to higher levels of therapeutic engagement. Secondly, through a system of **tiered flexibility**, where different rules were imposed on different patient groups, depending upon their needs for care, protection and support, and patients were able to move from one tier to the next, and given more liberty and responsibility as their condition improved. This would also enable more individualised approaches to rule enforcement.

Management of intimidating patients: This general concept was linked to a more specific theme in that a lack of a therapeutic context for rule enforcement exacerbated patient aggression, and contributed towards instability within Z ward particularly. The failure to carefully confront and deal with the challenges raised by intimidating patients, coupled with avoidance, can lead to greater instability in the longer term.

Rule clarity: The rules were defined inadequately. Lack of agreement particularly within the Z ward team on which rules should be enforced rigidly/flexibly led to lack of rule clarity amongst the teams, and patients were distressed when they were reprimanded for breaking rules of which they were unaware. The Y ward team clarified treatment rules, and this was associated with a stable ward atmosphere. Rule clarity could be achieved through three means. Firstly, through **verbal and written information to patients during the early stages of admission to the ward**. Patients were not given clear information about the rules during the admission process. This led to an increase in instability within Z ward because certain intimidating patients remained non-compliant for the duration of admission. The quantitative data showed that the levels of ward incidents were higher in this ward. Y ward staff expected compliance to increase with an improvement in patients' mental states, and they concentrated on gaining compliance with treatment rules during the early stages of admission. Secondly, through **effective nursing & MDT communication about the rules**. Responsibilities for the construction and enforcement of ward and treatment rules were spilt between nurses and the MDT. Nurses were largely responsible for the maintenance of ward order, and the enforcement of treatment rules this increased the risk of aggression against nurses when patients reacted adversely to the rules. If responsibilities for all rules had been diffused throughout the team this might have led to improved rule clarity, and lessened the risk of aggression against nurses. This could also have produced tiered flexibility because the team in the rule construction, and enforcement role would support the nurses. Thirdly, **team consistency**. Inconsistency was a major factor in a rise of disorder within Z ward. Higher grades of staff were exposed to aggression because lower grades of staff avoided interactions with intimidating patients, generally and during situations that involved rule enforcement. Other patients perceived unfairness because they were treated with rigidity, and this led to an increase in rule breaking. The Y ward team enforced treatment rules consistency, but tended to overlook minor infractions.

Therapeutic context for enforcement: This fourth element of the model is portrayed as overarching or embracing, because it represents an inclusive general concept that impacts upon all three previously described critical concepts, as well as directly upon ward stability. The lack of a therapeutic context for rule enforcement emerged as a general theme across the interviews. It was closely related to the feelings of ambivalence expressed by the staff in relation to the use of control, and the reactions of patients to the way that the rules were divorced from a therapeutic context. Staff need to understand and accept their responsibility for the creation of a safe and therapeutic environment on the ward through the application of ward rules. For this to happen, **supervision training and monitoring** are required. The study data revealed inadequate monitoring, training and role modelling for less qualified or experienced staff, leading to difficulties in regulation of the ward.

Study recommendations

Rule clarity

Staff should know the rules, and communicate them to patients during the admission process. Methods of dissemination might include patient information leaflets and ward posters. The rules should be clearly communicated during other patient staff interactions. Regular staff patient meetings should act as forums for rule clarification and negotiation. Changes to rules should not be initiated unless all staff and patients have been informed about the reasons for the change, so that they can be enforced consistently, and so that patients are not upset by reprimands for breaking rules of which they are unaware.

Nurses perceived that they were softening the impact of admission, quelling resistance, and ameliorating the distress of mentally disordered or psychologically distressed patients by absolving them temporarily from the rules. However it may be kinder and safer in the long run to honestly inform patients about the reality of their situation during admission; given that it may be impossible to assess at this stage whether non compliance arises from mental disorganisation, persistent behavioural difficulties, or reactions to the environment. Moreover certain rules must be non negotiable to protect the safety of patients, and to ensure the provision of a therapeutic environment. The qualitative results showed that patients were humiliated, distressed and angry when they were reprimanded for breaking rules, which they had not been told about.

The Department of Health (2001) recommended that a code of conduct for patients should incorporate behavioural expectations. The code should also contain guidance on ward rules, which should be negotiated with service users, and patients should be given written information on reception to the wards. The Department of Health also identified a need for regular forums that encourage service user involvement in deciding how the ward is organised, and should include what rules of conduct are appropriate. The provision of early verbal and written communication may decrease adverse reactions towards the environment, and have an impact on aggression or absconding. Bowers et al (1999) identified a lack of rule clarity as a factor in absconding. A successful trial of an intervention to reduce absconding from acute psychiatric units by Bowers et al (1999) incorporated rule clarity as an element of the intervention.

Multi disciplinary team involvement in rule construction and enforcement

Multi-disciplinary teams could provide more input into decision making (based on continuous assessment) re the construction and enforcement of rules. In collaboration with service users and carers the team could agree on those rules that could be flexible or inflexible. This would provide tiered flexibility in line with patients' individual levels of functioning. The split between the construction of ward and treatment rules should end, and should be reciprocal, for example patients who are allowed out on leave for long periods should not be prevented from taking a bath or making a cup of tea on their return. New rules should not be constructed arbitrarily in response to isolated ward events

The results showed that nurses were overburdened by responsibilities for rule enforcement. The increased involvement of multi disciplinary team members might mean that responsibilities for rule construction and enforcement might be diffused throughout the team. This might promote individualised patient care in line with their unique levels of functioning. More input from team members might provide support for nurses and lessen rigidity. Consequently patients' adverse reactions to rule enforcement might be lessened, and aggression against nurses might decrease. The Department of Health (2001) identified insufficient clinical input from all members of multi disciplinary teams.

The ward round system meant that newly admitted patients might be confined to the ward pending an assessment by the Consultant Psychiatrist. Consultants need to be more accessible to nurses and patients in between ward rounds. Additionally systems should be set up whereby senior nurses and junior medical staff take joint responsibility for the management of patients in the absence of consultants.
As a result nurses may experience less role strain and the risk of patient aggression or absconding might lessen.

O'Rourke and Bird (2001) write about the elements of good practice in risk management. The qualitative results of this study showed that risk management was inextricably linked with the rigid enforcement of rules. Davenport (2002) describes how the use of rehabilitation principles, and the collaboration of the multi-disciplinary team in individual care plans could contribute towards acute inpatient care. She described a method of case management, which used the expertise of the team, and increased cooperation. This method of working also clarified roles, and had an impact on the use of reflective techniques within the team. The adoption of a modified version of this approach might have an impact on issues related to ward rules.

O'Rourke and Bird (2001) state that practitioners must be able to justify the decisions that they make, and acknowledge that the pressures on mental health staff to explain their actions can result in defensive as opposed to justifiable practice. They recommend that mental health practitioners unite in multi-disciplinary decision making in consultation with service users and carers. They must ensure that they are able to provide evidence for the decisions that are made, and defend them as a group.

Effective leadership

Ward managers should ensure rule clarity through effective lines of communication, and they should monitor consistent enforcement. They should provide clinical supervision and support nurses in the rule enforcement role. They should model interventions for less qualified or experienced staff. They should confront unacceptable behaviour from patients and staff in relation to rules. They should be accessible to staff and involved in all the organisational activities of the ward.

> *"The role of the nurse in charge of the ward should be reviewed and strengthened. She/he should be the point of contact for consultation, negotiation and decision making for all ward organisational matters. There needs to be an investment in the development of managerial and leadership competencies of ward managers or sister/charge nurses".* DOH (2001) p.17

A comparison between the qualitative results from the wards showed that the Y ward manager maintained a high profile within in patient areas, and he acted as a role model for staff. He was patient centred, but did not provide enough monitoring and support for nurses in relation to rule enforcement. The other ward manager was staff centred and tended to leave the clinical management of the ward to the team. It appears that both managers could have benefited from further development of their management and leadership skills as recommended by the DOH (2001).

The Y Ward Manager worked closely with the Consultant Psychiatrists. The quantitative results showed that the level of ward incidents was low in this ward. The close involvement of both clinicians may partly account for the low rate of ward incidents, and in relation to the control of over occupancy within Y ward. The DOH point out that deficient leadership intensifies over-occupancy, and increases pressure on the ward environment. In turn this creates a more custodial and less therapeutic environment for patients. The DOH recommendations included the development of joint medical and nursing practice for the deployment of staff in the management of risk, and the promotion of a therapeutic environment for patients. One of the factors that could have influenced disorganisation within Z ward was that the manager did not attend ward rounds, and this might have had a detrimental effect on the management of patient care.

> *"Rethinking the organisational arrangements for inpatient care addressing the question of*

leadership is a matter of priority. The process of achieving the changes outlined in this guidance must be clinically led, and sustained with clearly identifiable clinical and professional lead within each ward". DOH (2001) p.16

The Management of Intimidating Patients

Intimidating patients should be targeted before their behaviour escalates into aggression. Staff should receive training in the psychological management of aggression. For example assertiveness techniques might have an influence on consistency. They should receive clinical supervision and support, and the same kind of monitoring as described under effective leadership. Efforts should be made to modify the punitive impression of containment methods such as time out, seclusion, control and restraint and enforced medication.

The results showed that a failure to enforce the rules at an early stage of admission led to constant problems in the management of intimidation, within Z ward in particular. The Y ward team were less ambivalent about the management of intimidation because they viewed patients' behaviour from an organic perspective on mental illness. This resulted in a consistent approach towards intimidation, and low rate of ward incidents, which is borne out, by the quantitative results. The qualitative data shows that nurses in charge of Z ward were exposed to aggression because those working in patient areas avoided confrontations with intimidating patients when they broke or questioned the rules. Consequently the nurses in charge of the ward, who might not be the most experienced, bore the brunt of aggression when rule enforcement could not be avoided. This suggested that consistency was an important factor in aggression. Nurses might benefit from the kind of training that Whittington and Wykes (1996) found to be effective for the management of aggression.

There is evidence that less qualified and experienced Y ward staff also experienced high levels of stress when they dealt with these patients. Whittington and Wykes (2002) found that more experienced staff were less inclined to be intolerant of aggression. They also exhibited a stronger sense of confidence and control than less experienced staff. The qualitative results showed that less senior nurses experienced unacceptable levels of stress during interactions with intimidating patients. Duxbury (2002) found that patients viewed staff approaches towards aggression as controlling, and they identified inadequate communication, and the environment, as factors in aggression. However staff ascribed aggressive behaviour to internal and external patient factors. Arguably support from the staff group with the attitudes that Whittington and Wykes described might have had an impact on stress and improved communication with patients. This might have prevented the kind of uncontrolled emotional responses towards patients that appear in the data. These reactions affected patients adversely as is evidenced by the sections related to their perceptions of rule enforcement.

A report from the Royal college of Psychiatrists (**1995**) on the management of aggression recommends the use of preventative therapeutic approaches that might decrease the use of the practice of seclusion. They found that a small group of patients are repeatedly secluded, and state that this measure should only be resorted to when there is an immediate risk of considerable physical harm. The prevention of aggression requires early recognition of signs that the individual is losing control. Whittington et al (1996) identified verbal and non-verbal behaviour as antecedents to aggression. Aggressive patients were dissimilar to non-aggressive controls in that they displayed the same type of behaviour three days before the assault. This evidence should be used to predict aggression, and for the introduction of therapeutic strategies for de-

escalation. Lowe (1992) investigated the interventions used by nurses when they were confronted by challenging behaviour. He suggested that the emergent categories should be used to provide a framework for the analysis of dangerous incidents from a nursing perspective. This process could be used to support reflective practice and supervision, and might also form part of debriefing techniques for staff and patients in an analysis of effective prevention.

Debriefing following ward incidents through individual and group methods

The qualitative results showed that patients were disconcerted and distressed when they witnessed ward incidents, and they tended to perceive containment measures as punitive rather than therapeutic. A study by Bowers et al (1999), which investigated the reasons for absconding from acute wards, showed that patients left the ward because they were frightened by ward incidents. A successful trial to reduce absconding from acute wards incorporated de briefing as an element of the intervention. Debriefing techniques ameliorate patients' negative interpretations of the use of containment methods such as control and restraint procedures. The Z ward quantitative results revealed a high level of ward incidents, and the use of containment measures such as control and restraint, PRN medication and seclusion. A lack of debriefing for patients and staff may have given rise to a cyclical effect as described by Whittington and Wykes (1994). They found that violent experiences produces stress in staff, which results in a deterioration in their levels of functioning, and causes them to behave in ways that exacerbate the risk of violence. In another study Whittington (2002) found that certain staff reported high levels of stress, which continued for a considerable time after the incident. Such support as they did receive was usually informal in nature, and was strongest in the immediate aftermath of the incident. The qualitative results of this study confirmed Bowers (1999) results in relation to the anxiety experienced by patients following ward events, and it also supports Whittington and Wykes (1994) findings. This evidence indicates that debriefing techniques and support should become a routine feature in relation to rules.

Access to drinks and refreshments and other facilities

Patients should have open access to drinks and refreshments, and other facilities that decrease the depersonalising nature of ward environments.

Y ward patients had open access to drinks and refreshments, and the WAS results showed that this facility was restricted within Z ward. Patients were not provided with a television in the Z ward smoking room, and the qualitative results showed that this resulted in a need for constant reinforcement of the smoking rule. A lack of these facilities exacerbated conflict between staff and patients. The Z ward quantitative results showed that patients expressed more anger than Y ward patients. Poorer facilities within Z ward may have been a factor. The Z ward qualitative results also showed that patients did not have a lockable space for valuables. This caused patients anger and distress. The DOH guidance (2001) asserts that patients should be provided with a good quality environment, which covers personal safety, privacy, leisure facilities and good hotel services. They state that this should be supported by a set of minimum standards for example all patients should have a lockable personal space.

A therapeutic context for rule enforcement

Rule construction and enforcement should be simultaneous with risk assessment. Both functions should be based on therapeutic engagement rather than surveillance, and a reliance on the external observation of patients' behaviour. Nurses should reflect on the rule enforcement role in an effort to reconcile the caring and controlling function.

The qualitative results showed that rule enforcement was generally divorced from a therapeutic context. This tendency could be associated with Goffman's concept of mortification in 1961. Y ward staff did engage with patients to a certain extent when they helped them with activities of daily living, but they adopted a parental approach, and patients were infantilised. The disorganisation within Z ward led to frequent rule breaking, and nurses were drawn into uncontrolled emotional responses towards patients, which depersonalised them. The results also demonstrated the impact of wider social forces, and beliefs about mental illness, such as societal reaction theory. Certain categories of patients were treated differently because nurses perceived that they were culpable rather than genuinely ill. Others were feared and shunned.

A shift away from surveillance towards engagement might have an impact on rule flexibility, compliance and risk because nurses would have access to patients' internal processes, which might reveal psychosocial distress or concerns. As previously mentioned Bowers et al (2003) reduced levels of absconding in acute psychiatric wards. Another element of the intervention involved spending 15 minutes of targeted nursing time with patients on a daily basis, to elicit social worries and concerns, which might lead them to abscond.

The qualitative results showed that nurses disliked rule enforcement, and they had difficulty in reconciling this aspect of the role with the caring function. They coped by increasing social distance from patients, and tended to use surveillance rather than engagement as a means of monitoring compliance and risk. They feared that they might be drawn into situations that might threaten objectivity, and overall control of the ward. Verkek (1999) describes the concept of 'compassionate interference'. This concept sheds light on the dichotomy between care and control that emerged from interviews with nurses in this study. The results showed that Z ward nurses in particular tended to restrict nursing interventions, such as help with activities of daily living, because this interfered with patients' autonomy. Y ward staff did help patients with these activities, and this meant that they did incorporate the rules into therapeutic engagement to a degree. Verdek describes compassionate interference as a process where the autonomy of the patient is not respected through non-interference, and professionals play a more active role. This view corresponds with aspects of the Y ward qualitative data in that the team adopted a paternalistic perspective towards rule enforcement. Despite a tendency too infantilise patients this perspective helped the team to reconcile the caring and controlling function of the role.

Verdek states that idea of interference may provoke an angry reaction in the caring community because it suggests a rise in modern paternalism. However the author argues that current care practices that respect patients' autonomy do not give them the help they need. The qualitative data from both wards showed that patients were expected to little more than take meals and medication. This meant that they were largely left to their own devices, and contact with staff was minimised. She points out that although individuals have a right to autonomy many have a deep need for productive strong relationships, and part of their problem is that their capacity to form relationships is impaired.

She argues that compassionate interference need not represent a threat to autonomy it can be the means towards the achievement of independence. The qualitative data showed that rule enforcement was generally divorced from engagement, and patients were dehumanised by this approach. The adoption of a compassionate interference perspective might help nurses overcome ambivalence and anxiety towards the rule enforcement role. A move towards engagement away from surveillance would mean that the rules were incorporated into other forms of therapeutic interventions, and enforcement would be based on continuous assessment of risk.

Several writers describe innovations that represent a move away from surveillance towards therapeutic engagement (Jones et al 2000; Bowles et al 2002; Mistral and McKee 2002; Haigh 2002 and Holmes 2002). Three of these papers advocate the introduction of therapeutic community principles in the acute ward environment. Bowles et al argued that formal observation may be dehumanising, and they used engagement as an alternative to this containment measure. The nurses in this study disliked formal observation duties, and the data showed that the measure was generally enforced from therapeutic engagement. Bowles et al define engagement as ... *'a* process *of emotional and psychological containment of distress'.* p.255. Jones et al (2000) found that the patients' in their study viewed observation as a negative experience. A significant variable was therapeutic engagement, and information from the nurse who performed the function about the process.

The DOH (2001) made the following recommendations in relation to the provision of a therapeutic environment.

> *"High therapeutic intervention and interaction environments diminish disturbance, violence and boredom. poor amenities and lack of structured activities and individual attention promote untoward incidents and create risks. Inpatient units that that provide appropriate stimulation and structure as part of individual care plans have a more therapeutic and safe environment. Yet a recurring theme in most on inpatient care is 'lack of something to do' (as one report put it a sort of suspended animation)".* p. 18

Further the DOH point out that there are a variety of evidence-based interventions and skills that are particularly relevant to inpatient care, but they are not usually adopted in these settings. The qualitative results from this study contained few references to evidence based interventions, apart from behavioural strategies such as time out. However if they were available, then rule clarity and enforcement could be incorporated into interventions, such as cognitive behavioural therapy, and this might lessen the dehumanising impact of control especially when it is divorced from therapeutic engagement. O'Rourke and Bird (2001) also state that working closely with individuals decreases risk because the person is prompted to form partnerships in care, and the individuals strengths and skills can be accessed. They point out that patients are liable to react negatively if solutions are imposed upon them, and are less likely to take them on board. The qualitative and quantitative results from this study showed that Z ward patients in particular reacted adversely, when the rules were imposed in an authoritarian manner.

The fulfilment of the study aims

Qualitative research asks different types of questions to quantitative studies. Key questions in this study aimed to discover the content of ward rules within acute psychiatric admission wards; to explore patients responses to the rules; to evaluate the impact of rules and rule implementation on nurse patient relationships, and on ward events; and to investigate the relationship between ward rules, ward atmosphere

and ward design. The content of ward rules was not immediately apparent to the interviewees, and they emerged during the course of the interviews through examples rather than as a result of direct questioning. Most patients were extremely co-operative, and the interviews gave them an opportunity to ventilate feelings about the regimes. It would have been easy to slip into a counselling mode or become entangled in certain patients' disordered thoughts during the interviews, but the semi-structured nature of the questions enabled me to gently focus attention on the topic. I felt that the interview material threatened certain nurses, but only one person directly refused to be interviewed. Questions about ward rules focused on nurses' responsibilities for social control, and the interview material exposed inherent conflicts.

However the interviews were augmented by periods of non-participant observation, and this placed nurse-patient responses in context. I felt that one team of nurses remained quite guarded throughout the period of data collection, and this reflected aspects of the results in that they seemed to be more affected by a blame culture within the institution. The other nursing team were rather cautious at first, but they became more open and I perceived they made no attempt to conceal aspects of ward rules or methods of enforcement. This reaction also reflected features of the results in that they were generally less contained. They tended to display uncontrolled responses towards patients, each other and to myself to a much greater extent than nurses within the other study area. They were generally more constrained and hyper vigilant. Interestingly nurses' different reactions to my presence were reflected in patients' differing responses towards the regimes.

Dissimilarities between the ward atmospheres also affected me during the period of data collection. The peaceful soporific atmosphere within one study area induced feelings of calm. Nurses moved slowly and spoke quietly, and at times it was hard to remain alert. Conversely the other ward was noisy the staff were more excitable. The ward environment jangled the nerves, and felt generally less safe.

Study limitations

Sample

Only two wards were studied, and even they were not randomly chosen. A larger study might have produced a broader generalisable picture of the relationship between ward nursing regimes, and patient outcomes. The wards were chosen because it was thought that they might contrast well in that a previous study on absconding by Bowers et al (1999) suggested that differences in structure produced differing patient outcomes. Twelve wards participated in the study and the results showed that Y ward had the lowest and Z ward the highest absconding rates. Therefore at the outset it was anticipated that Z ward might be less stable than Y ward, and pre-conceived ideas might have influenced my perspective of the regimes.

Data collection

The data collection period spanned a limited time, and Z ward might have been in a state of flux. Conversely Y ward might have been in a stable, steady phase. Differences in the patient population might also have accounted for differing rates of ward incidents between the wards. The Z ward patient population might

have contained a small ethnic group who were prone to react more adversely control, and this rather than structural variations alone might account for some of these differences.

Differences in attitudes towards my presence might have skewed the results in that the nursing teams might have created changes to give a good impression of the wards, or they might have concealed aspects of ward events. For example Z ward staff gave the impression that they embraced therapeutic community ideals, but this was confounded by the poor attendance of staff and patients at community meetings. When I was engaged in non-participant observation the Y ward manager tended to enact interventions with patients in a way that suggested that he was doing this to impress me with his therapeutic skills.

The Y ward team constantly referred to the ward as the patients home, but the other methods of data collection supported the hypothesis that the ward environment tended to be oppressive in that the WAS results showed that the number of restrictions on patient activity was greater than Z ward. These results contradicted the impression that Y ward nurses tended to give about the easygoing nature of the regime. They also tended to under report ward incidents, and this suggested that they were generally anxious to give higher management or myself an impression of ward stability. However only a slight tendency to under report ward incidents emerged from an analysis of the interviews.

Interviews

The decision about the interview format was partly driven by the study setting, by time and financial constraints. It was also predicted that if an unstructured format had been used the patient group might have been placed under too much pressure. However important information that did not correspond with the interview might have been missed.

It is possible that the responses of staff and patients were inhibited by the study context, and by a perceived need to provide information that would put the wards in a good light. The fact that interviews were conducted within the wards may have inhibited responses from nurses and patients. A different setting away from the ward might have elicited less guarded responses, but this was not possible because of constraints on staff time and patient safety. The interviews were conducted within a condensed period of time. There was little time to reflect on the emergent data, and consequently certain subtle aspects of interaction may have been lost in the process, but the time for completion of the study was limited The methodology was appropriate for the study, and the text search method generated an in depth analysis of the data. Underlying themes emerged that enabled an understanding of nurses' attitudes towards control and patients' reactions to the regimes. The results exceeded the original aims of the study, and the topic of ward rules was instrumental in bringing the inner experiences of participants to light.

Summary

Acute psychiatric ward rules were situated within a wider sociological context. They reproduced social practices associated with expected standards of behaviour, order and safety. They were also associated with the treatment function of the institution, in that nurses viewed patient compliance as a measure of deterioration or recovery from symptoms. The models of mental illness adopted by the nursing teams were

underpinned by differing views about causation, and the degree to which patients' were able to control their behaviour. These concepts influenced rule construction and enforcement. The adoption of parental attitudes towards rule enforcement corresponded with the socialisation function of the family. This perspective particularly influenced the Y ward team, and stemmed from the leadership vision of the ward manager. Differing attitudes between the teams towards ward rules matched Giddens (1976) perspective, in which he argued that rules could not be divorced from the structural means, through which they are incorporated and changed into social practices. He associated this process with the diffusion of power and domination throughout society. Both teams of nurses held negative views about the rule enforcement role, but the Y ward team were more comfortable with authority because they used the sociological framework of the family, and identified with their own experiences of socialisation within it. This perspective had a major impact on ward order as exemplified by the low rate of ward incidents, but this approach tended to infantilise patients.

Both teams relied heavily on surveillance to the detriment of therapeutic engagement. This finding could be associated with the influence of historical sociological forces as described by Foucault (1979), and as observed by Goffman in 1961. Current acute ward studies have identified an emphasis on surveillance, and it may be that this is an endemic feature of hierarchical institutions. Foucault perceived that surveillance was an important element of discipline, and of a process of normalisation. Aspects of the data from this study showed that surveillance was used to monitor compliance with the rules. The corrective function that Foucault described swung into operation through the same system of rewards and sanctions. However the corrective function was also associated with treatment and safety. This process failed to combine these functions successfully when nurses were presented with situations, or with individuals that challenged systems of rules and surveillance. The Z ward team were particularly susceptible to role strain because the team lacked the same cohesive force as that of Y ward. Both teams of nurses protected themselves against role strain by subjecting all patients to the same rules. This finding corresponds with Merton's analysis of the detrimental effect of institutional pressures on organisational aims, in that inflexibility interfered with the development of patient autonomy (in Cotgrove 1970)

Communication in relation to rules was poor within both wards, and this was linked with power and an emphasis on surveillance. Another major factor was the generally low levels of therapeutic engagement within the wards, which meant that the rules were not incorporated into other forms of interaction between nurses and patients. Poor rule clarification was also linked with role ambivalence and institutionalised attitudes. Lack of information giving also enabled overall control in the same way as surveillance in that this maintained patients in a state of uncertainty. Z ward staff was more aware of power relations, and they tried to improve the situation, but the weak ward structure could not support innovation. Conversely the rules were so embedded in the Y ward regime that they were largely taken for granted. Nurses perceived that they were overburdened by rule enforcement duties, and it was glaring obvious that greater involvement from the multi-disciplinary teams in rule construction and enforcement might have an impact on role strain. This might have a reciprocal effect on patients' adverse reactions to rule enforcement that was partly evoke d by inflexibility, and nurses' uncontrolled emotional responses during enforcement. Multi-disciplinary team involvement might have an impact on consistency. The results showed that this was particularly vital for intimidating patients, and consistency was a factor in an increased risk of aggression against nurses in charge of the ward within Z ward. The close working relationship between the Y ward manager and the multi-disciplinary team may have been a factor in the low rate of ward incidents, but the certain members of the nursing team expressed a similar degree of role strain as the Z ward nurses.

Both teams of nurses were influenced by deviancy theory in relation to certain groups of patients, but this was less evident amongst the Y ward team who worked from an organic model of mental illness. Consequently they were less inclined to separate behaviour from symptoms. Less ambivalence equated with a more cohesive, and less critical approach. Y ward staff feared intimidating patients, but they overcame this. A generally stronger sense of team support may have been a factor, but the results also highlighted a lack of monitoring by experienced staff, and of clinical supervision, which left them exposed to unacceptable levels of stress. The Z ward team were far more conflicted about the causes of non-compliance, and weak team support caused fear and avoidance of intimidating patients. Certain staff were courageous, and confronted patients. As the ward progressed towards instability the team reacted by increasing overall control, and generally compliant patients were treated harshly whilst others were ignored. This led to an escalation in disorder, which in turn produced a state of anomie in staff together with increased defensiveness, and a tendency towards uncontrolled emotional responses towards patients. Aspects of the results correspond with Cohen's work on disorganisation, and how this can cause a rise in the use or threat of containment measures.

A comparison with Goff man's work on Asylums showed that many restrictions on patients' activities have lessened. However therapeutic engagement was lower than might have been expected given the advances in psychiatry that have occurred since the time of his study. The use of surveillance and recording of external observations was still very much in evidence. Ward rule rigidity, surveillance and the use of the step system was still very much in evidence. Arguably the rule rigidity that this study identified may be relatively new because the inmates in asylums were granted more privileges by the staff in line with compliance with the regime or for other reasons. The patients were longer stay, and therefore more likely to be trusted by the staff because they had more time to assess and get to know them than the nurses on the two wards in this study.

The results or recommendations that are made in this study may not be generalisable to other acute psychiatric wards because this was a small-scale investigation. The hospitals and the study wards were not randomly chosen, but many of the reports and studies that have addressed problems within acute psychiatric wards since the data was collected for this project pinpoint similar problems. There are also positive signs that some of the issues that arose in this study, such as low levels of therapeutic engagement and a lack of service user involvement are being seriously addressed at Government and at service level.

This study has described and interpreted specific situations and what they mean to the research participants on two acute psychiatric wards. An overview of the report shows that the theoretical framework as exemplified by the literature and the research questions exerted a reciprocal influence on the methodology. The initial data analysis led to interim summaries and preliminary discussions. Following this, explanatory conclusions were drawn and verified across cases. The key concepts that emerged were based on a synthesis of clustered themes and sub themes. These concepts were connected to sociological theoretical structures outside the specific remit of the study. The final recommendations were built around a series of 11 theoretical concepts, and relationships between them were used to explain actions, which may have a significant influence upon changes in clinical practice.

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Interview Questions

Section 1

STAFF. Age, ethnic background, grade, qualifications, experience; post basic training, length of time on the ward.

PATIENTS. Age, ethnicity, duration of admission up to point of interview. Previous admissions

BOTH. Thinking about the rules on this ward, can you tell me what they are? What are patients allowed/ not allowed to do? (Offer prompts if necessary) E.g. smoking, leaving the ward.

Thank you, now thinking about the rules you have mentioned, could we go through them together and could you tell me what they are for? (Reflect to participant)

Section 2

BOTH. Thank you, now if we go back to the rules again. If I was with you during your stay/shift on the ward, what would I be likely to see you doing, or hear you saying about what is allowed/ not allowed

Would there be changes in what patients can and cannot do?

Would staff explain what patients will be expected to do and why?

Which patients would be breaking the rules?

Would certain patients be stopped from doing things that other patients are being allowed to do?

PATIENTS How would staff be getting patients to keep the rules?

STAFF. How would you be getting patients to keep the rules?

Section 3

BOTH. Now I would like to ask you a few more questions to see what you think about the way rules work on the ward.
Do you think that some things are allowed that should not be allowed?

Do you think that some things should be allowed that are not allowed?

In your opinion are all patients treated the same when it comes to what they can/ cannot do?

Do you think that every patient should be treated the same when it comes to what they can or cannot do?

What do you think about the decisions that are made about new rules, is everyone on the ward asked for their opinion? Can you give me an example?

Thinking about your stay/ work on the ward. In your opinion is there any rule that makes life better for patients/ better for staff? Could you give an example?

Is there any rule that makes life worse for staff/ worse for Patients? Could you give an example?

What do you think about the number of rules? Are there too many?

Or are there too few?

Are they made clear enough?

Do patients understand the rules?

Are patients given the reason for rules?

In your opinion, do patients break the rules on purpose?

What reason do you think they have for doing this?

Do you think that patients are allowed to give their opinion and make choices about the rules during their stay in hospital?

Section 4

STAFF. Thank you, now can I ask you how you feel about implementing ward rules.
Is there anything that you find particularly difficult? Could you give me examples?

PATIENTS. Could you tell me how it makes you feel when you are told that something you are doing is not allowed?

Do you feel you can ask any of the staff if you want to do something?

How do you feel when you are refused permission by staff?

BOTH. What do you like about the rules on this ward?

What do you dislike about the rules on this ward?

RESEARCH IN PROGRESS

ST BARTHOLOMEW SCHOOL OF NURSING AND MIDWIFERY
CITY UNIVERSITY

THE INTERACTION BETWEEN THE INFLEXIBILITY/FLEXIBILITY OF WARD NURSING REGIMES AND PATIENT OUTCOMES

NON- PARTICIPANT OBSERVATION

DATE:

TIME: From Until

For further information or to discuss any concerns please speak to Jane Alexander RMN (PhD Student Mental Health Nursing) I will be pleased to talk with you in person about my work and the aims of the study. Or contact me on: 0171-5055840 if I am not in the ward.

A

PRINT THE TITLE OF THE RESEARCH PROPOSAL HERE:-

THE INTERACTION BETWEEN THE FLEXIBILITY/INFLEXIBILITY OF WARD NURSING REGIMES AND PATIENT OUTCOMES

.....

.....

DECLARATION BY THE CONSULTANT OR PRINCIPAL INVESTIGATOR IN CHARGE OF PROPOSED RESEARCH:

I ACCEPT RESPONSIBILITY:

1. To inform all relevant medical and nursing staff at each location where a patient/volunteer may be treated, that a subject is enrolled in a trial or experiment, what drugs (if any) or invasive procedures will be used (or not as may be) and what precautions they should take, if any. In some cases it will be necessary to give special training to nurses or junior staff to prepare them to undertake procedures. Finally, with the patient's consent, the GP should be informed about the trial in which the subject is enrolled, including information concerning any adverse findings.

2. To ensure that details of each procedure to be done or drug to be given are entered in the clinical notes and that the date and time when the procedure was done and/or drug given are subsequently noted.

3. To make three copies of the "Written Explanation to be Given to Potential Subjects" and the signed "Written Consent Form", including the signed "The Declaration by the Consultant or Principal Investigator in Charge of the Proposed Research". **One copy of each should be kept by the patient/volunteer, one copy should be included in the patient's clinical notes and one copy should be kept by the Senior Consultant/Chief Investigator responsible for the Research.**

4. To ensure that each subject is verbally warned not to take part in more than one study at any time.

5. To inform the Committee of any adverse or unforeseen circumstances arising out of this research, including self-generated studies.

6. For clinical research, to provide the Committee with a letter reporting progress half way through the project and a summary at its completion.

7. To make every effort to tell the participants about the results of the study.

Principal Investigator JANE ALEXANDER.
Signature Alexander.....

The original signed copy of "The Declaration ..." should be attached to the application form when it is submitted.

form98

INVITATION TO PARTICIPATE IN A RESEARCH PROJECT (Patient)

The Interaction Between the Flexibility/Inflexibility of Ward Nursing Regimes and Patient Outcomes

Semi-structured interview and completion of two rating scales

I invite you to take part in a research study that I think may be important. The information that follows tells you about it. It is important that you understand what is in this leaflet. It says what will happen if you take part and what the risks might be. Try to make sure you know what will happen to you if you decide to take part. Whether or not you do take part is entirely your choice. Please ask any questions you want to, about the research and we will try our best to answer them.

As a patient and service user your views are very important and will help us to look at issues around the kind of care and services you receive, whilst in hospital. We are asking you to take part because it will enable us to understand these issues from your point of view. The study will also give you the opportunity to contribute towards ideas about ward rules and policies in particular .

I would like to find out if the rules and policies are made clear to you and whether you understand why they exist. I am interested in the way you see things and any concerns you may have. This will help to develop the services provided to you, and allow a better understanding and response to your needs.

You will remain anonymous and your name will not appear in any documents, no one will be able to identify you. No one else will have access to the records belonging to the research Should you wish to stop the interview at any point, or for any reason, you will of course be absolutely free to do so. The interview will last for 45 minutes and the rating scales should take approximately 30 minutes to complete. With your permission the interview will be tape-recorded, it will take place in a private room on the ward and your confidentiality will be respected. The tapes will be securely stored in accordance with the Data Protection Act and the researcher will be the only person listening to the tapes. You are reassured that those involved in your ongoing care will not have access to the tapes. They will be destroyed once the data is processed.

You do not have to join this study, it is your choice and you can decide not to be included or to drop out at any time. If you do decide not to be in the study, this will not put at risk you ordinary care.

We will take every care in the course of this trial. If through our negligence any harm to you results, you will be compensated. However, a claim may have to be pursued through legal action. Even if the harm is not our fault, City University will consider any claim sympathetically. If you are not happy with any proposed compensation you may have to pursue your claim through legal action.

Thank you very much for your time.

What happens if you are worried or if there is an emergency? You will always be able to contact an investigator to discuss your concerns and/or get help:

Name: Jane Alexander PhD Student Telephone number: **0171 5055840**
Address: City University, St Bartholomew School of Nursing
Philpot St, Whitechapel
E1 2EA

INVITATION TO PARTICIPATE IN A RESEARCH PROJECT
(Nursing Students)

The Interaction Between the Flexibility/Inflexibility of Ward Nursing Regimes and Patient Outcomes
City University

Semi-structured interview and the completion of two rating scales.

views as a student nurse are very important and will help me to look at issues around the of care and services you provide to patients I am asking you to take part because it will e me to understand this issues from you point of view. This study will also give you the rtunity to contribute towards ideas about ward rules and policies in particular. This study elp you develop the service you provide and contribute towards your knowledge base. It may help to decrease the incidence of aggression and violence on psychiatric wards. Any mation you give will be treated with the greatest confidentiality. You will remain anonymous. name will not appear on any documents. No one will be able to identify you. No one else will access to the records pertaining to the research.

d you wish to stop the interview at any point, for any reason, you will of course be free to do he interview should last for 45 minutes and completion of the rating scales should take 15 es. It will take place in private on the ward in a designated room. With your permission the iew will be tape-recorded.

confidentiality will be respected at all times. The tapes will be stored securely in accordance he Data Protection Act. The researcher will be the only person listening to the tapes. You assured that those no one else will have access to the tapes. The tapes will be destroyed once ta is processed. You don't have to join the study. You are free to drop out, this will not put your course of study.

ve this study is basically safe and do not expect you to suffer any harm or injury because of participation in it. However, I carry insurance to make sure that if your health does suffer as lt of your being in the study then you will be compensated. In such a situation, you will not to prove that the harm or injury which affects you is anyone's fault. If you are not happy ny proposed compensation, you may have to pursue your claim through legal action.

What happens if you are worried or if there is an emergency? You will always be able to contact an investigator to discuss your concerns and/or to get help:

Name: Jane Alexander PhD Student Telephone: 0171-5055840
Address: City University
St Bartholomew School of Nursing
Alexandra Building
Philpot St
Whitechapel
E1 2 EA

form98

INVITATION TO PARTICIPATE IN A RESEARCH STUDY (Nursing Staff)
The interaction Between the Flexibility/inflexibility of Ward Nursing Regimes and Patient Outcomes
City University

Semi-structured interviews and completion of two rating scales

I would like to invite you to take part in a research study that I think may be important. The information that follows tells you about it. It is important that you understand what is in this leaflet. It says what will happen if you take part and what the risks might be. Try to make sure that you know what will happen if you do decide to take part. Whether or not you do take part is entirely your choice. Please ask any questions you want to about the research and I will do my best to answer them.

As a member of staff on this ward your views are very important and will help me look at issues around the care and services you provide to patients. We are asking you to take part because it will enable me to understand these issues from your point of view. This study will also give you the opportunity to contribute towards ideas about ward rules and policies in particular. I am interested in your ideas and opinions and any concerns you may have. This study will help you develop the services you provide and may help decrease incidents of patient aggression related to ward rules and policies.

You will remain anonymous and your name will not appear on any documents, so you will be unidentifiable. No one else will have access to the records pertaining to the research. Should you wish to stop the interview at any time and for any reason, you will of course be absolutely free to do so. The interview should last for 45 minutes and the rating scales should take about 30 minutes of you time to complete. It will take place in private in a room designated for the purpose. With your permission the interview will be tape-recorded. your confidentiality will be respected at all times. The tapes will be stored securely in accordance with the Data Protection Act. The investigator will be the only person listening to the tapes. You are reassured that no one else will have access to the tapes. The tapes will be destroyed once the data is processed. You don't have to join the study. You are free to decide not to be in this trial or to drop out at any time. This will not put at risk your work on the ward or compromise your relationship with other staff, patients or the School of Nursing.

We believe that this study is basically safe and do not expect you to suffer any harm or injury because of your participation in it. However, we carry insurance to make sure that if your health does suffer as a result of your being in the study then you will be compensated. In such a situation, you will not have to prove that the harm or injury which affects you is anyone's fault. If you are not happy with any proposed compensation, you may have to pursue your claim through legal action.

What happens if you are worried or if there is an emergency? You will always be able to contact an investigator to discuss your concerns and/or get help.

Name: Jane Alexander PhD Student Address. City University, Alexandra Philpot St Whitechapel. E1 2EA Telephone: 0171-5055840

E

form98

WRITTEN CONSENT FORM:

Title of research proposal: The Interaction between the Flexibility/Inflexibility of Ward Nursing Regimes and Patient Outcomes
REC Number:
Name of Patient/Volunteer (Block Capitals):
Address:
(Delete if unnecessary to the research project)

- The study organisers have invited me to take part in this research. ☐
- I understand what is in the leaflet about the research. I have a copy of the leaflet to keep. ☐
- I have had the chance to talk and ask questions about the study. ☐
- I know what my part will be in the study and I know how long it will take. ☐
- I have been told about any special drugs, operations, tests or other checks I might be given. ☐
- I know how the study may affect me. I have been told if there are possible risks. ☐
- I understand that I should not **actively** take part in more than 1 research study at a time. ☐
- I know that the local East London and The City Health Authority Research Ethics Committee has seen and agreed to this study. ☐
- I understand that personal information is strictly confidential: I know the only people who may see information about my part in the study are the research team or an official representative of the organisation which funded the research. ☐
- I know that the researchers will/might tell my general practitioner (GP) about my part in the study. ☐
- I freely consent to be a subject in the study. No-one has put pressure on me. ☐
- I know that I can stop taking part in the study at any time. ☐
- I know if I do not take part I will still be able to have my normal treatment. ☐
- As a medical/ nursing student or qualified staff, I understand that agreement or
- refusal to take part will make no difference to the results of my course or my career. ☐
- I know that if there are any problems, I can contact:

Dr/Mr/Ms..**Jane Alexander PhD Student**.....
Tel. No. .**0171 5055840**. **Direct line**..... Bleep No./Ext. .....

Patient's/Volunteer's: Signature .....

Witness's Name .....

Witness's Signature: .....

Date .....

The following should be signed by the Clinician/Investigator responsible for obtaining consent
As the Clinician/Investigator responsible for this research or a designated deputy, I confirm that I have explained to the patient/volunteer named above the nature and purpose of the research to be undertaken
Clinician's Name: .....Clinician's Signature: .....Date:
.....

F

Mrs S J Studdy MA RGN RM DN DipEd.
Dean

CITY University
ST BARTHOLOMEW SCHOOL OF NURSING AND MIDWIFERY

Philpot Street
Whitechapel
London E1 2EA

Tel: 0171-477 8000
Fax: 0171-505 5811

Ms Dora Opoku
Chair, ELCHA Research Ethics Sub-Committee

Dear Ms Opuku,

Re: The Interaction between the flexibility/inflexibility of ward nursing regimes and patient outcomes

Thank you very much for your recent letter, I hope that the following will clarify the issues raised by the committee so that you can approve the protocol

a) c) Please see enclosures

b) Interpreters/ health advocates may be involved. Mr. Mahona Ward Manager, Ansell Ward St. Clement's Hospital has already signed to indicate that he has given permission for this involvement (p. 15) Mr. Marsh, Ward Manager Tuke Ward, The Homerton Hospital has stated that health advocates/ interpreters can be accessed through the Locality Teams. Both wards also have staff who can act as interpreters if necessary. These measures will not result in additional costs.

d) The information sheet has been amended replacing we with I as requested

e) The consent form has been amended to suit the study.

f) The reason for the inclusion of demographic questions is as follows:
In the case of ward staff, to ascertain whether this information relates to the way in which ward rules are created, imposed or implemented. To investigate also whether these factors correlate with incidents of patient aggression. e.g. Does grade, qualifications and experience influence ward nursing regimes or staff patient interaction, this has been shown to be the case in previous studies, e.g Whittington & Wykes (1996)
In the case of patients, to ascertain whether this information correlates with patient outcomes e.g. compliance with ward rules and policies. In a recent study by Bowers et al (1998) rates of absconding were found to correlate with age, ethnicity and domicilliary status.

g) Interviews will be arranged through prior arrangement with participants. Permission has been obtained to interview staff during working hours. Through discussion with the Ward Manager and ward staff, disruption of work schedules will be kept to a minimum. The needs of patients will be paramount, for example if the ward staff are under untoward pressure, the researcher will withdraw and work on another aspect of data collection until staff indicate that they can give time. Also care will be taken not to interfere with patient treatment programs, e.g. group work or occupational therapy. The data collection will take six months to complete so interviewing can be planned to coincide with relatively quiet periods and with fluctuations in admission levels and patient care requirements.

Yours sincerely and with best wishes.

Jane Alexander
RMN CPN (Cert) BA(Hons) MA (Couns Psych)
Ph.D. Student Mental Health

G

East London and The City **HEALTH AUTHORITY**

Ms J Alexander
24 Battle Road
St Leonards-on-Sea
East Sussex TN37 7AB

Our ref: DO/KH/n99071

22nd November 1999

Dear Ms Alexander

Re: N/99/071 - The interaction between the flexibility/inflexibility of ward nursing regimes and patient outcomes

Thank you for your letter received on the 18th October 1999 addressing the points of the Sub-Committee's earlier letter. I am happy to tell you that I am now able to approve this study on Chairman's action to be noted at future meeting of the Sub-Committee.

Please note the following conditions to the approval:

The Committee's approval is for the length of time specified in your application. If you expect your project to take longer to complete (i.e. collection of data), a letter from the principal investigator to the Chairman will be required to further extend the research. This will help the Committee to maintain comprehensive records.

Any changes to the protocol must be notified to the Committee. Such changes may not be implemented without the Committee or Chairman's approval.

The Committee should be notified immediately of any serious adverse events or if the study is terminated prematurely.

You are responsible for consulting with colleagues and/or other groups who may be involved or affected by the research, such as extra work for laboratories.

You must ensure that, where appropriate, nursing and other staff are made aware that research in progress on patients with whom they are concerned has been approved by the Committee.

The Committee should be sent one copy of any publication arising from your study, or a summary if there is to be no publication.

Chairman: Professor Elaine Murphy
Aneurin Bevan House 81 Commercial Road · London E1 1RD
Tel: 0171 655 6600 · Fax: 0171 655 6666

NHS

should be grateful if you would inform all concerned with the study of the above decision.

Your application has been approved on the understanding that you comply with Good Clinical Practice and that all raw data is retained and available for inspection for 15 years.

Please quote the above study number in any future related correspondence.

Yours sincerely

Ms Dora Opoku
Chair
LCHA Research Ethics Sub-Committee

I

rs S J Studdy MA RGN RM DN DipEd
ean

ef: CC\SDD

5 February 1999

Mrs Elizabeth Alexander
4 Battle Road
t Leonards on Sea
Sussex
N37 7AB

CITY University
ST BARTHOLOMEW SCHOOL
OF NURSING AND MIDWIFERY

Alexandra Building
Philpot Street
London E1 2EA

Tel: 0171-477-8000
Fax: 0171-505-5811
Direct Line: 0171-505-5812
E Mail: C.L.Cox@city.ac.uk

)ear PhD Student

e: Insurance Cover for City University Students/Staff Undertaking Nursing/Midwifery Research

ppended please find a letter from Dora Opoku, Chair - ELCHA Research Ethics Sub Committee, and University document from Ken Cridland, Corporate Accountant for the University, which specifies overage for you whilst you are undertaking your research on behalf of the University.

ours sincerely

arol L Cox PhD, RN
lead of the Department of Adult Nursing, and
ourse Director : MSc, MPhil/PhD in Nursing Programmes

ncs

Mrs S J Studdy MA RGN RM DN DipEd
Dean

CITY University
ST BARTHOLOMEW SCHOOL
OF NURSING AND MIDWIFERY

20 Bartholomew Close
London EC1A 7QN.

Tel: 0171-477 8000
Fax: 0171-505 5717
Direct Line: 0171-505 5709

Ref: cmt424
05 July 1999

Jane Alexander
St Bartholomew School of Nursing and
Midwifery
Philpot Street
Whitechapel

Dear Jane

Re: The Interaction Between the Flexibility/Inflexibility of Ward Nursing Regimes and Patient Outcomes

Thank you for your further letter about the above study. Having examined the work you intend to do, I am happy to give my approval for you to interview students from this School as part of your research project.

With best wishes for your project.

Yours sincerely

Mrs S J Studdy
Dean

K

TOWER HAMLETS
HEALTH CARE NHS
TRUST
ANSELL WARD,
ST CLEMENTS HOSPITAL,
2A BOW ROAD,
LONDON E3 4LL.
TEL: 0171 377 7984

15 th September 1999.

Ms Jane Alexander,
City University,
St. Barts School of Nursing & Midwifery,
Philpot Street,
Whitechapel,
London E1. 2EA.

Dear Jane,

Re: The Use of Ansell ward as a research area.

Further to our recent meeting, I have discussed the above research project with my staff and we have all agreed for you to conduct your study on this ward.

Yours Sincerely,

S. Maonah.

S. MAONAH (MR).
Ward Manager.

TOWER HAMLETS HEALTHCARE
NHS Trust

The Royal London Hospital
(St Clement's)
2A Bow Road
London E3 4LL

Telephone: 0171-377 7978
Facsimile: 0171-377 7979

15th September 1999

Ms J Alexander
City University
St Barts School of Nursing & Midwifery
Philpot Street
Whitechapel
London E1 2EA

Dear Jane

RE: The use of Ansell Ward as a research area

Further to our recent telephone conversation I am pleased to give my permission for Ansell Ward to be used as a research area in your study.

I assume that you have been able to contact the RMO's who work on the ward who presumably would also have to give their consent to the study.

Please do not hesitate to contact me if I can help any further.

Yours sincerely

PPM

Ian Young
Sector Manager

S-IY/alex/ansell

M

TOWER HAMLETS HEALTHCARE
NHS Trust

Department of Adult Psychiatry
3rd Floor Outpatient Building
The Royal London Hospital
(Whitechapel)
E1 1BB

Telephone: 0171 377 7729

DC/SAL

1 September 1999

Jane Alexander RMN CPN
PhD Student Mental Health
City University
St Bartholomew School of Nursing & Midwifery
Philpot Street
London
E1 2EA

Dear Ms Alexander

Re: Research Project

Thank you for your letter regarding this. As we have discussed, I am willing for you to have access to patients under my care.

Yours sincerely

Dr Dave Curtis MD PhD MRCPsych
Consultant & Honorary Senior Lecturer in Psychiatry

CITY & HACKNEY
Community Services NHS Trust

Please reply to

Tuke Ward
East Wing
Homerton Hospital
31.08.99.

Dear Ms. Alexander,

Further to your letter and our telephone conversation regarding your PhD study: on The Interaction Between the Flexibility / Inflexibility of Ward Nursing Regimes + Patient Outcomes I am happy to confirm, that following discussion with my nursing team we have agreed that this study can take place on Tuke Ward.

Yours sincerely

JERRY MARSH

MANAGER.

Trust Office St Leonard's Nuttall Street London N1 5LZ
Telephone 0171 301 3000 Facsimile 0171 739 8455
Chairman Professor Elaine Murphy · Chief Executive Averil Dongworth

CITY & HACKNEY
Community Services NHS Trust

Please reply to

Priority Service
Management Office,
East Wing
Homerton Hospital
Homerton Row
London E9 6SR
Tel: 0181 510 8008
Fax: 0181 510 8716

ur ref: JK/AS

September 1999

s Jane Alexander
MN CPN(Cert) BA(Hons)MA
ouns Psych) Ph.D.
udent Mental Health
ty University
Bartholomew School
Nursing and Midwifery
ilpot Street
hitechapel
ndon E1 2EA

ar Jean,

: Research study to be conducted on Tuke Ward from Oct 1999 -May 2000.

ave read your letter and on the understanding that this has been approved by the Research mmittee I agree to you carrying out the study on Tuke Ward.

ish you success and if I can be of any further help please call.

urs sincerely

Jim Keown
neral Manager

P

CITY & HACKNEY
Community Services NHS Trust

Please reply to

Division of Psychiatry
East Wing 2nd Floor
Homerton Hospital
Homerton Row
London E9 6SR
0181 510 8041 (tel)
0181 510 8716 (fax)

TT/jf/ /010999E

Jane Alexander
PhD Student Mental Health
St Bartholomew School of Nursing and Midwifery
Philpot Street
Whitechapel
London E1 2EA

1st September '99

Dear Ms Alexander

Re: Research study to be conducted on Tuke Ward from Oct 1999-May 2000

I am writing to confirm that I am willing for you to have access to patient subjects, with regard to the above research study. You should of course also ensure that the relevant Consultant Psychiatrist (Dr Salter and Dr Howlett) have given their written permission, and please let me know if you require any further clarification.

With best wishes.

Yours sincerely

Dr Trevor Turner
Consultant Psychiatrist

CITY & HACKNEY
Community Services NHS Trust

DEPARTMENT OF PSYCHIATRY

Please reply to *2nd Floor, East Wing*
Homerton Hospital
Homerton Row
London E9 6SR

☎ *0181 510 8950*
Fax : 0181 510 8716

ır Ref: MS/ves

d September, 1999.

. Jane Alexander, Ph.D. Student Mental
ealth,
ty University,
. Bartholomew School of Nursing and
idwifery,
nilpot Street,
hitechapel,
ondon E1 2EA.

ear Dr. Alexander,

E: RESEARCH INTO WARD ATMOSPHERE/REGIME

hanks for your letter of 26th august 1999. Your proposal looks very interesting, and I m happy to give you my consent for you to approach patients on my ward to ask them to articipate in your research. As you acknowledge in your protocol, patients would of ourse reserve the right to decline to participate in an interview, or terminate this rematurely should they see fit for whatever reason.

lease do not hesitate to get in touche if I can be of any further assistance to you in this roject.

Good luck with the Ethics Committee.

Yours sincerely,

Dr. Mark Salter
Consultant Psychiatrist

R

Jane Alexander
RMN CPN(Cert)BA(Hons)MA(Couns Psych)
Ph.D.Student Mental Health
City University
Philpot Street
Whitechapel
London E1 2EA

TOWER HAMLETS HEALTHCARE
NHS Trust

Elizabeth Fry House
Mile End Hospital
Bancroft Road
London E1 4DG

Telephone: 0171-377 7920/1
Facsimile: 0171-377 7931

MD/AH/PMF
1st October 1999

Dear Jane

Research Project: **The Interaction Between the Flexibility/Inflexibility of Ward Nursing Regimes and Patient Outcomes**

Researcher: **Jane Alexander**

Thank you for sending me a copy of your application form to the Ethics Committee. Following approval from the Research Ethics Committee to proceed with the research, I can confirm that you are covered by the Research Indemnity of the Tower Hamlets Healthcare Trust.

Yours sincerely

Alyson Hall

Alyson Hall
M.B., B.S., M.R.C. Psych., F.R.C.P.Ch.
Medical Director

Jane Alexander
RMN CPN(Cert)BA(Hons)MA(Couns Psych)
Ph.D.Student Mental Health
City University
Philpot Street
Whitechapel
London E1 2EA

TOWER HAMLETS HEALTHCARE
NHS Trust

Elizabeth Fry House
Mile End Hospital
Bancroft Road
London E1 4DG

Telephone: 0171-377 7920/1
Facsimile: 0171-377 7931

MD/AH/PMF
1st October 1999

Dear Jane

Research Project: **The Interaction Between the Flexibility/Inflexibility of Ward Nursing Regimes and Patient Outcomes**

Researcher: **Jane Alexander**

I enclose a letter of indemnity from Tower Hamlets Healthcare Trust for your study. I look forward to hearing about the study in due course.

I would like to also remind you to complete the appropriate 'Culyer form' available from Zakia Khatun on extension 4428.

Your sincerely

Alyson Hall

Dr Alyson Hall
M.B., B.S., M.R.C. Psych., F.R.C.P.Ch.
Medical Director

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1. Patients put a lot of energy into what they do around here.
2. Doctors have very little time to encourage patients.
3. Patients tend to hide their feelings from one another.
4. The staff act on patient suggestions.
5. New treatment approaches are often tried on this ward.
6. Patients hardly ever discuss their sexual lives.
7. Patients often gripe.
8. Patients' activities are carefully planned.
9. The patients know when doctors will be on the ward.
10. The staff very rarely punish patients by restricting them.
11. This is a lively ward.
12. The staff know what the patients want.
13. Patients say anything they want to the doctors.
14. Very few patients have any responsibility on the ward.
15. There is very little emphasis on making patients more practical.
16. Patients tell each other about their personal problems.
17. Patients often criticize or joke about the ward staff.
18. This is a very well organized ward.
19. Doctors don't explain what treatment is about to patients.
20. Patients may interrupt a doctor when he is talking.
21. The patients are proud of this ward.
22. Staff are interested in following up patients once they leave the hospital.
23. It is hard to tell how patients are feeling on this ward.
24. Patients are expected to take leadership on the ward.
25. Patients are encouraged to plan for the future.
26. Personal problems are openly talked about.
27. Patients on this ward rarely argue.
28. The staff make sure that the ward is always neat.
29. If a patient's medicine is changed, a nurse or doctor always tells him why.
30. Patients who break the ward rules are punished for it.
31. There is very little group spirit on this ward.
32. Nurses have very little time to encourage patients.
33. Patients are careful about what they say when staff are around.
34. Patients here are encouraged to be independent.
35. There is very little emphasis on what patients will be doing after they leave.
36. Patients are expected to share their personal problems with each other.
37. Staff sometimes argue with each other.
38. The ward sometimes gets very messy.
39. Ward rules are clearly understood by the patients.
40. If a patient argues with another patient, he will get into trouble with the staff.
41. Nobody ever volunteers around here.
42. Doctors spend more time with some patients than with others.
43. Patients set up their own activities without being prodded by the staff.
44. Patients can leave the ward whenever they want to.
45. There is very little emphasis on making plans for getting out of the hospital.
46. Patients talk very little about their pasts.
47. Patients sometimes play practical jokes on each other.
48. Most patients follow a regular schedule each day.
49. Patients never know when a doctor will ask to see them.
50. Staff don't order the patients around.
51. Patients are pretty busy all of the time.
52. The healthier patients on this ward help take care of the less healthy ones.
53. When patients disagree with each other, they keep it to themselves.
54. Patients can wear what they want.
55. This ward emphasizes training for new kinds of jobs.
56. Patients are rarely asked personal questions by the staff.
57. It's hard to get people to argue around here.
58. Many patients look messy.
59. On this ward everyone knows who's in charge.
60. Once a schedule is arranged for a patient, the patient must follow it.
61. The ward has very few social activities.
62. Patients rarely help each other.
63. It's O.K. to act crazy around here.
64. There is no patient government on this ward.
65. Most patients are more concerned with the past than with the future.
66. Staff are mainly interested in learning about patients' feelings.
67. Staff never start arguments in group meetings.
68. Things are sometimes very disorganized around here.
69. If a patient breaks a rule, he knows what will happen to him.
70. Patients can call nursing staff by their first name.
71. Very few things around here ever get people excited.
72. The ward staff help new patients get acquainted on the ward.
73. Patients tend to hide their feelings from the staff.
74. Patients can leave the ward without saying where they are going.
75. Patients are encouraged to learn new ways of doing things.

(Continued)

76. The patients rarely talk about their personal problems with other patients.
77. On this ward staff think it is a healthy thing to argue.
78. The staff set an example for neatness and orderliness.
79. People are always changing their minds here.
80. Patients will be transferred from this ward if they don't obey the rules.
81. Discussions are pretty interesting on this ward.
82. Doctors sometimes don't show up for their appointments.
83. Patients are encouraged to show their feelings.
84. Staff rarely give in to patient pressure.
85. Staff care more about how patients feel than about their practical problems.
86. Staff strongly encourage patients to talk about their pasts.
87. Patients here rarely become angry.
88. Patients are rarely kept waiting when they have appointments with the staff.
89. Patients never know when they will be transferred from this ward.
90. It's not safe for patients to discuss their personal problems around here.
91. Patients often do things together on the weekends.
92. Staff go out of their way to help patients.
93. The ward always stays just about the same.
94. The staff discourage criticism.
95. Patients must make plans before leaving the hospital.
96. It's hard to get a group together for card games or other activities.
97. A lot of patients just seem to be passing time on the ward.
98. The day room is often messy.
99. Staff tell patients when they are getting better.
100. It's a good idea to let the doctor know that he is boss.

A SOCIAL CLIMATE SCALE

WARD ATMOSPHERE SCALE

FORM R

Rudolf H. Moos

Instructions

There are 100 short statements in this booklet. They are statements about wards. Please decide which of these statements are true of your ward and which are not. On the separate answer sheet, mark under T (True) when you think the statement is true or mostly true of your ward; mark under F (False) when you think the statement is false or mostly false. Please be sure to answer every statement and to fill in your name and the other information requested.

Do not make any marks on this booklet.

Consulting Psychologists Press, Inc.
3803 E. Bayshore Road, Palo Alto, CA 94303

HOSPITAL – HOSTEL PRACTICES PROFILE

Please tick the box that applies.

Restrictions on Activity	Yes	No
Outside doors locked during the day		
Restricted visiting times		
Visits to the pub not allowed		
Not out alone in the evening		
Passes required after 7 p.m.		
Check that residents are in at night		
No TV after 11 p.m.		
Front door locked at night		
n bed by a given time		
Check that residents are in bed		
Up by given time (weekday)		
Up in mornings (weekday)		
n by 10 p.m.		
n by 11. p.m.		
Encouraged to be in bed by 11 p.m.		
p by given time (weekend)		
p in the morning (weekend)		
lovements known at weekends		
n by given time (weekends)		
ust stay out during day (week)		

ossessions	Yes	No
ot allowed razors, knives, scissors		
ot allowed matches, lighters		
edicines naded out		
ot allowed personal money		
elongings catalogued		
hecked for forbidden items (admission)		
heck for forbidden items (periodically)		
annot lock own things		
estrictions on display of items		

eals	Yes	No
t involved in planning meals		
er not allowed		
irits not allowed		
nnot make tea		
nnot make a snack		

alth and Hygiene	Yes	No
eighed on admission		
eighed periodically		
ess supervised		
lock on toilet door		
lock on bathroom door		
choice of bathtime		
thing supervised		
nnot wash own clothes		

sidents' rooms	Yes	No
nnot rest on bed during day		
ff can enter rooms		
posite sex not allowed at any time		
nnot smoke in rooms		
ds made by staff		

rvices	Yes	No
st ask staff for GP		
chiatrist visits routinely		
rdresser visits routinely		
cial shop available		
re are no patient-staff meetings		

No.	Records	Request
		The searches below are from: A:\SEARCH.HIS.
1	3305	rule*
2	4482	ward
3	193	regime
4	285	atmosphere
5	3030	routine
6	50059	management
7	5804	structure
8	106	ward near2 (regime or atmosphere or routine or management or structure)
9	979	boundar*
10	9747	limit*
11	12751	setting
12	4375	set
13	124	limit* near2 (setting or set)
14	22	disobedien*
15	3647	disciplin*
16	1014	disciplines
17	2633	disciplin* not disciplines
18	4281	authorit*
19	428	conform*
20	172	non-compliance
21	4314	medication
22	4544	(compliance or non-compliance) not medication
23	0	non-coop*or
24	0	nonco-op*
25	0	non-coop*or nonco-op*
26	0	noncoop
27	0	non-coop
28	0	noncoop or non-coop
29	0	non-coop*
30	0	noncop
31	0	nonco-op*
32	4630	resist*
33	12142	norm*
34	95	normalisation
35	12047	norm* not normalisation
36	743	regulate*
37	5960	order
38	49629	control
39	2703	restrict*
40	9747	limit*
41	2624	break*
42	2	limit* near2 break*
43	2572	conduct
44	73519	#1 or #8 or #9 or #13 or #14 or #17 or #18 or #19 or #22 or #32 or #35 or #36 or #38 or #39 or #42 or #43