

Patients' Experiences of Safety on an Acute Mental Health Ward

Daniel Wood

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University College London

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Abstract

A sense of safety is assumed to be a vital component of the therapeutic milieu, however, recent research has suggested that the incidence of violence on mental health wards may be increasing. Studies of safety in psychiatric settings have tended to focus on the experience of staff, with little consideration of the experience of patients. This study used a qualitative methodology to explore and describe the experience of being a patient on a mental health ward, specifically with regard to feelings of safety and threat. Sixteen interviews with both patients and staff on an acute mental health ward were recorded and transcribed. The Ward Atmosphere Scale (Moos, 1996) was administered to participants to provide a description of the ward environment and a context for these interviews. The transcripts were analysed using an interpretative phenomenological approach (Smith, 1995). A number of themes emerged with regard to situations in which patients felt unsafe, staff/patient communication, and actions that staff took that they believed made patients feel more safe. Important differences and similarities also emerged between staff and patient accounts. The results are discussed with special attention to their possible clinical utility.

Chapter 1: Introduction

Overview

“When someone is admitted to hospital it is...vital that their safety is protected.” (DOH, 1999). This statement from the Department of Health, with regard to mental health wards, is quite clear in its stress on the importance of the provision of a safe environment for those admitted to hospital. However, contained within it is a sense that not only do patients have a right for their personal safety to be protected, but also, that a sense of safety is a vital part of the hospital experience and the therapeutic milieu. So, in the light of the above statement, how safe are mental health wards, how safe do such wards feel, and what can be done to make the experience of being a patient on such a ward feel safer?

In this chapter government policy with regard to safety on mental health wards will firstly be presented. Secondly, studies of violence towards both patients and staff on wards will be examined and thirdly, studies that focus on the experience of the patient on a mental health wards will be explored. Finally, psychological theories of safety will be discussed. The chapter will end with a summary of the literature, the rationale for the present study and the research questions.

Safety in Mental Health Services and Government Policy

The safety of all service users in hospital is, and should be, of primary importance to all mental health professionals. Indeed in a current Department of Health policy document, “Modernising health and social services” (DOH, 1999), explicit reference is made to concerns with regard to safety, and requirements to ensure its provision. The document goes on to describe how women in psychiatric hospitals especially have

been placed at risk of sexual harassment or assault “in part as a result of physical and organisational arrangements in wards” (p. 36).

The National Service Framework for Mental Health (DOH, 1999) presents a range of standards that the NHS should achieve. Standard 7:5 states that one of the duties of local health and social care communities should be to “provide safe hospital accommodation for individuals who need it” (p.76). The document continues on to describe how some service users do not feel safe in hospital noting that “this is especially true for women, and for individuals with a history of abuse, and for young people” (p. 50). It notes how “reports of sexual harassment are increasing” and “how self harm and suicide can occur” in psychiatric inpatient settings. It also makes reference to the government’s national objective of “providing safe facilities for patients in hospital who are mentally ill which safeguard their privacy and dignity”. It would seem then that ensuring that psychiatric wards are places of safety is a prime objective of government policy. How safe therefore are the psychiatric wards of the National Health Service, and how safe do they feel?

Violence and Mental Health Wards

Research has indicated that the incidence of violence in psychiatric settings may be increasing. Haller and Deluty (1988), in a critical review of the area, state that considerable evidence exists to suggest that there has been a substantial increase in assaults on staff of psychiatric institutions in the decade preceding the publication of their report. They hypothesise a number of reasons for this increase including understaffing, an increasing number of re-admissions and involuntary admissions, an increase in the proportion of patients experiencing acute distress, and an increase in

the proportion of younger, more 'difficult to handle' patients. However, this study only considered assaults on staff, not patients.

Incidence of Violence

A survey of violent incidents at the Bethlehem and Maudsley Hospital (Noble and Roger, 1989) suggested a progressive increase in violence by inpatients from 1976 to 1984 followed by a slight decline in 1987. This survey made use of a register of violent incidents that had been kept by the hospital and examined violence to both staff and patients. Of the 137 incidents of violence analysed, it was found that 78 involved assaults on nurses and 53 involved assaults on patients, the remaining 16 incidents involving assaults on other staff and visitors. It would seem then, that patients are similarly at risk of experiencing violence as staff.

Drinkwater and Gudjonsson (1989), reviewing studies of violence in psychiatric settings, note that readily available official statistics of the prevalence of violence in such settings rarely exist. They also note that such studies tend to focus on examination of official incident reports. Since many violent incidents are not officially recorded in this way - for instance violence to objects, violence that does not result in physical injury and violence that was not observed by ward staff - it is likely that these studies may seriously underestimate the extent to which violence occurs in psychiatric settings.

Lion, Snyder and Merrill (1981) have suggested that the under-reporting of assault in psychiatric settings may be by as much as a factor of five, i.e. that 5 times more assaults occur than are actually reported. Haller and Deluty (1988) have summarised

some of the reasons why such under-reporting may occur. They suggest that staff may fail to report incidents because minor incidents occur so often that staff become 'inured' to them, that report writing is viewed as too time consuming especially when it brings forth little result or change, and that staff may feel that reporting incidents might leave them open to charges of negligence. Chaimowitz and Moscovitch (1991) asked psychiatric residents (trainee psychiatrists) why they felt that violent incidents might be under-reported. Residents gave a number of reasons including the belief that the staff member involved would be blamed for the incident; the lack of a clear reporting process; denial, shame and guilt on the behalf of staff members; and a belief that the reporting of such events was futile.

Some direct evidence of the extent of the under-reporting of assault in inpatient mental health settings is provided in a study by Crouner, Peric, Stepic and Van (1994). They studied video tape recordings taken over a period of time in an intensive care psychiatric unit and detected 155 incidents of assault. However in the same time period only 12 incidents were actually reported by staff. These figures would suggest that under-reporting may be occurring by as much as a factor of 12.

One problem of much of the research into ward safety is that it has been conducted from the perspective of staff members, that is, studies have concentrated on attacks and violence perpetrated on staff members, rather than examined violence toward patients. However, studies of violence perpetrated on staff members are highly relevant in that they suggest what the overall level of violence may be on such wards, especially given the suggestion of the Noble and Roger (1989) data that the level of violence directed to staff is comparable to that directed toward patients.

Assaults on Staff

Much research in Canada and North America has focused on assaults on psychiatric residents (trainee psychiatrists). Black, Compton, Wetzel, Minchin, Farber and Rastogi-Cruz (1994) questioned all 47 residents in a regional psychiatry training program and found that 56% had been physically assaulted, and that almost all had been threatened verbally, or had witnessed assault on others. Chaimowitz and Moscovitch (1991) sent questionnaires to all psychiatric residents engaged in training programmes in Canada and found that, of the 65% who responded, 40% reported having been the victim of physical assault by a patient. Of those residents in their final two years of training, 44% reported assault, suggesting a cumulative risk dependant on length of time in post.

One might wonder why the specific concern with assault on psychiatric residents, and whether the findings with regard to psychiatric residents are representative of mental health workers in general. One study, using questionnaires, by Whitman, Armao and Oran (1976) examined assault rates on different types of mental health therapists. Of the respondents to their questionnaire, 34% of the psychiatrists, 20% of the social workers and 7% of the psychologists reported having been assaulted.

Shah, Fineberg and James (1991) highlight a number of methodological problems that pertain to these studies. One major problem is that there is no common definition of what constitutes violence. Some studies include violence to property, some violence to self, and some verbal violence. Also a variety of different methods have been used, some retrospective, some prospective, some involving review of incident reports,

some using questionnaires. Shah et al. (1991) suggest that future studies would be improved by working prospectively, using well validated scales and employing a standard, comprehensive definition of violence.

Staff Perceptions of safety

One might assume that, given the high rate of violence experienced by staff, they might feel their work environment to be unsafe. Indeed in the Chaimowitz and Moscovitch (1991) study of Canadian psychiatric residents, only 35% of the respondents judged the hospital facilities available to them for assessing patients to be safe. However the link between level of violence experienced and feeling of safety is not as direct as one might imagine. A surprising finding of the Black et al. (1994) study was that psychiatric residents indicated that they felt safest in the hospital that had the highest rate of violence. Respondents commented that staff seemed more prepared to deal with violence and more alert to the possibility of violence in this hospital. So whilst respondents were, in probabilistic terms, more at risk of violence in this setting, they felt safer because of the attitude and behaviour of staff.

Assaults on Patients

A study by Nibert, Cooper and Crossmaker (1989) is one of the very few quantitative pieces of research to focus on assault on patients rather than staff. Nibert et al. (1989) interviewed 58 of the patients resident in an American state psychiatric unit (31% of the patient population). Over 70% reported having been threatened or abused whilst staying in a psychiatric institution - 53% reporting experiencing physical assault, and 38% reporting having experienced sexual assault. Those who reported being physically abused were asked who had abused them the most: 52% said staff and 39%

said patients. Those who reported being sexually abused were asked the same question: 55% said patients and 27% said staff. Such findings make disturbing reading. But perhaps more disturbing is the lack of subsequent research following on from this study. There are a number of criticisms that can be levelled at the study. Firstly, participants were self-selected and were offered assault prevention training (the research was conducted on the back of an assault prevention program). As such it may be that those with histories of experiencing assault were over-represented in the sample. Secondly, the data were obtained from self-report and there was no verification of these reports. Nevertheless, as an initial exploration of a previously unresearched area, the report should have provided much cause for concern and generated further studies. However, a search of psychological databases suggests that this has not been the case: little, if any, further quantitative research has been forthcoming. However, more recently a small body of research has begun to emerge, that is qualitative in nature, and focuses on explorations of patients' experiences. This work is discussed in a later section that focuses on the patient experience.

Patterns of Violence and Factors Affecting Violent Behaviour in Inpatient Units

Much research has centred on the various factors associated with ward violence, including the social and physical environment and the events preceding violent incidents. Such studies have obvious clinical utility if attempts are to be made to improve the safety of mental health wards.

The social environment

Palmstierna, Huitfeldt and Wistedt (1991), hypothesising that overcrowding might lead to violence on mental health wards, specifically examined the relationship

between crowding and aggression on a psychiatric intensive care unit. Following on from an earlier suggestion by Drinkwater and Gudjonsson (1989) that crowding might be a factor in aggressive behaviour, they set out to explore whether day-to-day variations in the number of patients on a ward might correspond to day-to-day variations in aggressive behaviour. They found that on the days when patients who had exhibited aggressive behaviour in the past were aggressive, a mean of .63 more fellow patients were present on the ward. Whilst this finding was shown to be statistically significant, Palmstierna et al. (1991) themselves concede that it is difficult to argue the clinical significance of a result that does not represent a single patient, but merely a fraction of one.

Of greater interest is the finding that a large proportion of the incidents occurred shortly after admission, 31.9% occurring within two days of admission and 51.3% occurring within eight days of admission. One might hypothesise that the first few days of admission to a psychiatric unit were a time of particular stress for patients and that this stress might result in aggression. However whether such stress is the result of being in a novel, frightening and fear-inducing environment, or more a function of the acute mental distress that necessitated the admission it is not possible to say. Also, inferences drawn from the findings of this study need to be treated with considerable caution, since the sample size was extremely small. Whilst 163 patients comprised the initial sample for the study, only 24 met the criteria for exhibiting past aggressive behaviour and thus became the sample for the main analysis of the study, the relationship between number of patients present on the unit and aggressive behaviour.

Katz and Kirkland (1990) examined how the social structure of the ward environment might impact on violent behaviour. By means of extensive participant observation and extended interviews with staff over a 38 month period, six wards were classified as either 'peaceful' or 'violence-prone' and their social structure analysed. Six characteristics of the 'violence-prone' ward were identified. These included:

1. A ward atmosphere of uncertainty, confusion and fear evidenced by the comments of staff that violence was an everyday occurrence, and that, in potentially dangerous situations, staff had sometimes had to wait for up to an hour for assistance from other staff members.
2. Staff, including both nurses and psychiatrists, tending to spend their time on the ward, isolated from patients, in glassed-in and locked nurses' stations.
3. Meetings being arranged on an occasional and ad hoc basis without regular times.
4. The completion of Care Plans and discharge being neglected.
5. A lack of clarity with regard to staff roles and responsibilities.
6. The failure of staff to report violent incidents in official records.

In comparison Katz and Kirkland (1990) found the 'peaceful' wards to be organised quite differently. Such wards, in an almost mirror-image of the 'violence-prone' wards, were found to have regularly scheduled meetings, and activities; clearly delineated staff responsibilities and procedures; staff confident in their own and other's abilities; thoughtful and comprehensive care plans for the patients; and an immediate review led by the psychiatrist on duty of the antecedents preceding violent incidents. Such wards also differed in the reporting of violent incidents: in the violence-prone wards fewer than half of the incidents were recorded in the nursing records, whereas in the 'peaceful' wards almost all violent incidents were recorded.

Such a finding suggests that under-reporting of violence in mental health wards may vary as a function of the violence that occurs on such wards, the wards that are the most violent being those that under-report the most.

Katz and Kirkland (1990) hypothesised that there may have been countertransference processes occurring on the violence-prone wards, suggesting that isolated, nervous staff members who did not feel secure in their roles may have been exacerbating the anxieties of disturbed patients and indirectly fostering violent behaviour. They concluded that violence flourishes in situations where there is “helplessness, fear and confusion”, but is inhibited in contexts that provide “a predictable, competent, trusting environment”. Whilst the study would appear to represent a thorough exploration of the characteristics of the social structure of the various wards, the focus of the study is very specifically on structures imposed by staff and from the perspectives of staff. The study states that whilst 131 staff members were interviewed for between 3 and 19 hours, only “some psychiatric patients were interviewed briefly about their perceptions of events on the ward”. This lack of attention to the views of the patients on the ward is perhaps reflected in the lack of consideration of the social structure of patient groupings and how these might effect violence on the ward. Whilst the patient population of a psychiatric acute ward is inevitably a fluid and transient one, there will nevertheless exist within that population social structures that, though changing and changeable, and therefore difficult to describe, will have profound effect on the social dynamics of the ward and therefore on the expression of violent behaviour.

The physical environment

Few, if any, studies have focused on the physical environment of the psychiatric ward and how it might impact on violent behaviour. Rotov (1994) makes a number of suggestions on how to improve the ward environment including advocating that wards be built in semi-oval shapes so that the various different sections can all be viewed from the one nurses' station; that depressed and anxious patients should not have views of "slummy back yards and noisy playgrounds" (p.261); and that secluded patients must not look out into recreation yards. Whilst Rotov's suggestions would appear generally sensible, he provides no evidence with which to support them, save for anecdotal evidence and his own professional experience. As such his report does little more than list his personal preferences for ward design.

Patterns of violence

Depp (1976) analysed 379 violent incidents that had been reported to have occurred in a psychiatric hospital over an eight month period. One comparison was between 'striking' patients and patients who were 'struck'. The study found a mean age of 37 years for the sample of 'striking' patients and a mean age of 53 years for the 'struck' patient sample. Such a finding would seem to suggest that older patients may be more at risk of violence and assault on mental health wards. However in an attempt to clarify the struck/striking distinction, patients who retaliated were excluded from the study, as were patients who were involved in incidents that also involved staff members. It may be therefore that the struck/striking distinction is a somewhat artificial distinction and possibly unuseful. It could be that younger patients are equally at risk of violence, but rather, violence that involves staff members and is protracted, i.e. involves retaliation.

Another marked difference that the study reports between striking and struck patients is with regard to seclusion. The striking patients averaged 22 hours of seclusion and restraint per month previous to the incident, and the struck patients 5.8 hours per month. The report debates whether the increased rate of seclusion is a factor of these patients' increased assaultiveness, or whether the seclusion itself triggers anger and violence, necessitating further seclusion, and setting up a vicious circle.

With regard to gender differences, the study reported that 63% of strikers and 62% of those struck were male; and that assaults across gender divides were less likely than within gender groups, only 27% of incidents involving violence between men and women. Male patient only wards, female patient only wards and mixed wards were surveyed and differences discovered in the rate of violent incident in each. Measured as "annual rate of reported assault per patient", values of 0.114 for mixed wards, 0.101 for male patient only wards and 0.043 for female patient only wards were found. The report notes how, if the evidence suggests that the majority of striking and struck patients are men, one would expect the male patient only ward to have the highest rate of violent incident followed by the mixed ward and then the female patient only ward. Since this was not the case, the report hypothesised that it may be that the presence of female patients caused competitiveness between male patients and led to increased violence. Whatever the reason for the difference in violent incident rates, it would seem from the findings of this report that mixed gender wards do not advantage female patients in terms of protection from violence. However, it is difficult to assess the significance of any of the differences reported in this study since no statistical analyses were presented. It may very well be that the differences reported

are statistically significant but, from the evidence provided, there is no way of knowing this.

Whilst the Depp (1974) study focuses on factors within patients that may lead to violence, two studies, Lavender (1987), and James, Fineberg, Shah, and Priest (1990), examine the impact of staff factors on ward violence. Lavender (1987) employed a quasi-experimental design to assess the effect of nurses changing from uniforms to everyday clothes on a psychiatric ward. Employing pre and post change measures he found a statistically significant reduction in verbal aggression and self-injury, but no significant reduction in violence to objects or violence to people. However he also found a statistically significant difference in the number of 'patients' confidants' - the number of nursing staff that patients reported they could talk to about their problems. It may be that the change to non-uniformed staff had the effect of reducing the difference between staff members and patients and making staff members seem more approachable to patients. It may be that this 'approachability' enabled patients to voice their fears and concerns to staff in more appropriate ways, thus reducing frustration and aggression, if not violent incidents per se.

James et al. (1990) used a retrospective design to analyse all reported incidents of violence over a 15 month period on a 12 bed 'high-dependency' psychiatric ward. Over this period a substantial increase in violent incidents occurred. James et al. (1990) found this increase to be strongly associated with an increase in the proportion of temporary, or agency, staff employed on the ward ($r = 0.63$; $p = 0.0005$). No association was found between violent incidents and other factors such as admission rates or bed occupancy rates. James et al. (1990) concede that the nature of the

direction of effect of this relationship was unclear - it could be that inexperienced, temporary staff were less able to prevent violent incidents occurring, or it could be that permanent staff left the ward as violent incidents increased. However the authors report that their discussions with staff who left the ward suggested that they did so for reasons other than that of increased violence. It would seem likely therefore that a high proportion of temporary staff on a ward may have serious consequences with regard to the safety of patients on a ward. It would also seem likely that the appearance and demeanour of staff would have an effect on patients' willingness or ability to confide in staff and, therefore, patients' sense of safety on a ward.

Antecedents to Violence

Whilst the previous studies have largely concentrated on the intra-personal factors, such as the staff and patient characteristics that contribute to ward violence, a study by Powell, Caan and Crowe (1994) examined the events that precede violent incident in psychiatric hospitals. Powell et al. (1994) collected a massive amount of data: all the violent incidents reported in a 13 month period at the Bethlem, Royal and Maudsely Hospitals, a sample comprising over 20,000 patients and 1550 staff. During this time 1093 violent incidents were reported. Powell et al. (1994) analysed the standard 'untoward incident' forms that had been completed by staff - nursing staff in 95% of cases - immediately after the incident. A typology was constructed that accounted for 92% of incident antecedents that included characteristics of the patient, characteristics of the hospital regime and interactions with other individuals. The most commonly attributed antecedent was 'Patient Generally Agitated or Disturbed' (26%), followed by 'Restrictions (Clinical and Legal)' (19%), and 'Provocation by other Patients, Relatives or Visitors' (17%). Powell et al. (1994) also found that a small number of

patients were involved in a substantial proportion of the incidents. Their results showed that a group comprising 8% of the patients involved in the incidents were responsible for 10 or more incidents each, or, 46% of all incidents. Powell et al. (1994) suggest that special attention needs to be paid to these patients if ward violence is to be reduced.

Whilst this study benefits from a particularly large sample size and scope, it contains within it a number of substantial difficulties. Firstly, it relies on official incident reports for its basic data. Such a reliance is problematic if under-reporting occurs to the extent previously discussed, especially given the previously discussed finding by Crowner et al. (1994), that official incident reports may reflect less than 10% of inpatient assaults. It may be that the incidents that are reported comprise a particular subset of all incidents that occur on mental health wards, with a range of particular and individual characteristics, and this would compromise the generalisability of the findings. Secondly, it is not stated whether the reports are written by an onlooker or an actively engaged participant and one might hypothesise that the degree of objectivity of a person who was actively involved might differ from that of someone who was a passive observer. Thirdly, the category 'Patient Generally Agitated or Disturbed' says little about the specific antecedent events that led to the patient becoming agitated or disturbed, and one might imagine that all patients involved in violent incidents might be described so. It is perhaps not surprising therefore that this category was the most commonly assigned and it may be that many of the incidents so categorised would be better described as 'Antecedent not Known'. Finally, this report only tells one half of the story. Only reports by staff are analysed and there is no mention of the views of the patients involved in these incidents. One wonders whether the researchers

considered the views and beliefs of patients as containing less veracity, or being less valid, than the views of the staff.

Taken as a whole these studies of violence and assault in mental health services paint a very negative picture of the experience of being resident in a psychiatric institution. However studies of incidence of assault tell only a part of the story. For every act of violence and aggression against a member of staff or patient, there will have been a number of people who have observed the event and who may have felt threatened and fearful; and for every incident that resulted in violence there will have been a number of events when aggression, threat and hostility were expressed, but physical violence did not occur. The cumulative effect of all these events on the individual, resident in a psychiatric institution, is likely to be considerable.

The Patient Experience

Wood and Copperman (1996) discuss the lack of systematic research in the U.K. with regard to physical and sexual abuse in mental health services. Their report highlights how, whilst little is published in academic journals with regard to abuse in psychiatric hospitals, reports are plentiful in other fora, such as in magazines, radio and television programmes and personal letters to mental health charities. They suggest that accounts of abuse may often only be told when publicity with regard to the issue has appeared elsewhere. Wood and Copperman (1996) present a particular account that appeared in a letter to MIND and was reported by Lynch (1991):

“My daughter was raped whilst in St Mary Abbots Hospital in London. The man in question had simply walked through the adjoining mixed ward into Emma’s unattended dormitory and into her cubicle. Although the police found the man, they thought there was little mileage in dragging Emma through court

proceedings – she would only be further distressed if the man’s solicitor made play of the fact that she was a mental ‘patient’.” (Lynch, 1991, p. 4)

This account highlights how vulnerable women can be even when they have access to women only areas, and also how little protection, in actuality, they are afforded by the law. However, Cleary and Warren (1998) also present what appears to be the same account, this time gleaned from McMillan (1992). Whilst anecdotal evidence can be extremely informative in the early stages of research into a particular area, reference to it can be problematic if it becomes part of a process of ‘Chinese whispers’ whereby its provenance is unclear and its veracity compromised. That an uncorroborated account first published in 1991 is still quoted in a research article published in 1998 would seem to illustrate the extent of the paucity of research into this area.

A small body of research does exist that attempts to explore the experience of being a patient on mental health wards. Myers, Leahy, Shoeb and Ryder (1990), adopting a quantitative methodology, constructed a questionnaire to examine “patients’ view of psychiatric hospital life” and administered it to 248 patients across 4 English psychiatric hospitals. However none of the 45 items in the questionnaire probed patients’ feelings of safety and the authors give no clue as to the basis on which they constructed the questionnaire, for instance whether on the basis of their own assumptions and beliefs, or informal discussions with patients. Meyers et al. (1990) conclude that the results of the study should be taken as a “minimum estimate of dissatisfaction” on the part of patients with psychiatric hospital life. They concede a number of methodological difficulties with the study, such as participants misunderstanding questions and having difficulty concentrating for the length of time it took to complete the questionnaire. Consequently the results would seem to provide

little information with regard to patients' experiences, over and above the authors' own personal beliefs on the subject.

Goldberg (1990) attempted to construct a "Psychiatric Hospital Stressful Event Rating Scale" with the aim of identifying which ward events patients found most stressful. In order to do this he asked a sample of 160 inpatients from three Canadian psychiatric hospitals to rate the stressfulness of 84 situations or events. These were situations that had been identified by inpatient members of a stress management group that he had run. The most stressful events were identified as:

- seeing a patient attack someone on the ward
- having a sudden unplanned hospitalisation
- having personal items stolen
- being physically restrained
- having a patient attempt suicide on the ward
- being punished for something that was or was not done
- thinking it will never be possible to go home
- having an opinion treated as a symptom of an illness
- having personal clothing taken away

Unfortunately Goldberg (1990) does not reveal how he collated this list or in what manner, or on what scale, his participants rated these events. Nevertheless it does represent a real attempt to ascertain patients' experience and perspective.

Cleary and Warren (1998) adopted a more qualitative approach in an exploratory investigation that focused on women's experiences on a mixed acute ward. They conducted a number of focus group sessions that explored topics such as ward design,

sharing with others, privacy, comfort and safety. In contrast to their expectations Cleary and Warren (1998) found that participants, even though reporting experiences of feeling frightened and vulnerable, tended to describe the ward as comfortable and safe. Cleary and Warren (1998) wondered whether, what they described as the participants' minimising and downplaying of the incidents they discussed, might be a factor of their being disempowered by the experience of being an inpatient, or a reluctance to appear critical of their care. However it is possible that, on the ward on which they conducted their research, incidents were dealt with effectively and patients did feel safe. It is also possible that group processes may have been in action in the focus groups, whereby different views became suppressed or silenced in an attempt to achieve consensus. These difficulties highlight one of the problems of small exploratory studies with regard to the interpretation of results and indeed the authors are at pains to point out the "the findings of this study cannot be generalised" (Cleary and Warren, 1998, p. 39). One finding of interest was that the women in this study indicated that they preferred mixed sex to single sex wards.

A less positive account of the experience of being an inpatient on an acute psychiatric unit is presented by Williams, Pacitti, Sbaraini, Hole, Perera, and Rothwell (in press). Williams et al. interviewed 33 patients who were, or had been, resident of a 20-bed mixed-sex locked unit, over a 6 month period. They found that only 47% of their sample said they felt safe and secure on the unit, 35% saying they did *not* feel safe and secure and 18% saying they *sometimes* felt safe and secure. The most common explanation given by the participants for not feeling safe was, as categorised by the researchers, "the mix of vulnerable and violent patients". Other explanations given were categorised as the "mix of male and female patients" and "poor

staff/understaffing". Forty seven percent of the sample reported having been assaulted or threatened whilst on the unit and 53% reported having witnessed someone being assaulted or threatened whilst on the unit. No significant differences were found in responses between men and women.

Williams et al. point out that the finding that approximately half of participants reported having been assaulted or threatened whilst on the unit is especially worrying given that half of the sample had been on the unit for less than a month. Also the study had been carried out within the context of a hypothesis that safety was a matter of particular concern for women patients. Though the findings showed no statistically significant differences between men and women, the actual difference across the measures, of feeling safe, being assaulted or threatened, and witnessing others being assaulted or threatened, consistently suggested men feeling more unsafe than women. Williams et al. conclude that it should not therefore be assumed that safety in mental health services is primarily a women's issue.

The method used by Williams et al. was to concentrate on a small population, the patients of a single mental health acute unit, and conduct multiple and intensive interviews with each participant. Baker (2000) adopted an alternative technique, constructing a questionnaire which was sent to 4500 members of MIND and associated Mental Health action groups and charities, who had had experience of being patients on mental health wards. The questionnaire was designed to elicit patients' views of conditions on mental health wards in England and Wales. A response rate of 9% was achieved. 30% of respondents described the atmosphere on the last ward that they had experienced as unsafe and frightening, only 22% describing it as safe. 16%

reported having experienced sexual harassment during their last admission, and of the 55% that complained, only 28% reported that any action had been taken to prevent it happening again. 56% of respondents described the atmosphere of the ward that they had been on as un-therapeutic.

These results would seem to suggest a very negative picture of the experience of being a patient on a mental health ward. Whilst 30% of respondents described the ward as frightening and unsafe, the converse of the statistic that 22% said that they felt safe, is that 78% of respondents were unable to say that they did feel safe on the ward. Such a finding would seem to represent a worrying indictment of the atmosphere on mental health wards, even given the circumstances of the questionnaire whereby it may have been that those who felt most strongly about their experiences of mental health services were those that responded.

Theories of Safety

So far the experience of threat and safety has been largely discussed with reference to the experience and witness of violence. However the experience of feeling safe is not simply the absence of threat. In certain situations when threat is present persons may still feel safe.

Safety Signals

Rachman has developed a 'safety signal' perspective to analyse generalised anxiety disorder (Woody and Rachman, 1994) and agoraphobia (Rachman, 1984). Such a perspective views GAD and agoraphobia as resulting in part from obstruction in access to 'safety signals' - stimuli in the environment that have become conditioned to

experience of reduction in fear. In agoraphobia common safety signals are 'home' and 'trusted friends'. Thus persons become anxious in situations where they are obstructed from reaching home, such as in a long queue or in a lift.

Viewed in this way psychiatric settings can be seen as being devoid of safety signals - the individual is in a strange environment that is not only unlike 'home' but also serves to prevent or obstruct return to 'home'. The individual is also separated from 'trusted friends'. The experience of being an inpatient is likely therefore to decrease feelings of safety.

An Ethological Approach

Bowlby (1973) adopted an ethological approach to human fear and safety, that examined the causes, cues and functionality of fear in animals, in order to expose some of the misperceptions, with regard to fear and safety, that he believed existed in psychiatry. He summarised these misperceptions thus:

“One type of mistake concerns the nature of the stimuli and the objects that frighten us and lead us to retreat. Not infrequently, it is found, they bear only an *indirect* relationship to what is in fact dangerous. The second type of mistake is just as basic. We are frightened not only by the *presence*, or expected presence of situations of certain sorts but by the *absence*, or expected absence of situations of other sorts.” (Bowlby, 1973, p. 102)

Bowlby's comments have much relevance if attempts are to be made to explore the experience or perception of safety on mental health wards. The researcher must be alert to the power of indirect threats to cause fear and concern and also make attempts to discover what it is that is not present that may also cause fear and concern. It may not be the presence of threatening others that is frightening, but the lack of a place to

be private. Research in the context of safety on mental health units has tended not to focus on this.

Safety and the Therapeutic Milieu

Fry (1987) employed the idea of 'safe space' as a concept to link the experience of the people who he encountered as patients in his role as a psychiatrist with responsibility for a busy acute psychiatric ward. For Fry (1987) the concept of safe space went beyond aspects of the physical and material environment and, in the way in which safe space related to his patients, encompassed,

“the personal links that they made with the world, whether these were intimate or social, and as well as that the way they thought about those links and the way they felt in general about their world” (Fry, 1987, p.24).

For Fry (1987) such people were 'soldiers' who had adapted to the 'war' or trauma of their early experience and now, even when in good enough conditions, or in the 'demilitarised zone', could feel no sense of peace, or safety. Safe space referred to the "quality of personal, social and material environment", whether it was "a deep and trusting relationship between two individuals" or the aspects of a house that made it suitable for human habitation. Safe space was something that was missing, in the lives of the patients he encountered on his ward.

Fry (1987) believes the provision of safe space to be a vital part of the healing process. Garland (1998), employing a psychodynamic approach to the understanding of trauma, discusses the seeking of a place of safety as the natural and functional response to traumatic experience. For Garland (1990) trauma provokes a return to an extremely regressed level of functioning whereby the individual's only effective means of communication is projective identification, and their overwhelming need,

“the wish to find something or someone [they] can perceive, even temporarily, as offering primary maternal care.” (Garland, 1998, p.525).

This ‘something’ may be represented by a person or a place, but the common factor is that it must be somewhere that the person feels safe. As such it is a place of containment - a place where distressing events may be processed and come to terms with. The availability of such a place is viewed as vital for the healing process to be able to happen.

The work of both Garland (1998) and Fry (1987) would therefore seem to suggest that for a mental health ward to be a therapeutic environment, that enables persons in distress to recover from that distress, it is essential that it be perceived by such persons as a place of safety.

Summary of the Literature and Rationale for the Present Study

Studies of the incidence of violence on mental health wards would seem to suggest that violent incidents are increasing (Haller & Deluty, 1988; Noble & Roger, 1989). Evidence exists that such studies may be significantly under-reporting the extent of the violence (Lion et al., 1981; Chaimowitz & Moscovitch, 1991; Crowner et al., 1994). Many studies of violence on mental health wards have focused on violence against staff (Black et al., 1994; Chaimowitz & Moscovitch, 1991) rather than patients, but evidence suggests that patients may experience equivalent levels of violence to staff (Noble & Roger, 1989). Staff themselves report feeling unsafe on mental health wards (Chaimowitz & Moscovitch, 1991) and in a rare study that focused on assaults on patients (Nibert et al., 1989) 70% reported having been

threatened or abused whilst staying in a psychiatric institution. A number of studies have identified factors that are hypothesised to increase violence on mental health wards. These include overcrowding and the stress of admission (Palmstierna et al., 1991); social structure and atmosphere of the ward, in particular a sense of uncertainty and confusion (Katz & Kirkland, 1990); and rates of seclusion (Depp, 1976). Staff factors are also considered to be important: the use of temporary, agency staff resulting in increased level of violence (James et al., 1990); and the adoption of a more informal staff demeanour, as represented by the loss of uniform, being associated with less verbal aggression (Lavender, 1987).

Only a few studies have attempted to explore the experience of being a patient on a mental health ward. The results of earlier studies such as Myers et al. (1990) have been inconclusive, however Goldberg (1990) has identified a number of situations that patients have found stressful. More recently, evidence from small scale qualitative research (Williams et al., in press; Cleary & Warren, 1998) and large scale quantitative research (Baker, 2000) has suggested that many patients have experienced violence on mental health wards and few patients have felt safe on them.

Psychological models of safety suggest that a sense of safety is not merely evoked by an absence of threat but by the presence of safety cues or signals (Rachman, 1984). Conversely fear may also be evoked by the absence of certain situations or signals as well as their presence (Bowlby, 1973). Psychodynamic theorists have suggested that a sense of safety is a vital component of a therapeutic milieu (Fry, 1987; Garland, 1998).

It would seem therefore, from a review of the literature, that mental health wards are not particularly safe places to be and that the persons who are resident on those wards do not feel particularly safe either. For wards to be therapeutic they need to feel safe and if attempts are to be made to make them feel more safe we need to know what it is about them that feels unsafe. Some studies have attempted to ascertain this but have been primarily influenced by researchers' own beliefs and assumptions rather than the patients themselves. This study attempts, by the use of a more exploratory approach, to allow the experience of the patient on a mental health ward to be told.

Some of the questions left unanswered by the literature are: Are there different ways of feeling safe or unsafe? Is it the same or different for men and women? What are the particular threats that patients may experience on a ward? How does it feel to hear the cries of a highly distressed patient, to witness or experience control and restraint or seclusion? Does it feel safer to be in a single room or does a multi-bedded room feel safer because of the presence of others? We may have intuitive beliefs about what may or may not feel safe, but would we feel the same way if we were experiencing acute psychological distress?

The purpose of this study is to explore and describe the experience of being an inpatient in a psychiatric setting specifically with regard to feelings of safety and threat. The study will focus specifically on patients' experiences and perceptions, since very little research has looked at safety from the viewpoint of the patient. Staff views of patients' perceptions will be explored too as it is assumed that such beliefs govern the actions that staff take in their endeavours to make patients feel safe on their wards. Since the area is relatively un-researched, with little psychological theory to

suggest specific hypotheses, an interpretative phenomenological approach has been chosen (Smith, 1995). The focus of such an approach is on 'discovery' rather than 'verification' (Gherardi and Turner, 1987). As Barker, Pistrang and Elliott (1994) comment, a 'discovery oriented' approach is most appropriate when a research area is relatively new and little is known about it. The aim of interpretative phenomenological approach is to construct a coherent narrative of lived experience (Smith, 1995). The aim of this study therefore is to describe patients' experiences of safety and threat in a coherent, narrative form. The clinical relevance of the study is to suggest ways in which feelings of safety can be increased, feelings of fear and threat reduced, and a more therapeutic atmosphere in psychiatric settings effected.

Research Questions

This study asks a number of questions:

- How do service users conceptualise safety and threat?
- Do men and women have different experiences of being an inpatient with regard to feelings of safety and threat?
- Do staff and patients have similar understandings of the experience of being an inpatient with regard to feelings of safety and threat?
- What could be done to make the experience of being an inpatient feel more safe and less threatening?

Chapter 2: Method

Overview

This was a descriptive, qualitative study that attempted to describe the experience of being an inpatient in an acute psychiatric ward, with regard to feelings of safety. Semi-structured interviews were conducted with 9 patients and 7 staff members. The interviews were tape-recorded, transcribed and analysed using Interpretative Phenomenological Analysis (Smith, 1995). To provide a context for the interviews the Ward Atmosphere Scale (Moos, 1996) was administered to 6 patients and 10 staff members.

Ethical Approval

Ethical approval for the study was obtained, on 31st may 2000, from the Brent Medical Ethics Committee (see Appendix 1). Approval was given subject to care being taken to obtain the volunteers' informed consent, and the provision of a short report of the findings of the study, to the committee, once completed.

Research Setting and Recruitment

Participants were recruited to the study from a 28-bedded acute ward of a 4 ward mental health unit. The ward drew its patients from an ethnically diverse inner city area, and all patients were under the care of one of two consultant psychiatrists of two Community Mental Health Teams. Most patients slept in multi-bedded rooms and the ward contained within it a 'female-only' area, however not all female patients were able to be accommodated within this area. Analysis of official incident records, over a two year

period from April 1999 to April 2001, revealed a total of 123 reported incidents of 'violence, abuse or harassment' against patients or members of staff on the ward.

In order to recruit patients to the study, a notice (see Appendix 2) was placed on the community notice board giving brief details of the study and providing a space for patients to sign their names if they were interested in taking part. The ward had a weekly community meeting, open to all staff and patients, with an open agenda. This forum was used to deliver a short talk about the nature and purpose of the study and answer any questions and concerns that patients might have.

Once patients had signed up for the study, senior ward staff were consulted as to whether any of the patients' mental state was such that it might be adversely affected by the interviewing process. Patients identified as such were excluded from the study.

In order to recruit staff to the study, a letter was sent to all staff members on the ward, detailing the aims of the study and inviting them to participate (see Appendix 3). The ward had a twice-daily 'hand-over' meeting. As with the community meeting, this forum was used to deliver a short talk about the nature and purpose of the study and to answer any questions or concerns that staff might have.

Participants

Seven staff members and 9 patients took part in the study. Three staff members asked to participate in the study and a further 5 staff members were approached and invited to participate. Of these 5 staff members, 4 accepted the invitation and one refused.

Of the 12 patients who signed their names on the notice, 2 were discharged from the ward before they could be interviewed, and one was excluded because of staff concerns with regard to their mental state.

All participants were asked to describe their ethnic identity with reference to the Ethnic Group Categories from the UK census. Results are presented in Table 1.

Table 1. Ethnic Group Membership of Patient and Staff Participants

Ethnic Group	Frequency	
	Patients	Staff
White	6 (67%)	5 (71%)
Black – Caribbean	1 (11%)	
Black – African	1 (11%)	1 (14%)
Indian		1 (14%)
Chinese	1 (11%)	

The mean age of the patient sample was 43 (range 26 – 61) The sample comprised 5 men and 4 women. Patients’ diagnoses (ICD-10, World Health Organisation, 1994) were ascertained by review of ward notes and are presented in Table 2.

Table 2. Diagnoses of Patient Participants

Diagnosis	Frequency
Bipolar Affective Disorder	3 (33%)
Depression (moderate and severe)	3 (33%)
Borderline Personality Disorder	1 (11%)
Schizophrenia	2 (22%)

The mean age of the staff sample was 30 (range 24 – 50) The sample comprised 3 men and 4 men. The professional grades of the staff members interviewed are presented in table 3.

Table 3. Professional Grade of Staff Participants

Grade	Frequency
Student	1 (14%)
E	3 (43%)
F	1 (14%)
G	1 (14%)
H	1 (14%)

Researcher's Perspective

The impetus for this research arose through the researcher's previous experience of working as a care assistant on a variety of mental health wards such as an intensive care psychiatric ward, a psychiatric rehabilitation ward and an elderly mental health ward. The researcher had been struck by the seemingly chaotic nature of these wards and had wondered how both patients and staff coped with such an environment. The researcher's theoretical orientation was influenced by his current work in the Child and Family Department of the Tavistock Clinic, London. As such the theoretical models that inform his thinking have been largely systemic and psychodynamic.

Procedure

Interviews were conducted with staff and patient participants concurrently, over a period of ten weeks. The first two interviews were conducted with patient participants and from then on the interviewer alternated the conducting of the interviews between staff and patients. Where possible, interviews took place in an office in the psychology department. In instances when staff had concerns with regard to patient participants' behaviour or state of mind, patient interviews took place on the ward, in the 'doctor's office'. Participants were given an information sheet that detailed the aims of the study. Separate information sheets were prepared for staff and patient participants (see Appendices 4 and 5). Participants were asked to sign a consent form (see Appendix 6), giving their consent for verbatim excerpts from their interviews to be published.

Interviews were tape-recorded and later transcribed (for example see Appendix 7). All references to individuals' identity, as well as place and ward names were omitted.

The Ward Atmosphere Scale, (see Appendix 8) was administered to all patients who took part in the study after they had been interviewed. Six patients completed the questionnaire and three refused to do so, for reasons of fatigue. The Ward Atmosphere Scale was also sent to all staff working on the ward at the time of the study.

Questionnaires were placed in staff pigeon holes with a return internal envelope to ensure anonymity. Completed questionnaires were returned by ten staff members. Interviews with a subset of these staff members were conducted afterwards.

Measures

Semi-structured interviews.

Two interview schedules were constructed specifically for the study to guide the interviewing of patient and staff participants (see Appendices 9 and 10). These interview schedules functioned as a guide rather than a protocol to allow any new information that emerged in the course of the interview to be explored.

The style of the interviews was one of 'directed conversation' (Pidgeon and Henwood, 1996). In practical terms this meant that attempts were made to phrase questions in open terms that did not predicate specific answers. For example the opening question to patient participants, allowed for both feelings of safety and unsafety on the ward:

As you know the aim of this study is to find out how it feels to be a patient on Shore ward specifically with regard to feelings of safety. In what ways does the unit feel safe or not so safe for you?

Nevertheless, as Pidgeon & Henwood (1996) point out, a tension exists between the researcher's desire not to constrain the participant's responses, and the need for the interview to remain focused on the specific research area. Consequently, in this study, follow up questions were employed to re-focus participants toward safety issues, if it was felt participants' answers had strayed too far from the research area.

The interviews were designed to last about one hour and focused on a number of areas. Questions were open-ended to facilitate disclosure. Separate interview schedules were prepared for patient and staff participants.

Interview Schedule for Patient Participants

The interview schedule for patient participants contained eight sections:

Getting to Know the Participant. The purpose of this section was to gain some basic demographic information about the participant and to develop rapport. The section began with a brief restatement of the aims and objectives of the study, confidentiality and anonymity, and a reminder that the participant was able to withdraw consent at any time.

Safety and Security. The aim of this section was to move the focus towards discussion of issues of safety, threat and security.

Experience of Arrival. The purpose of this section was to explore participants' feelings when they first arrived on the unit, and find out if those feelings had changed over time.

Other Residents. The aim of this section was to find out how participants felt about the other residents of the unit and whether this had had an impact on participants' feelings of safety or threat.

Staff. The purpose of this section was to discover how participants experienced the staff.

Specific events. This section was designed to explore any actual experiences of violence.

The Physical Environment. This section was designed to explore how participants felt about the physical environment on the ward, such as ward design and layout, security, and bedroom configuration.

Closing the Interview. The aim of this section was to thank the participant for their participation and to provide an opportunity for them to express any concerns that they might have had or clarify any points they wished to.

Interview Schedule for Staff Participants

The interview with staff participants contained seven sections:

Getting to Know the Participant. The purpose of this section was to gain some basic demographic information about the participant and to develop rapport. The section began with a brief restatement of the aims and objectives of the study, confidentiality and anonymity, and a reminder that the participant was able to withdraw consent at any time.

Staff Beliefs with Regard to Patients' Feelings of Safety and Security. The aim of this section was to encourage staff to reflect on the experience of being a patient on the ward with regard to issues of safety, threat and security.

Impact of Gender. The purpose of this section was to explore staff's views with regard to mixed gender wards and also to encourage them to reflect on the impact of their own gender on patients' feelings of safety.

Specific Events. This section was designed to explore what staff believed was the impact on patients of either experiencing or witnessing violence.

Staff Feelings of Safety. The purpose of this section was to find out if staff felt safe on the ward and to explore this in terms of transference and counter-transference.

The Physical Environment. This section was designed to explore how staff felt about the physical environment on the ward, such as ward design and layout, security, and bedroom configuration.

Closing the Interview. The aim of this section was to thank the participant for their participation and to provide an opportunity for them to express any concerns that they might have had or clarify any points they wished to. Because of the sensitivity of the issues discussed, particular care was taken to detect any sense that participants might have had that their work had been scrutinised or criticised during the interview process.

The Ward Atmosphere Scale (Moos, 1996)

This is a 100-item questionnaire for both designed for both staff and patients which measures respondents' perceptions of ward atmosphere. There are 10 sub-scales: involvement, support, spontaneity, autonomy, practical orientation, personal problem orientation, anger and aggression, order and organisation, programme clarity and staff control. Respondents are required to mark 'true' or 'false' against a number of descriptive

statements that pertain to the atmosphere on the ward. The same form was used for both staff and patient participants.

Analysis

The data from the transcripts of the semi-structured interviews was analysed using an interpretative phenomenological approach (Smith, 1995). The term 'interpretative phenomenological approach' implies a 'duality' of approach to the analysis. According to Smith (1995) this duality is represented by an attempt to understand respondents' psychological world from examination of their manifest and overt communication, as well as the researcher's own interpretations of the text that can make clear less 'transparent' meaning. In this way the approach is both 'phenomenological' and 'interpretative', respectively.

Smith (1995) described the process of 'looking for themes' as involving several stages. The first stage involves reading the transcript and jotting down meanings and researcher's own associations in one margin. The second stage involves refining these jottings into theme titles that capture the nature of what is being said. Next these theme titles are further refined by referring back to the original transcript. These themes are then ordered hierarchically into themes and sub-themes and finally, quotes from the transcripts are added that exemplify the theme titles. Once this has been done for one transcript the theme titles can be used to analyse further transcripts and can be further refined or added to as necessary. This process was used to analyse the patient and staff interviews. The

patient and staff interviews were analysed separately, in effect two separate analyses being conducted.

This process is illustrated with the following extract from an interview with a patient:

Because when I complained a few times about the way I was being treated they said they couldn't look after me all the time, they didn't have eyes in the back of their head and they couldn't keep an eye on me all of the time. (PP3).

Initially the phrase 'staff too busy to protect' was written next to the quote. This was refined into a theme title of 'staff unable to protect patients'. Reading of further transcripts identified instances when patients felt staff were able to protect them and so this theme title was renamed 'ability of staff to protect patients' in order that the duality of both views could be contained in one theme.

Credibility Checks

A credibility check of the categories derived from the analysis was undertaken by an auditor - a second researcher with experience of qualitative methods. A range of unlabeled quotes and a list of the corresponding categories, in random order, was provided for the auditor and a concordance rate of 100% was achieved between the categories chosen by the auditor and those chosen by the researcher.

In addition at several stages of the analytic process a third researcher, with extensive experience, audited the themes being identified and related to the data.

Chapter 3: Results

Overview

The results of the Ward Atmosphere Scale (Moos, 1996) are presented first in order to give a description of the ward environment and a context to the interviews. The analysis of the interviews with patients and staff are then presented separately in two sections entitled, 'Patient Accounts' and 'Staff Accounts'. The similarities and differences of these accounts are explored in the discussion.

Excerpts from the transcripts that appear in the results section have, in some instances, been edited for the sake of brevity. Where material has been edited, this is represented by three dots, "...". Where dialogue is presented, "I" refers to interviewer and "P" refers to participant. The provenance of each quotation is indicated by the code "PP" (Patient Participant) or "SP" (Staff Participant) plus the research identification number of that participant.

Perceptions of Ward Atmosphere

The Ward Atmosphere Scale (Moos, 1996) measures patients' and staff members' views of the ward environment. Table 4 shows the means and standard deviations for the patient sample and, as a comparison, normative data from patients in 36 British mental health wards. Table 5 shows the means and standard deviations for the staff sample and normative data from staff from the same 36 wards. Because of the small staff and patient sample sizes of this study it was not possible to perform t-tests on these results.

Table 4. Ward Atmosphere Scale (Moos, 1996) Means and Standard Deviations for Patient Participants and British Normative Sample

Sub-scale	Patient Participants (n = 6)		Normative Sample (n = 450)	
	Mean	SD	Mean	SD
Involvement	2.50	2.42	4.32	1.34
Support	5.16	2.31	6.03	1.18
Spontaneity	4.50	1.52	4.79	0.86
Autonomy	3.50	0.84	4.84	0.93
Practical Orientation	2.83	1.94	5.46	1.03
Personal Problem Orientation	4.00	1.10	4.21	0.95
Anger and Aggression	5.17	1.94	4.30	1.28
Order and Organisation	2.67	1.75	6.43	1.65
Programme Clarity	3.17	1.72	5.38	1.05
Staff Control	4.17	2.14	3.96	1.26

Whilst the means of the staff sample from this study seem broadly similar to the means of the normative sample, such similarity would not seem to be evident between the patient sample of this study and the normative sample. One sub-scale where difference would seem to be evident is Involvement. This sub-scale refers to how active and energetic patients are in their 'programme'. A lower mean score would indicate less involvement. Other sub-scales where difference with the normative sample seemed evident, were Practical Problem Orientation, and Order and Organisation. These sub-scales refer to the extent to which patients learn practical skills and the importance given to organisation on the ward. It may be that the patient participants in the sample felt that the gaining of practical skills and the organisation of the ward was not given prominence by staff members.

Table 5. Ward Atmosphere Scale (Moos, 1996) Means and Standard Deviations for Staff Participants and British Normative Sample

Sub-scale	Staff Participants (n = 10)		Normative Sample (n = 290)	
	Mean	SD	Mean	SD
Involvement	5.90	1.52	5.50	1.68
Support	7.30	0.95	6.97	1.06
Spontaneity	5.90	1.52	5.80	1.09
Autonomy	5.30	1.49	5.48	1.11
Practical Orientation	6.20	2.53	6.70	1.22
Personal Problem Orientation	5.70	1.77	5.25	1.07
Anger and Aggression	5.60	2.07	5.35	1.57
Order and Organisation	5.60	2.27	6.63	1.78
Programme Clarity	7.50	1.58	7.17	0.86
Staff Control	1.00	0.82	2.40	0.92

Patient Accounts

This section concerns data drawn from interviews with patient participants. In essence it is an account of the experience of being a patient on an acute mental health ward, with particular reference to safety, from the perspective of the patient. Analysis of the transcripts of these interviews revealed that patients' feelings of safety and threat were impacted by a variety of different types of experience, such as their experience of other patients, of ward staff, and of significant events such as seclusion. Table 6 shows how these experiences have, through the process of the analysis been organised into 'Domains' and 'Themes'.

Table 6. Domains and Themes Drawn from Patient Accounts

Domains (Higher order Categories)	Themes (Lower Order Categories)
Patients' Experience of Fellow Patients	Physical Assault
	Verbal Intimidation and Threatening Language
	Sexual Harassment and Assault
	Abuse of Street Drugs
	Sharing Bedrooms
Patients' Experience of Ward staff	Supportive Friendships
	Ability of Staff to Protect Patients
	Ability of Staff to Listen and understand Patients Patients' Aversive Experience of Staff
Patients' Experience of Significant Events	Seclusion
	Forcible Administration of Medication
Own and Other's Mental State	

Domains are higher order categories and were largely determined by the areas covered in the interview and partly by what participants spontaneously spoke about. Themes are lower order categories and, in a reversal of the previous emphasis, were largely determined by what participants spoke about and partly by the structure imposed by the interviewer. For instance the theme, 'Verbal Intimidation and Threatening Language', a lower order category, emerged from participants' discussions within the domain, 'Patients' experience of Fellow Patients', a higher order category. Within the results section therefore this theme is presented as subsumed within that domain. One way of understanding this distinction is by viewing domains is as categories whose organisation was driven more by the

interviewer and themes as categories whose organisation was driven more by the participants themselves.

Patients' Experience of Fellow Patients

Participant spoke of their relationships and interactions with fellow patients as having an impact on their own sense of personal safety in a number of ways and functioning to both increase and decrease their sense of personal safety. Interactions with fellow patients gave rise to a range of different types of experiences some, such as physical assault and sexual harassment, leading to patients feeling more fearful, and others, such as supportive friendships, leading to patients feeling more safe.

Physical Assault

Many participants related experiences of assault by fellow patients and described how such assaults had affected how they felt with regard to safety on the ward. This participant recounted a litany of such assault:

I've been punched by patients. One patient punched me very hard in my left eye. And when I used to be in [ward name] I used to get punched in my stomach. There was a patient who was very unwell, he just used to come up and punch me very hard in the stomach ... Another patient tried to strangle me as well. Cleaners had to take their hands off my throat. (PP2).

There is a sense in this account of the violence having a random quality. The rescue appeared equally random too – it was not staff who removed the assailant's hands from the victim's throat, but cleaners, who happened to be standing nearby.

A male participant, with a number of past psychiatric admissions, reported feeling safe currently, but not having always felt that way. The randomness of the violence is echoed in this account:

On three separate occasions I've been attacked ... and hit hard. The first time by - he was only a short chap - completely out of the blue he took a swipe at me. I was holding a cassette radio, my main concern was to keep holding the cassette radio, which I managed to do. The second time was a man who I befriended and on the ward at that time was an elderly gentleman who was very disorientated and this black boy was playing very loud music. I told him to turn it down and he wouldn't and then he attacked me ... The third time was last time, which was in [date], there was another bloke on the ward called [name], for some unknown reason he took a dislike to me, for no apparent reason, just maybe it was because we both had the same name, I don't know. We were both in the day room, it was about six o'clock in the morning, the only two in there. All of a sudden he kicked me in the bollocks, I went crashing across the room, flying, my glasses went over one way. I was completely taken aback, for about 30 seconds disorientated, but I soon recovered...

I: The first time it happened, what did you think, how did you feel?

P: Well, I thought, we are in a psychiatric hospital, people are apt to do all sort of bizarre things, out of the blue, you've just got to expect it. And that applies to the other occasions as well.

I: What were you feeling?

P: I just, I was terrified, basically.(PP8)

The assaults that this participant described were not only unprovoked, but unexpected.

Lacking a rational context within which to place these assaults, the participant was left to construct a view of his environment which was unpredictable – “people are apt to do all sort of bizarre things, out of the blue”, and over which he had no control – “you've just got to expect it”. It is not surprising then, that the feeling he described was one of terror, and that the sense of safety, to which he initially referred, was that one can safely expect that anything can happen.

For some participants a single incident was enough to damage, or destroy, their sense of safety:

I: And did you feel safe the first time when you came in the summer?

P: In the summer? Basically, yes. Towards the end one of the patients punched me in the face towards the end of my stay.

I: And how did that make you feel?

P: Well I felt threatened by being punched in the face, because he made threatening gestures towards me. I thought he might throw food over me or throw some hot water over me.

I: So did that change the way that you felt on the ward after that?

P: Well it meant that I wanted to leave and so I was quite relieved when I was discharged. (PP9)

For this participant, the assault provoked fears of further assault by the same patient and a strong desire to leave the ward environment to avoid further attack, his eventual discharge provoking a keen sense of relief.

Verbal Intimidation and Threatening Language

However it is not only the physical expression of aggression that participants found frightening. For many participants verbal intimidation and spoken threats functioned to increase fearful feelings. A female participant reported:

P: Someone threatened to kill me the other day.

I: Did they, here, on the ward?

P: This woman, she threatened to kill me.

I: And what did you do.

P: I shouted out ... and they restrained me ... and they told me to calm down.(PP3)

In this instance, the participant's shout for help resulted in her being physically restrained by staff and having the validity of her distress denied. The same participant also described her experience on a secure ward:

P: I was getting spat on, I was getting threatened, people, some of the other male patients, threatened to beat me up, and I couldn't escape because I was on section.

I: And how did that make you feel, I wonder?

P: I felt quite threatened.

I: That must have made you feel very frightened.

P: I was frightened, every day I was frightened. (PP3)

For this participant fear was a quotidian experience that had to be endured, and from which she had no escape.

Whilst the above threat focused on the patient's gender, a threat reported by another participant, who identified as Jewish, related to his ethnicity and religious beliefs:

P: Well it normally feels quite safe but sometimes I feel threatened by other patients who may give the impression of being potentially violent. For instance there's one patient here who said that he was a Muslim, that only Muslims would go to heaven and that he hated all Christians and Jews, particularly Jews, and that I would be going to hell and he hoped that I would die soon. He said all those things to me, which I found quite distressing. (PP9)

Such threats, whilst intimidating enough with their implicit threats of violence, have the added function of highlighting individuals' racial and religious difference, and potentially increasing their sense of vulnerability and isolation.

Sexual Harassment and Assault

Threats that focus on gender can have a similar function to those that focus on racial and religious difference, increasing individuals' sense of vulnerability. Such threats may be verbal and explicit, or non verbal and implicit. A female participant described her fear of a particular patient, his sexually charged behaviour, and how this impacted on her feelings of safety on the ward:

I feel terrified ... there's one patient who's a bit bolshy, everyone knows that, you always get someone on the ward, he's just a bad man that's all ... he makes sexual, lewd sexual advances, not to me but to every female inside. Well I don't like that, I've said once is enough, but every time he starts sticking his tongue out at me, you know I'm just disgusted. (PP5)

This account of sexual harassment by a fellow patient, and its concomitant effect on the individual's sense of safety, was echoed by another female participant:

One of the men kept coming up to me and trying to hold me, and I had to tell him to stop it. I think women get a bad deal in psychiatric hospitals because the men think ... the men see them as sexual objects and they think that they've got a right to touch you and because you're a woman they think they've got the right to use you. I've only been here a week but when I was in

the secure unit every day I was continually hassled ... by men, wanting me to have sex with them, and they used to try and touch me (PP3)

Another female participant described how sexual activity between her and another patient came to be experienced by her as a sexual assault:

I slept with somebody and I don't think that that's a good thing because I could have got pregnant...but even when I slept with him at one point it didn't feel like sleeping with him, it felt like rape, because I told him to stop and he sodomised me. If you tell someone to stop they're supposed to stop aren't they? ... and he just kept on sodomising me, because he's ill, he's on crack cocaine, but I didn't know that at the time.(PP2)

In this instance the participant attributed her partner's disregard of her wishes to stop, as being due to his mental state and drug use. Another instance of male patients' mental state, as evidenced by their disinhibited behaviour, increasing female patients' sense of vulnerability is apparent in the following account from a female patient:

P: Quite frequently the male patients will go into the female bedrooms. That happened just yesterday. One man, one male patient took his clothes off and went and lay on a woman's bed, with a woman there, and all the staff did was say to the woman, 'oh, he says he's sorry'. What good is that?

I: So you feel it's not taken seriously?

P: It's not taken seriously.

I: That must make you feel quite vulnerable that things like that can happen.

P: It does make me feel vulnerable. (PP3)

In this extract the participant seems to be expressing a belief that staff are unable, or unwilling, to protect patients from the actions of other patients. The participant also experiences a lack of acknowledgement from staff of the serious effect that such disinhibited behaviour can have on female patients. It is likely that the effect of the incident itself, in terms of its impact on individuals' sense of vulnerability, will be exacerbated by the participant's perception of staff as uninterested and uncaring.

This male participant corroborated the account of sexual harassment, by men, of women, on the ward:

P: Women should have their own section, where they're not molested by men.

I: Do you think that happens on the ward?

P: Yes, I think a lot of the men harass the women, sexually. (PP9)

Abuse of Street Drugs

Witnessing drug abuse by fellow patients on the ward was, for two participants, connected with fearful feelings:

I: I wonder if we could talk about the other residents...the other patients on the ward. How did you feel when you first met the other residents here?

P: I was really scared of them...basically I just wondered why they were taking crack cocaine and things like that.(PP2)

Another participant described his first meeting with one of his fellow patients:

[name] scared me a bit, he's a bit big, I wasn't sure, he offered me a spliff.(PP6)

It is possible that one of the fearful aspects of witnessing illicit drug use on the ward is the sense it can engender of an under controlled ward environment and a 'laissez faire' attitude of staff not only toward drug use in particular, but also, to ward safety in general.

Sharing Bedrooms

On the ward on which the interviews were conducted, and indeed on many National Health Service mental health wards, patients are often required to share bedrooms.

This participant described the atmosphere in his dormitory:

I share a room with three other people. It's a dormitory, I've got my own bed area. The other patients can't see - there's a curtain. It's a four man dormitory ... they talk a lot, they some of them talk to themselves and one of them's praying constantly and [name] doesn't give me any trouble, sometimes at night he puts his radio on or he talks up until real late. And then it's very noisy

in the mornings and I get woken up and go back to sleep and then get woken up again. (PP6).

Whilst the participant described a somewhat chaotic environment he went on to say that he does not have specific concerns for his safety. However another participant told of how he felt his possessions were at risk at night in the dormitory:

Well again, when I was here over the summer there was somebody here who was stealing money from me and everybody, and I kept having to sleep on top of my money. And he kept going through my pockets when I was asleep. And I saw him do that on a number of occasions. (PP9)

Another participant told of how unsafe he felt at night in a shared room:

P: I was worried that at night someone would come ... into the room, because the rooms are not locked ... because some of them they wander around, you know, in the morning at three, four, five am and they can come to the room and I am asleep some may, you know, strangle you or do something or whatever (P1)

For this participant night time was a time of particular insecurity when he felt he was vulnerable to attack from other patients. It is hard to imagine how anyone would be able to sleep in such circumstances.

Supportive Friendships

Whilst many participants described experiences involving fellow patients that had left them feeling fearful and frightened, participants also spoke of the support that friendships with fellow patients could provide, especially in terms of reduction of anxiety when they were first admitted to the ward:

I: Has talking to any of the other residents, getting to know any of the other residents, helped?

P: Some of them are alright. There's only one person ... I've only been here a short while but there's only one person who's been nice to me.

I: What did they do that was nice?

P: When you come in to a hospital the only people that really understand your problems are the other patients because they've been victims of the problems

themselves. So they can understand you more than staff do, the staff don't understand anything.

I: So talking to someone who understands can make you feel a lot better?

P: It doesn't make me feel a lot better but it makes me feel a bit more comfortable. (PP3)

There is a sense in the above quote that what is important, in feeling more safe when first admitted, is being able to experience a sense of being understood by another person. There is also a sense that being understood is not an experience gained from interaction with ward staff. However, as another participant noted, there are potential costs to forming close relationships with other patients on the ward:

I: Talking to some of the residents...getting to know some of the patients on the ward for you...has that made you feel a bit more comfortable being here, a bit better?

P: No it's going to be worse because when I go I'm going to be sad that I leave them.

I: So it's sad about losing people that you've made friends with.

P: Yes

I: Do you find that you make quite strong friendships here...with the other patients?

P: I try not to because I know I'm going to have to leave...(PP2)

In this instance fear of the pain of separation prevents the participant from being able to access the support that friendships could potentially provide. However, as another participant poignantly described, the acute need for friendship and support when a patient is first admitted, can leave patients, especially female patients, vulnerable to exploitation:

Because when you come into a hospital - I've seen it myself and I've talked to a load of women - when you're not well and you come into a hospital, you're vulnerable, and sometimes you just want someone to comfort you and be on your side. And sometimes some of the male patients say that they'll look after you. And because you think that they'll look after you, you think that you have to be nice to them. (PP3)

One theme that a number of participants discussed is the degree to which staff are able to protect patients from aggression. One might hypothesise that a belief that staff

are able to protect patients might act as a mediating factor with regard to how patients' feelings of safety are affected by threatening experience and the witness of aggression.

Patients' Experience of Ward Staff

Participants spoke of the ward staff, their relationships with them, and the ways in which this impacted on their feelings of safety in a number of different ways. One way in which ward staff were spoken of was with regard to the extent to which they were believed to be able to protect patients from the actions of other patients. Another way was with regard to whether or not staff took time to listen to, or understand patients. Patients also spoke about times when staff had made them feel fearful - times when their experience of staff had been aversive.

Ability of Staff to Protect Patients

Participants reported quite different experiences and beliefs with regard to whether or not they felt staff were able to protect them. Some spoke of times when staff had protected them and how this had made them feel safe and others spoke of feeling that staff were unable to ensure their safety. This female participant spoke about feeling that she needed to rely on male fellow patients for protection:

I: Did you feel that the staff couldn't look after you?

P: Yes

I: Why do you think that was?

P: Because when I complained a few times about the way I was being treated they said they [the staff] couldn't look after me all the time, they didn't have eyes in the back of their head and they couldn't keep an eye on me all of the time. (PP3)

A male participant spoke of a particular patient who was repeatedly aggressive to him and how he felt staff were unable to protect him:

P: [name] was a patient here and he got violent with me, he grabbed my leg and twisted my whole body around, well my leg, he almost broke my leg. And he fought me three or four times, just every time I talked to him, he had to fight me. It was very, very unnerving, very worrying.

I: Did you feel you could be protected by the staff?

P: Not really, no, because he kept coming on, he kept wanting to fight me so it was very difficult to avoid him.

I: And what about when he did start fighting you, could you call for staff or call for help?

P: Well I suppose so but it's very difficult. It wasn't easy to get the staff to help. (PP6)

Contained within both of these accounts is a sense of staff as unwilling or unable to help. There is a sense that staff cannot be everywhere, all the time, but also that this belief has led to an attitude of resignation in both staff members and patients. The first participant described staff as becoming defensive when threatening behaviour was reported to them and the second participant described not feeling it worth calling to the attention of staff that he experienced violent behaviour.

For another participant the presence of staff did evoke a sense of safety. However this sense of safety was only available to him when staff were directly visible:

P: When the nursing staff were around I felt safer, because I thought they were observing what was going on and would potentially stop any fights.

I: So there were times when the nursing staff weren't around?

P: Yes.

I: And then you didn't feel things were quite so?

I: Safe. Breakfast time for instance. When people are clustered around the cereal, I felt that potentially somebody might throw hot milk over somebody.

P: So that felt like a time that wasn't particularly safe?

I: No, because staff were behind the bar and there was nobody in the front area of the dining room. (PP9)

One way in which patients' perception of staff, as able to protect them, was formed seemed to be with regard to the action that staff took after incidents occurred that directly impacted the patient's sense of personal safety. This participant recounted a theft of his personal property:

Regarding the money that was stolen from me, I did complain to the nurses, but they did nothing ... that's why I had to take my own initiative.(PP1)

In this instance, even though the participant reported the theft to staff no action was taken. The participant described being left to rely on his own resources to resolve the matter. However another participant recounted feeling safe after reporting an incident to staff, in which she was assaulted by her roommate:

I: When the woman punched you, did you tell the staff?

P: Yes, they know...the doctor, a lady, came with me and the manager and staff too. They give me much comfort, they protect me, no happen nothing, they change me the room immediately.

I: So you didn't have to share with her anymore?

P: For safety.

I: So that made you feel good?

P: Yes, yes.

I: So they very quickly changed the room?

P: They quickly changed me the room, yes. And interfere immediately, the staff. (PP7)

It would seem that in this incident staff were able to take immediate, concrete and effective action. The immediate consequence of this was that the participant's physical safety was protected, but a more long term consequence was that the participant was able to preserve a feeling of being safe and protected on the ward.

Ability of Staff to Listen and Understand Patients

Connected to staff's ability to take action when patients report specific incidents, or feeling unsafe, is staff's ability to listen and understand – if staff do not hear patients' distress they cannot act, and if patients do not feel staff listen, they cannot feel understood. Not being listened to can lead to a profound sense of powerlessness as the following excerpt reveals:

They didn't listen to me about what I was feeling, about what I wanted. And when I said I didn't want to take the medication they said that I was treating this place as a hotel. And that I was playing at being sick and that I was

attention seeking ... It made me feel, made me feel really small, and insignificant, as if I had no rights, I had no right to say anything. (PP3)

For some patients their relationship with staff is so negative that they feel unable to even begin the process of talking to staff that might eventually lead to experiencing a sense of being understood. This participant reports feeling too fearful of staff to speak to them about a patient who had threatened her:

I'm too frightened of them...I'm terrified of them, terrified. I'm terrified of being jabbed in the bottom or being put in their cooler. So I'm too frightened of them, terrible state of affairs. And this is supposed to be a hospital. (PP5)

For this participant, the defining events in her relationship with staff are being placed in seclusion and being forcibly given medication. As such, the emotion that seems to characterise her relationship with staff would seem to be fear. To be fearful of staff, places the individual in a uniquely vulnerable position: for if the individual feels they need to be protected from the staff, to whom can they turn for that protection?

Patients' Aversive experience of Staff

Some participants spoke of times when they had had experiences of staff that had left them feeling frightened and unsafe. One female participant told of times, on other wards, when she felt she had been abused by staff members:

I think as a woman you're not safe from the male patients and some of the male staff. Because I've been, on two occasions, when I was in a private hospital, and I was on [ward name], and on several occasions the male staff tried to - I think it was abuse - they would try and touch me and say they were my friend. And when you're in hospital as a woman you're vulnerable, more vulnerable than a male patient. I think you are anyway. I'm not saying all male staff would abuse you, but there are some male staff that take advantage of your situation and if you are on a section and you can't get away, what are you supposed to do? (PP3)

This participant felt especially vulnerable on the ward because of her gender. The particular sense of helplessness and hopelessness, engendered by a view of staff as persecuting and attacking, was painfully evident in her final question.

This sense of helplessness was again apparent in the following quote from another female participant:

P: The seclusion room I don't like, because of my experience in the eighties once when I was given an injection. I was assaulted by a nurse.

I: In hospital?

P: Yeah.

I: And that happened in the?

P: Sexually abused by a nurse, it happened in the eighties.

I: Where you able to report that?

P: I didn't report it because I felt that I didn't have any rights because I was mentally ill. I thought no one would believe me so I didn't bother. (PP2)

This participant described feeling that the veracity of her account of her assault would inevitably be questioned, because of knowledge of her mental health problems. This belief that her diagnosis means she will not be believed, prevented her from feeling able, or feeling that there would be any point, to report any abuse that might be perpetrated against her. Placed in this context, her comment, when asked about whether or not she felt safe on the ward, that, "I don't trust anybody, not even you", seems perfectly understandable.

For another female participant her principal fear of staff revolved around a fear of male staff prurience:

I object to the male staff coming into the room, the male doctors don't do it, nobody else does it, the male nurses are all in and out in the middle of the night. There's plenty of female nurses on duty, instead of which we're half naked, we've got all these ... men appearing at us in the middle of the night. I don't like that ... I think it's rather prurient of them to be perfectly honest. It is prurience, men, male nurses are just as prurient as all other males. The place is full of Irish girls, Australian girls, Scottish girls [nurses], but why is it the men

are always showing up? It's because they're fucking prurient, sorry to swear, that's my feeling anyhow - a glimpse of a piece of ...female flesh. (PP5)

For this participant, the presence of male staff at night checking the rooms was experienced as deeply threatening. Because of the presence of other female staff on the ward, who could check the female patient rooms, the participant interpreted the male staff's checking as having a sexual motive, rather than being driven by a concern for patients' safety. Her fear of possible sexual assault by male staff members was further compounded by witnessing the distress of her roommate:

P: The woman across the bed from me today she had a knife...

I: And what did the staff do about that?

P: I don't know what they did about that, I said right, I'm leaving the room, I can't stand it here, because she started shrieking and I thought, if there's a knife, and it was obviously a sharp one ... she said she wanted it for self protection and I don't blame her. She said one of the men, one of the nurses was molesting her last night and that's possibly true. And I heard her shrieking at it, "don't you touch me, you've done it before and you're not doing it again". (PP5).

In this instance the staff were able to safely remove the knife that the participant referred to, however there is a sense that whilst something dangerous has been removed, so has something that might have been protective. Even though staff have taken swift action there is no sense that a feeling of safety has been regained, since the patient has a perception of staff as potentially assaultive.

Patients' Experience of Significant Events

Patients' perceptions of staff are formed by their interactions with staff. The way that staff behave and carry out duties such as seclusion and the forcible administration of medication have consequences with regard to whether or not patients feel safe with staff members. However these events can have an effect on patients' sense of safety in

their own right. Participants reported not only experiencing these events as extremely frightening, but being left fearful that they would happen again.

Seclusion

Participants identified two frightening aspects of seclusion: the process of being forcibly taken into seclusion, and the being left alone in the seclusion cell. A female participant described her experience of seclusion on another ward:

When I was in the secure unit, I don't understand how people, how the nurses minds work, because when I was on the secure unit I tried to drown myself in the bath and they pulled me out of the bath and then they restrained me on the floor and then they took me to - they wouldn't let me get up - and then they took me - there was about six of them - and they took me into the seclusion room and took off my clothes, with male staff being there, and then they gave me an injection and left me in there. And when you've just tried to kill yourself you don't need people doing that to you, because they made me feel as if I did something wrong, as if I was a criminal.

I: Being in a seclusion cell must be frightening.

P: It is frightening, and they won't let you out for ages. You can't speak to anyone, you can't speak to the nurse, all you can do is bang the door. (PP3)

For this participant, the actions of the nursing staff following her suicide attempt were incomprehensible, only serving, from her perspective, to further alienate them from her. She describes her discomfort with regard to the presence of male staff during what is clearly an intimate procedure, and the sense that the treatment she received was punitive rather than caring. Finally she also describes a sense of profound isolation, the only means of communicating left available to her being to beat on a door. This sense of isolation was echoed by another participant:

When you're in there, that doors locked and you're in darkness, and you feel like the walls are going to crash in on you. It's very frightening, you know. (PP2)

Forcible Administration of Medication

Participants discussed both experiencing the forcible administration of medication themselves and witnessing others experiencing it. A male participant described his own experience of being given medication against his will:

When I'm getting injections I feel unsafe because they hold me down, they grab me and they hold me down, they give me the injection and I have to go to sleep for a few hours... Yeah, they used to grab me. I used to stop, get raring off a bit, they'd grab me, they'd all put me in the strip room, then they'd pull down my trousers and bosh, injection, very painful, very scary as well. It was like death row injections you know. (PP6)

For this participant the experience evoked images of execution and death. He also described witnessing other patients being given injections and hearing their screams.

Again fears of execution and murder were evoked:

P: I've seen patients come in, they're not being assaulted but they get an injection straight away, the staff all team up, round them up, put them in the strip cell, give them an injection. They're screaming sometimes.

I: So how does that make you feel?

P: It's very frightening sometimes, because you think 'is he going to die?' You think about a death squad or something - very frightening. (PP6)

A female participant described the method of injection administration as akin to molestation:

I don't feel at all safe. And people who keep jabbing needles in my bottom just because I'm not doing what they want, it make me feel positively molested and that's an offence in law (PP5)

However, for another female participant, watching another patient receiving an injection evoked a sense of safety. In halting English she told of her relief when a male patient, who she feared was potentially violent, was given medication, with the result that he went to sleep:

I: How does it feel when you see other people having injections forcibly, people being forced to have injections?

P: Normal, because I feel people care for me, maybe protect me. One day give him the injection, maybe safety, I feel safety, because once the people sleep, I feel safety.

I: So you feel a bit more comfortable when you see that happen.

P: Yes, yes, safety. (PP7)

Own Mental State

Aside from fears with regard to other patients, staff members or incidents on the ward, some participants described how their own mental state could leave them feeling unsafe. Two ways in which this occurred were identified. For one participant, the realisation that her illness had a deleterious effect on her decision making made her fearful for her own actions, and the consequences of those actions:

P: When you're ill you can do things that you don't know what you're doing...I slept with somebody and I don't think that that's a good thing because I could have got pregnant, or I could have caught a case of sexually transmitted disease...

I: So in a way one thing that makes you feel unsafe is your own - if your not feeling well, if you're not well?

P: Your own actions, especially if you don't get along with the nurses, you feel isolated. (PP2)

For another participant the altered perceptions and beliefs, consequent to his mental state, made him feel frightened:

P: That's quite scary, I was under the idea I was supposed to blow the other patients up, I was pointing my fingers at the other patients, I was clicking my fingers, you could hear it - but the patients are all still alive, I'm quite pleased. I got a lot of injections on [ward name], but the injections were playing mind games with me, when he put the injections in I thought I disappeared and when he took it out I thought I was a new body floating or something. It was terrible. (PP6)

Staff Accounts

This section concerns data drawn from interviews with staff members. Staff members were asked to think about what it might be like to be a patient on the ward, to reflect on their own feelings of safety and to think how these feelings and thoughts might affect their clinical work with patients on the ward.

As before, these experiences have, through the process of the analysis, been organised into 'Domains' and 'Themes'. Domains are higher order categories and were largely determined by the areas covered in the interview and partly by what participants spontaneously spoke about. Themes are lower order categories and, in a reversal of the previous emphasis, were largely determined by what participants spoke about and partly by the structure imposed by the interviewer.

Table 7 shows how these domains and themes have been organised. The domain, 'Fearful aspects of patient's experience on the ward' concerns staff's beliefs about what might be the more frightening aspects of being a patient on an acute ward. The domain, 'Impact of staff', contains two themes, 'Making it Better' - the ways in which the staff felt that they could help patients feel more safe, and 'Making it Worse' - the ways in which staff felt they might sometimes make patients feel less safe. The domain, 'Staff Feelings of Safety' contains two themes, 'When Staff Feel Unsafe' which explores the various situations in which staff reported feeling unsafe, and, 'Consequences of Staff Feeling Unsafe' which reports what staff think the effect of them feeling unsafe might be for the patients in their care. The domain, 'Impact on the recovery Process' contains staff's thoughts with regard to what impact they felt patients' feelings of safety, or otherwise, might have on their recovery.

Table 7. Domains and Themes Drawn from Staff Accounts

Domains (Higher Order Categories)	Themes (Lower Order Categories)
Fearful Aspects of Patients' Experience on the Ward	Admission
	Events
	Gender
Impact of Staff	Making it Better
	Making it Worse
Staff Feelings of Safety	When Staff Feel Unsafe
	Consequences of Staff Feeling Unsafe
Impact on the Recovery Process	

Fearful Aspects of Patients' Experience on the Ward

This section explores the various situations, events and circumstances that staff believed might cause patients to feel unsafe. Many similarities and differences emerged between the situations identified by staff and those identified by patient participants and these are explored in Chapter 4. One situation that staff thought might be particularly frightening for patients was admission. Other aspects of the experience that staff felt might be frightening were the witness or experience of various events on the ward, such as restraint and seclusion. Staff also felt that gender had an important impact on patients' feeling of safety.

Admission

Staff members identified a number of reasons why admission might be particularly frightening for those admitted, such as the myths that people might have about 'psychiatric patients', being admitted in the middle of the night, and having to share a room, possibly for the first time. This participant felt that the process of admission might make patients feel unsafe:

I think the whole process of being admitted to a psychiatric ward is very frightening. I think, you know, restricting your leave, the whole culture of the ward, the queuing up for the medication. (SP7)

For this staff member it was the institutionalised nature of the ward experience that she felt would be frightening. For another staff member it was the possibility of sharing a room with a group of strangers who have psychiatric diagnoses that he felt would be the most frightening:

To be admitted to a psychiatric ward... you might have to share a dormitory with three strangers in a four-bedded dormitory. I think that would be a very daunting prospect and certainly one I wouldn't want to do. I'm sure it's very difficult to sleep and to relax when there's three other people and you know they all have psychiatric illness as well. (SP2)

This staff member went on to describe how particularly frightening this would be if the admission took place at night:

You might be admitted... via A&E... in the middle of the night, and you've got to move into this dark room, with three other people sleeping there. I'm sure it's very worrying. (SP2)

Many staff members seemed most able to empathise with patients for whom it was a first admission to psychiatric services. This was thought of as a particularly frightening experience:

If it was my first admission I would say it's probably terrifying... completely, I don't know about people who have been more than once. But for first time patients it's probably quite a terrifying experience. (SP3)

One of the reasons why a first time admission was thought to be so frightening was because of the prevalence, amongst the general public, of negative stereotypes of people with mental health problems:

Especially people who've first been admitted, there's all these myths about psychiatric patients, that they're axe murderers, that they'll stab you and stuff, so I'm sure it's all very worrying. (SP2)

This view was shared by another staff member who provided an observation to support his view of first admissions as a time of particular fearfulness:

I would say it's a very frightening experience because almost every time that someone is admitted for the first time they try by all means to get out. They are constantly asking to leave. So, plus, you know they've never been in there, the prejudices they've known from outside, that they have heard about being on a mental health ward, they don't know what to expect. I think they felt very, very unsafe about such a situation. (SP5)

However there was no sense from staff that experience of, and interaction with, other patients corrected misconceptions and reduced anxiety. Rather staff suggested that newly admitted patients' observation of other patients on the ward only served to make them more fearful for the future:

There's people who sort of never had any experience and maybe they look at people and kind of think, my god, is that what I'm going to be like? (SP1)

Fear for the future was also thought to be evoked by patients watching others being restrained:

It's fear if they get aggressive, they think how would I be treated if I became angry? If I was angry, particularly when they see patients being seized and pushed down on the floor, when the heavies come in, as it were, when they see four big blokes holding someone down and dragging them to the seclusion room (SP6)

Events

Staff discussed a range of events that occurred on the ward that they believed might cause patients to feel unsafe. Restraint was thought to be a particularly frightening experience both for the observer and for the individual restrained:

Sometimes we have to restrain other patients or even that patient themselves. And that must be terrifying, absolutely terrifying...it must make them think, what if this happens to me? Am I next?...it must feel like being attacked. Although we're all trained to do that in a harmless way, without inflicting any pain...it just must be terrifying. I wouldn't like to be on the receiving end at all. (SP3)

Another staff member echoed the idea of restraint being experienced as attack, and as an attack with a particularly worrying motive:

Well can you imagine what it's like to be restrained, you've just come into hospital and you're restrained by six men and they bring you to this room. Well I know what would be going through my head, you'd think you were going to get...raped ...especially if you don't know anything about the psychiatric services and you don't know you have a psychiatric illness and there's people holding you down, six big men holding you down. You'd think, I'm going to get raped here. (SP2)

Seclusion was also viewed by staff as a frightening experience. One participant had researched patients' experience of seclusion as part of her training:

The majority of them feel frightened, very few said they feel safe, some did say they felt safe - about 15 %...85 % feel frightened, they feel isolated, they feel punished. (SP7)

This participant described a sense that patients experienced seclusion as a punishment, rather than as a procedure intended to ensure their safety. Another participant noticed how patients' fear of seclusion became acted out in their interactions with staff:

I've noticed that other patients, no matter how little their disruption may be, if staff tend to come in to try to calm them down, other patients have been really, really frightened, thinking they're being taken into seclusion. So I should think from that point of view it should really be a very traumatic experience being locked up in there. (SP5)

One staff member spoke of how it felt to be involved in the forcible administration of medication:

It is frightening when you're approached by three or four members of staff who are going to inject you whether you want it or not. Yeah, it's horrible. It's horrible having to do that as a nurse sometimes...It's horrible for the patients...it really damages the nurse patient relationship. (SP7)

For this staff member, the realisation of how unpleasant and frightening the experience of being forcibly given medication could be, made it hard for her to be involved in the procedure. Not least among her concerns was the damaging effect that she believed such a procedure had on her relationships with the patients in her care.

Gender

Gender was thought to have an impact on patients' feelings of safety in the context of both other patients' gender and the gender of staff. One staff member commented on how female patients were vulnerable for sexual harassment on the ward:

You're a female patient, you've got psychiatric patients who've got no outlet for their sexual expression, they see female patients and they're going to approach them with 'sexual requests'. (SP2)

The same staff member also commented on how female patients could find male staff threatening:

Female patients can sometimes be scared of male staff ...and I'm sure they could feel unsafe if they had to deal with totally male staff. (SP2)

Another male staff member spoke of his awareness of the impact his gender could have on female patients:

It's important that I demonstrate sensitivity ... going into a female-only area...I'm aware that I could have a particularly frightening impact on somebody who's feeling particularly vulnerable. (SP6)

A female staff member told of complaints that female patients had made with regard to male staff entering the female patient area:

Men do have to go into the female dormitories to see who's there, and we have had women complaining about that (SP3)

However she also told of how, although staff initially responded sensitively to these complaints, such sensitivity did not always endure:

But, saying that, patients make complaints every now and then and then it's stepped up, you know people are more cautious for a while. But I think it wears off after a while until people are reminded. (SP3)

Implicit in the above account is the idea that whilst staff may sometimes know what it is that they can do to make patients feel less unsafe it is often hard for them to remember to do it.

Impact of Staff

This domain contains accounts from staff of how they believed their actions could influence patients' feelings of safety, in both positive and negative ways.

Making it Better

Staff identified a number of ways that they felt they could help patients feel more safe, such as offering reassurance and support at admission, after violent incidents and during restraint.

Many staff had identified the admission process as a time when they felt patients would feel particularly unsafe and this staff member told of how important she felt it was to ensure that patients were not left unattended at this frightening time:

You can have a big impact when you meet the person when they first come in and in that first half an hour it's very important that the person feels ok. If the person's just left on their own, which often happens, it might be busy time - 'have a seat in the day room, the doctor will come and see you' - that can increase anxiety. So the admission process would probably improve if there was somebody allocated to do the admission before the person arrived and explore whether the person needs somebody with them or not. (SP7)

Another staff member had other practical suggestions, again focusing on first time admissions:

Well giving them side rooms, just trying to spend really a lot of time with them, encouraging their relatives, if they've got relatives, to be around a lot. I suppose just trying to make the environment as safe for them as they can really, lots of reassurance...a lot of contact...so they don't feel alone. (SP1)

Her suggestions were threefold: to offer reassurance, to ensure continuity of family contact, and if possible to ensure vulnerable patients have their own room rather than being expected to share with other patients. The idea of being available to reassure patients rather than being closeted away in a staff room, was echoed by another staff member:

Reassuring them and just being available to them as well which can be difficult at times since there are so many patients and so few staff...but you know, within reason we need to be there for everybody and not locked in the office as sometimes happens. (SP3)

Being available to give reassurance was also felt to be helpful at times on the ward other than admission, such as after a violent incident:

I think a lot of the time, when that sort of thing is going on, staff tend to concentrate on that particular patient and there's a lot of staff with that one patient, but we need to think about the other patients as well and make sure that somebody is with them and everyone's not just away from them, and they're just standing watching whatever's going on. People need to be with them saying, "it's all under control", even if it's not. Reassuring them that we're not going to let things get out of hand (SP3)

Another staff member reiterated this point, stressing the difference that such a small intervention could make to patients:

But it makes such a difference if you just go out and take thirty seconds to explain what's going...just giving some information - the reassurance can help a lot. (SP7)

These suggestions referred to reassurance given to patients who witnessed violent incidents on the ward. However staff also spoke of the importance of giving

reassurance and information to patients who were in the process of being restrained and were actively involved in the incidents themselves:

Reassurance, communicating, and trying to give them as much dignity as possible...keeping other people away so there aren't people standing around staring, getting them somewhere where it's sort of private... talking through exactly what you're doing - often they aren't in a state where they'll understand what you're saying, but at least you say exactly what you're going to do, so...that there are not just people kind of man-handling them and they don't know what's going on. (SP1)

This staff member stressed the importance of giving information to patients being restrained, perhaps mindful of the fears and fantasies that she thought that patients might have about the possible motives behind the restraint. Another staff member was concerned with the end point of the restraint process – seclusion. For this participant, if patients were to feel safe and protected, it was important not to abandon them at this stage:

Maintain contact through the window or stand outside and talk to them through the door. Just don't leave them, explain to them how long they're going to be in there, what we have to do now, why we're doing it. (SP7)

In summary, many staff felt that patients' feelings of safety could be facilitated by improvements in communication with staff - offering reassurance, explanation, and 'running commentary'.

Making it Worse

In contrast, many staff felt that patients felt less safe when communication with staff was impeded – when staff were taciturn, surly, or unavailable. Lack of contact and communication with patients by staff was felt to be a major factor in making patients feel unsafe on the ward. Staff discussed a variety of factors that they felt could

influence the quality of staff-patient communication. One important factor was, quite simply, the amount of time staff had available to them:

You can come in and then just feel kind of abandoned...especially if the ward's busy, you just don't have enough time for the patients sometimes. It's just one of those things, if the wards short staffed... the first thing to suffer is the patient contact. (SP1)

Another staff member explained how this happened:

I've done it myself, I've said, can I come and see you in ten minutes - you've forgotten about it, they've had to come back and see you later on. (SP2)

Such busyness can result in the staff being viewed as intimidating:

I think that sometimes nursing staff can be intimidating, even though they don't mean it... you know, you've got 29 patients, you're in charge of a busy ward, you're seeing someone, so people are afraid to come and ask for something else, something simple (SP2)

Patients were seen to be very sensitive to individual staff's ability to listen to them, discriminating between approachable and unapproachable staff:

Some of the staff ... are very unapproachable. You know you can actually see the dynamics at play, patients really are more inclined to approach some staff than others, depending on how they relate to them. Some staff are not very sympathetic, or empathetic with patients. I wouldn't say it amounts to bullying them, but I've noticed that some staff are not really approachable by patients. So I think that would contribute quite a lot to feelings of unsafety. (SP3)

One way in which patients and staff were seen to become estranged from one another was by the adoption, by staff, of a 'them and us' attitude:

Certain staff...have that kind of 'them and us' attitude...I think there's a really fine line between being a patient and not being a patient. Some people...they're quite condescending or treat patients as if they're lesser people, which can be very humiliating and very distressing. I think it's about sort of - 'I'm the member of staff and you're the patient and you've got to do what I'm told and you're in here and I'm sort of the better person or the stronger person'. I think that can make someone feel very unsafe, sort of have their dignity or their rights taken away (SP1).

While the effect of such an attitude might very well be to make patients feel unsafe, its function for staff members is likely to be to protect them from uncomfortable

feelings generated from a genuine understanding of patients' experience. This view of patients as inherently different gives staff respite from painful empathy and allows them to carry out their duties with less discomfort. Such a state of 'not thinking' can also protect staff themselves from feeling unsafe.

Staff Feelings of Safety

This section explores times and circumstances when staff felt unsafe and also the consequences for patients of staff having those feelings.

When Staff Feel Unsafe

All the staff interviewed spoke of times when they felt unsafe on the ward. A range of situations and circumstances in which they felt unsafe were identified. These included being hit, experiencing sexual harassment and assault, working with a high proportion of unqualified or temporary staff, and during the admission of potentially violent patients. This staff member spoke of specific fears of physical assault:

We're all shitting ourselves, we all work with someone who's got a scar there, or some bit of a scar somewhere, or had a serious accident. We're front-line for getting assaulted, front-line. We're the highest statistic - mental health nurses. It's so scary, you don't want to get a chair in you back, you know, vicious, vicious assaults. (SP7)

A female staff member spoke of having to deal with sexual harassment from male patients on the ward:

My major concern is young men on the ward because a lot of the time they don't know what they are doing or they make a pass at me and that isn't nice and it's never going to be, but it's something I've got used to, because I've had to and you just brush it off.(SP3)

The same staff member described how she had to learn to live with this level of harassment. However, she went on to describe how 'brushing off' incidents was not always a viable option:

But sometimes...I remember once, when I first started here, I was in the smoking room with one male patient, he pinned me up against the wall and went to kiss me and there was nobody else in the room, there was nobody around and there was no alarm bell in that room. And luckily he stopped, but I did try to push him off and there's no way I could have done anything and I wouldn't have been able to get away. That is very worrying and I think we should all have alarms on us, never mind the alarms on the wall, because if it's on the other side of the room or just outside the door, it's no help whatsoever. (SP3)

The sexual assault that this staff member experienced left her feeling vulnerable and concerned that the facilities on the ward to protect her own personal safety were inadequate. Another female staff member described feeling vulnerable when having to admit a patient in the middle of the night:

One unsafe time on the ward is when you get a new admission in that's come in via the police, out of hours, and we don't really know what's happened or who they are... This has happened to me, it's four o'clock in the morning, don't know who he is, never been on the ward before, picked him up with no clothes on...they're with six riot police. So the riot police go, take the cuffs off ...and they leave the patient with you - me like! And maybe an agency nurse and a junior...That is scary. (SP7)

This staff member described a fear that the other staff members may not be sufficiently experienced - being too junior, or being temporary staff - to be able to deal with a potentially dangerous situation - the admission of a patient who required six riot police. Other staff members described feeling unsafe when they felt they were unsupported by other staff, possibly because such staff were 'agency' (temporary) staff:

There's been times when I've been the only regular member of staff on a night shift and if a patient is behaving aggressively and you're not confident in the other member of staff's ability to deal with it...it's quite frightening...if the other staff are agency...I certainly feel less unsafe when I know I'm working with regular staff, or agency staff that I know are competent to deal with an aggressive incident. I feel then... they'll be able to respond spontaneously and will be able to deal with the incident. If I'm not confident of that it's quite frightening. (SP6)

This staff member's sense of safety came from a confidence in his fellow staff members' ability to cope with dangerous incidents. When he was working with temporary staff who he did not know, he could not be sure of their competence, or that the way that they would respond to a violent incident would be compatible with his own way of responding. It was not working with agency staff per se that was a problem, but working with agency staff who he did not know.

Another staff member spoke of how the combination of a busy ward and unpredictable patients could leave him feeling unsafe:

Sometimes it's just been because the ward's so busy there's just so much going on. And sometimes it's because you've got one or two patients who you know are very unpredictable and you're just not sure what they're going to do and that can be very threatening. (SP1)

The same staff member felt that patients were very sensitive to the feelings of staff and could detect when staff felt unsafe:

I think as well patients know when staff are unsure, or not in control, or scared. I think patients sense that a lot of the time. It's very important...not giving any kind of inkling to a patient that you are scared and that you are worried. (SP1)

Contained within this account is an idea that there are consequences to staff feeling unsafe and to patients realising this.

Consequences of Staff Feeling Unsafe

Staff spoke about feeling unsafe as having an effect in two ways: on the way that they worked and on the patients themselves. This staff member spoke about the impact that his feeling unsafe had had on his patients:

I think it must do. I don't think that I can completely hide my feelings. It must come across somehow...If I can pick it up in the patients I'm sure they can pick it up in me. ...If they know that I'm frightened, if they know they can get

a response, they may utilise that...to get the response that they want... to take advantage of that. (SP6)

Embedded in this account is an idea that patients may in some way 'take advantage' of instances when staff felt unsafe, an idea that patients are in an antagonistic relationship with staff and will use any perceived weakness in staff for their own gain.

This idea was also echoed by another staff member:

I think they push boundaries - some obviously will just feel more unsafe. I think patients who can will just try and push the boundaries, take advantage of that really. (SP1)

However this staff member believed that staff feeling unsafe might have effect in a more direct way – patients might feel unsafe too. Nevertheless the fear of patients 'taking advantage' seems uppermost in this staff member's mind.

The accounts above contain a sense that patients can pick up when staff are feeling unsafe because staff behave differently on the ward at these times. This staff member spoke about how staff do behave when they feel unsafe:

They're afraid to go about their usual nursing duties, and what they should be doing for the patients in terms of their duties towards them as named nurses and members of a multi-disciplinary team. They're just worried about getting their shift out of the way without getting hit, not worrying about getting the patient discharged. (SP2)

In this account there is a sense that staff feeling unsafe results in their being able only to perform the most rudimentary of their duties for their patients. Another staff member spoke of how feeling afraid had affected how he had responded to a challenging patient:

I had to be equally confrontational which doesn't help matters at all, because I thought there was no way - I was just trapped in a corner - there was no way to react to a threatening situation. The last thing that you need is to react in an equal way. But if I had been given the support I would have acted differently...I wouldn't have been confrontational, I would have been more calm about the situation and tried to talk reasonably to the patient. I wouldn't have had to equally raise my voice in equal measure to the patient. (SP5)

For this staff member, feeling afraid and unsupported on another ward, meant he was unable to react in a calm and measured way to a confrontational patient and became equally confrontational.

Impact on the Recovery Process

Many staff spoke of their concerns with regard to whether the ward environment was one that was therapeutic for patients:

I've seen patients come into hospital, get better and then before we've had a chance to discharge them they've got worse again, possibly because sometimes the ward's very disturbed and, you know, it's disturbed them...I think the more settled the ward is the easier it is for people to get better. (SP1)

The concern voiced by this participant was that the unpredictable and possibly violent atmosphere on the ward had had an adverse effect on the patient's mental state.

Another staff member spoke about the effect that he believed experiencing an assault would have on the patient:

It's soul destroying for the patient, it's like if you were just assaulted in the street, you'd think, why was I assaulted? It'd effect your confidence, you'd be worried about your safety, maybe you wouldn't go about your normal life anymore. And it's exactly the same if someone is on a psychiatric ward. (SP2)

This fear that, in certain instances, the ward environment may actually be aversive to patients' mental health was apparent in the exasperation with which he described his attempts to make the ward a safer place for patients:

Admission wards are supposed to safe places where you're supposed to get better. You're supposed to have hotel-like accommodation, you're supposed to be able to get better, to come outside. You're not supposed to be assaulted. (SP2).

Staff members spoke of the ways that they thought patients' experience of violence on the ward might affect their mental health. This staff member thought that experiences on the ward might evoke painful experiences from the past:

I think it's really quite traumatic. Because some violent incidents are really, really, very violent...because...suppose their illness has got something to do with violence when they are young ... If that is something to do with their illness, they are constantly coming across reminders in the form of violence on the ward, feelings of unsafety on the ward. I think that would have a profound effect on their lack of recovery. (SP5)

For this staff member the ward environment seemed almost iatrogenic: the violence experienced on the ward by the patients linked to the very causes of their mental health problems. Another staff member spoke of how patients' paranoia might be confirmed by their experiences on the ward:

If someone's paranoid you're trying to reassure them that their paranoia is not founded, when in actual fact some of the paranoia may be founded. And you've got to work around that... You might say, "oh, it's quite safe today", but half an hour after you discussion, you find another incident occurs. (SP6)

One staff member, however, did feel that the ward was a place in which patients could feel safe and recover:

They feel safer here, than the community, some of the patients... Because they often say, "it's a wicked world outside". I don't know if it's the right thing to say but they do. Often they ring up in the night to talk to staff. You know it's a feeling of safety, isn't it? A feeling of being comforted that they ring up. (SP4)

Chapter 4: Discussion

Overview

In this chapter the findings of the study will be discussed in relation to the existing literature. Strengths and limitations of the study will be explored in terms of methodological issues and potentially profitable future avenues of research will be suggested. Finally, the implications of the findings will be discussed in terms of their clinical relevance and the pointers they provide for better practice.

Study Findings

This study aimed to explore the experience of being a patient on an acute mental health ward, with regard to feelings of safety from the perspective of both patients and staff. The study asked a number of questions: What are the fearful aspects of the experience of being a patient on an acute mental health ward? What is the impact of gender on this experience? What impact do staff have on this experience? These questions will be discussed in turn as will the similarities and differences between staff and patients accounts. However, as is discussed in a later section, because of the scale of this study, caution must be exercised with regard to making inferences about the differences between the attitudes and beliefs of mental health users and staff in the wider, general population.

Fearful Aspects of the Experience

Patients and staff identified many fearful aspects of the experience of being a patient on a mental health ward. With regard to some areas there was broad agreement, but in other areas opinions differed and in this section some possible reasons for these differences and the effect that such differences may have had are discussed.

Fear of 'Mental patients'

Both patients and staff identified other patients as sources of patients' fearful experience, but in different ways. Staff tended to focus on fear of other patients in terms of fear of 'mental patients' engendered by societal myths and stereotypes. Staff members commented that they felt patients would be intimidated by other acutely unwell patients – the 'mad' aspects of the fellow residents of a psychiatric ward. However patients spoke more in terms of being fearful of violence, abuse or coercion - the actions of other patients - rather than qualities intrinsic to those patients. None of the patients interviewed spoke of fear of other patients' mental illness, rather others' mental illness was used as a qualifier or explanation for aggressive actions, to make them understandable.

Admission

Both patients and staff identified admission as a very frightening time. Some patients felt that they were especially vulnerable at this time, but it was staff particularly who identified this time as frightening. It may be that staff found it easier to imagine the experience of first entering a psychiatric environment, because that experience was somehow closer to their own experience, than the experience of being a mental health patient with a long history of admissions. In other words, what was easier to imagine was themselves as they were now being admitted to the ward. What seemed harder for staff to imagine was how it would be to have an extended psychiatric 'career' as a patient and how that might feel. It might have been that this was too far from staff members' own experience, or that such an imagining was just too painful and frightening for staff members to countenance.

The idea of admission as a time of particular stress for patients and staff - since staff members identified the late night admission of a new unknown patient as a time when they themselves felt fearful - finds resonance in the Palmstierna et al. (1991) study. This study found that a large proportion of violent incidents occurring on a ward occurred soon after admission. It may be therefore that what contributed to this high proportion of violent incidents was not only the increased anxiety of patients, but staff also.

Assaults and Harassment

All patients spoke of times when they had been assaulted themselves or had witnessed others being assaulted. Some patients also spoke of having personal property stolen whilst they were on the ward and other patients spoke of experiencing verbal intimidation and threats. Whilst all spoke of these experiences as frightening, there was also a sense, in many cases, that these experiences changed how the patients felt on the ward – that patients who had felt safe up until the assault or threat, no longer did so afterwards. In Fry's (1987) terms therefore, the ward ceased to be a 'safe space' for these individuals. For one patient this loss was experienced in a very real way, the assault resulting in a desire to leave the ward to, in Garland's (1998) terms, return to a place of safety, a place the ward could no longer represent for him.

Witnessing assault and having personal property stolen both feature on Goldberg's (1990) list of most stressful events for patients. For the patient whose money had been stolen and who felt compelled to sleep on top of his possessions at night it would seem his stay on the ward was very stressful indeed.

Some patients spoke of having property stolen, or having been assaulted, and not having reported this. Reasons that were given for not reporting included a belief that they would not be believed because they were a 'mental patient', and feeling it would not be worth it as staff would not be able to do anything. This finding would seem to support the suggestion of Lion et al. (1981) that a substantial amount of assaults may not actually be reported, not only because staff do not report them in official incident reports, but also because patients themselves do not feel it worth reporting them to staff.

All the patients interviewed spoke of either being assaulted themselves or witnessing others being assaulted. However because the sample size of this study was small these results cannot be taken as confirmatory evidence of the Nibert et al. (1989) finding that over 70% of patients reported being threatened or abused whilst staying in psychiatric institutions. Nevertheless the findings of this study most certainly do not contradict it.

Restraint and Seclusion

Both staff and patients were in agreement with regard to their mutual dislike of restraint and seclusion. Patients spoke of the terror of being left alone in the 'cell'; of feeling that the restraint was a punishment - inappropriate and unnecessary; of the use of restraint making them feel terrified of the staff; of restraint feeling like molestation; and of fear of the effects of the drugs that were forcibly administered during restraint. Staff members spoke of thinking that restraint would feel like rape and that this would be a very real fear for many patients; of hating having to perform restraint; of

believing that the majority of patients were frightened by the experience of restraint, or the witness of others being restrained; and of feeling the act of restraint was deeply damaging to the nurse/patient relationship. With such strong negative feelings on both sides the finding of Depp (1976) that high levels of seclusion were associated with high levels of violence on psychiatric wards is perhaps not so surprising. One can very well imagine a vicious circle of high rates of seclusion leading to lower staff morale, patient frustration and resentment and this in turn leading to greater expressed aggression.

Impact of gender

With regard to the impact of gender on patients' feelings of safety, both male and female patients spoke of female patients as particularly vulnerable on the ward, especially to sexual harassment and assault. Female patients spoke of being continually pestered by male patients and of two distinct feelings of vulnerability. Firstly, feeling vulnerable because their own mental state might lead them to make decisions with regard to sexual activity that they ordinarily would not and secondly, feeling that to ensure their safety they needed the protection and good will of the male patients. Related to this was a feeling that they therefore had to be nice to the male patients and that male patients might take advantage of this.

There was little sense from the female patients interviewed that they perceived staff as able to protect them from the male patients. In fact female patients described feeling threatened by male staff. The account, by one female patient, of a man coming into the female area, taking off his clothes, and lying on a woman's bed, and of her belief that staff did not take this seriously, worryingly evokes the account of Wood and

Copperman (1996) of the man who walked into a female only dormitory, unchallenged and raped one of the residents. It would seem that women only areas are still not necessarily safe areas.

Staff members were more equivocal than patient participants with regard to who was more vulnerable on the ward, suggesting that male patients might also be vulnerable to the sexually disinhibited behaviour by female patients - a concern not shared by the male patients interviewed. The nature of this equivocality is illustrated by a female staff member who held a conviction, seemingly at odds with her own personal experience, that female patients were no more at risk, or vulnerable to feeling unsafe, than male patients on the ward. She related how an incident with a young male patient, in which he had attempted to kiss her, had resulted in her no longer allowing herself to be alone in a room with a patient. This also had the effect of her viewing young men on the ward as her major concern with regard to her safety. Yet she expressed the belief, with regard to female patients, that there was no reason for women to feel unsafe on the ward. One might speculate that an adoption of the 'them and us' attitude, discussed earlier, prevented this staff member from linking her own experience to that of her patients.

Difference in staff and patient attitudes, with respect to the impact of gender on feelings of safety, were also apparent in their comparative beliefs in the impact of staff gender on female patients. A number of female patients spoke of how uncomfortable and fearful the entry of male staff members into their bedroom areas made them, especially at night. Indeed many staff members related how patients had voiced these concerns to them. However staff seemed to find it difficult to act on

these concerns: the idea that male staff members might refrain from entering women's sleeping areas was not considered by any staff member, and the idea, that male staff members should knock before entering women's sleeping areas, was described as a procedure that was only partially adopted.

One might ask what would have to change for staff to take patients' comments, with regard to them feeling unsafe when male staff members entered sleeping areas, more seriously. It might be that it was difficult for male staff to consider that their presence might actually be threatening to female patients. Or it might be that if they did consider this, the consequences, in terms of the changes to nursing practice on the ward that would be required, would be too difficult and inconvenient to implement.

One might also wonder what effect staff not being able to hear patients concerns, or show understanding of those concerns, might have on patients' sense of agency, safety or, conversely, their feelings of helplessness. Either way staff's lack of response to patients' expressed concerns would be unlikely to foster therapeutic patient/staff relationships on the ward.

Impact of staff

The impact of staff on the experience of patients on the ward is discussed in two ways. Firstly the extent to which their ability to communicate with their patients impacted those patients feelings of safety and secondly, the extent to which staff members own feelings of safety affected their work and patients' feelings.

Staff/Patient Communication

Connected to staff's ability to hear patients concerns and fears is their ability to empathise with patients' experience. Most staff, when asked to imagine what it might be like for a patient to be admitted to the ward, said that they thought the experience would be terrifying. One senior staff member, who declined to take part in the study, did so because patients' feelings of safety were "not something [he had] thought about". One might wonder what made it difficult for this staff member to think about patients' feelings of safety, or other staff members to hear patients' concerns.

Systemic practitioners such as Tomm (1987) view difficulties in understanding - 'stuckness' - as representative of 'dilemmas'. Dilemmas occur when the resolution of a difficulty is apparent, but the perceived cost of that resolution too high. Staff on a busy acute ward would seem therefore to face a number of such 'dilemmas'. One dilemma that staff might face is how to reconcile their identity as caring workers with their place in a system that is terrifying. Another might be that to attempt to make the ward environment a 'safer-feeling' and more homely environment would require them to appraise that environment from the perspective of the patient. Becoming any more in touch with the terrifying aspect, or part, of the ward would make the aforementioned reconciliation even harder, since an honest appraisal of a system that can induce fear, leaves individuals open to feelings of disturbing ambivalence with regard to their place in that system. A third dilemma might be that to 'hear' patients' concerns, or empathise with them, would reduce the emotional distance that some staff placed between themselves and their patients. This distance is exemplified by the 'them and us' attitude of certain staff reported by staff members and would seem to

function to enable staff to protect themselves from painful emotion and to carry out some of their more unpleasant duties, such as restraint and seclusion.

Some idea of the negative aspect of this attitude can be found in the Lavender (1987) study that examined the effect of psychiatric nursing staff changing from wearing uniforms to wearing everyday clothes. The wearing of uniforms can be seen as a reinforcement of separate group identity for patients and staff - an increase in the 'them and us'. The abandonment of uniform therefore represents a lessening of the distance between staff and patients. In the Lavender (1987) study this was accompanied by a decrease in verbal aggression and an increase in the number of staff members that patients could identify as confidants - a facilitation of patient/staff communication. The negative aspect of a 'them and us' attitude in staff members therefore, is the increased isolation it engenders in patients and the increased frustration and aggression consequent to that isolation.

Nevertheless staff tended to have a particular direction in mind when they spoke of improving patient/staff communication. Staff identified giving information, for instance whilst in the process of restraining a patient or to other patients witnessing a restraint, as one of the most important ways that they could make patients feel safer on the ward. However a common complaint from patients was not that they were not given enough information or told enough about what was happening, but that staff did not listen to their concerns or act on them.

Staff Fears

Staff identified a number of instances when they themselves felt afraid and unsafe on the ward. This finding would seem to be in line with the finding of the Chaimowitz and Moscovitch (1991) study that many staff do indeed feel unsafe in mental health settings. Staff reported feeling unsafe during night-time admissions and when there was a high percentage of agency or temporary staff on duty. At these staff felt patients were able to sense how staff felt and would 'take advantage', or behave in problematic ways. Katz and Kirkland (1991) suggest that counter-transference processes may be in operation in such situations. Whilst staff would seem to interpret patients' actions and motives at these times as having a malevolent intent, it may be that it is staff members who are projecting their frightened feelings into patients at these times, and patients who are then acting out in aggressive or violent ways.

One of the reasons staff gave for feeling unsafe on the ward was working with a high proportion of agency staff. Research by James et al. (1990) suggested that they may have good reason to feel unsafe. James et al. (1990) found an association between increases in violent incidents and an increased proportion of agency staff on duty. They suggested that temporary staff might be less able to prevent violent incident occurring. However it may be that the very presence of such staff led to increased anxiety in the staff group as a whole and a less safe atmosphere on the ward.

Impact of Absences

Both Rachman's (1984) model of safety signals and Bowlby's (1973) model of human fear emphasise not only the presence of certain stimuli as evoking feelings of safety and fear but also their absence as having equivalent effect. Both staff and

patients spoke of the importance of family members maintaining contact with patients once they had been admitted to the ward. In terms of Rachman's model such family members represent safety signals and such contact therefore represents the continued availability of such signals and the possibility of a continued sense of safety.

For some patients the staff had come to represent safety figures. One patient spoke of feeling fearful at breakfast time when staff were unavailable or could not be seen. For this individual it was the absence of staff that evoked a sense of fear, to use Bowlby's words, this individual's words he became frightened by an absence. It may be therefore that one way of fostering a sense of safety on the ward is the maintenance of a visible presence of staff.

A Place of Safety?

Whilst many patients and staff described feeling unsafe and frightened on the ward there was also, in the accounts, a sense that aspects of the ward did represent a 'safe space' or 'place of safety' for patients. Garland (1998) speaks of the individual's need to seek containment at times of acute distress and perhaps this is what was being sought by the ex-patients who telephoned the ward in the middle of the night to speak to staff. As the staff member put it "it is a feeling of safety... a feeling of being comforted that they ring up"(SP4).

Strengths and Limitations of the Study

This study explored an important but unresearched area: the experience of being a patient on an acute mental health ward, with regard to feelings of safety from the perspective of both patients and staff. The safety of those who use inpatient mental

health facilities is an important area especially in the light of recent governmental policy statements. Research in this area has commonly adopted a quantitative approach, focusing on staff members rather than patients. More recently research has begun to explore the experiences of service users. This study adopted a qualitative approach that allowed service users voices to be heard, without the constraints inherent in a more quantitative technique, such as a questionnaire. Also, this study focused on the experience of both service users and staff and as such is the first that has incorporated both of these groups' perspectives. This has allowed an exploration of the differences and shared understandings between these two groups that contribute to ward dynamics and atmosphere.

However a limitation of a more qualitative approach, and one that uses small sample sizes, is the extent to which the findings are generalisable, i.e. the extent to which the sample used for this study is representative of the broader population of patients and staff. This issue will now be discussed as well as the extent to which participants' mental state affected the data and the methodological considerations inherent in a more qualitative approach.

Generalisability of Findings

The present study identified a range of areas of concern, with regard to safety, for both the patient participants and staff participants interviewed and it may be very well be that these areas of concern are shared by other service users and staff. However the scale of the study is not such that this can be stated unequivocally. As has been shown, some interesting differences were apparent between patients' accounts and staff members' accounts. However these differences may or may not be indicative of

more generalised differences between staff and patients' attitudes and beliefs. Caution must, therefore, be exercised with regard to making inferences with regard to the beliefs, attitudes and experiences of the wider population of mental health service users and staff.

Nevertheless the sample of patients comprised a broad range of ages and diagnoses and a comparative number of men and women were interviewed. One type of patient that was conspicuous by their absence from the sample was the patient for whom this would have been a first admission. Given some of the comments from staff with regard to how frightening a first admission might be this is unfortunate. However all of the patients in the sample had had, by definition, a first admission, and many were able to recall and reflect upon this experience.

In terms of the staff sample and the setting, the staff sample consisted of a broad range of ages and grades – from student nurse to 'H' grade. Given some of the comments from staff with regard to working with agency or temporary staff, it might have been interesting to have interviewed some agency staff to gain their perspective. Also all staff interviews were conducted with nursing staff. The study might have benefited from interviews with medical staff on the ward.

Participants' Mental State

The use of data gained from individuals currently experiencing psychological distress is potentially problematic in terms of the influence of the individual's mental state on the veracity of their perceptions. However the extent to which this is problematic is highly dependent on the theoretical and epistemological viewpoint adopted by

researcher or reader. A tension exists in clinical psychology research between two views: a positivist view of research that posits an externally verifiable reality; and a more postmodern, relativist position that views reality, or rather realities, as constructed by the individual in interaction with their environment, equally relevant and valuable and ultimately unverifiable (Barker, Pistrang and Elliott, 1994).

Whilst the tendency of the author would be to adopt the latter view, in some sense, for the purpose of this study, the argument is academic and immaterial. The subject of this study is patients' perception of safety and such perceptions, whether or not grounded in an externally verifiable 'reality', will effect the way they feel on the ward and the eventual course of their recovery, and must, therefore, be taken into account. To attempt to describe the patient experience and exclude accounts from those judged to have the veracity of their perceptions compromised by their mental state, would be, ultimately, an empty and meaningless exercise.

Nevertheless a number of difficulties became apparent during the interview process, partly as a consequence of the mental state of those interviewed. Some patient participants found it hard to concentrate on the subject, deviating from the point and at times becoming somewhat incoherent. Clinical judgement was required at these times with regard to whether to let the participant continue to speak about a topic, such as the reason for their admission, or re-focus them towards the subject of the study.

One issue that emerged early on in the study was with regard to the quality of the data that was obtained from participants. Participants found it easier to speak of what had

happened to them, rather than how they had felt or what they had thought. In essence what emerged in the interviews were vivid accounts of experience rather than protracted explorations of meaning. One result of this was that a decision was made to switch the method of analysis from a grounded theory approach (Pidgeon & Henwood, 1996) that would attempt to produce some form of grand theory of safety, to an integrative phenomenological approach (Smith, 1995) that presents data at a lower level of abstraction (Smith, 2001) and tells a coherent narrative of experience. This seemed justified in the light of the difficulties that some patient participants had reflecting on their current experiences. For such participants, who were currently in the midst of processing and living through difficult and frightening experiences, measured reflection and exploration of the nature of feelings of safety was simply not possible. However what such participants were able to do, in vivid and eloquent ways, was to describe their immediate lived experience. An integrative phenomenological approach provided a useful way of telling these stories.

Evaluating Qualitative Methodology

A number of authors have addressed the subject of evaluating qualitative methodology such as Stiles (1993), Smith (1996), and Elliott, Fischer and Rennie (1999). Elliott et al. (1999) have produced a set of guidelines for reviewing qualitative research in psychology with the intention of encouraging better 'quality control' in this area. These guidelines are a useful tool with which to evaluate such research and will now be used to think about the present study. However, the concepts of reliability and validity, drawn from a consideration of quantitative research methods do not map easily onto qualitative research.

Owning one's perspective

Elliott et al. (1999) stress the importance of research containing explicit reference to the researcher's theoretical orientations and personal anticipations. In the present study these are presented in the section, "Researcher's Perspective". One anticipation that the researcher had was that patients would have experienced some sense of feeling unsafe. In the light of this care was taken to allow participants to speak of times when they had felt safe on the ward. Also the researcher's orientation was largely influenced by psychodynamic and systemic models. As such the consideration of events on the ward largely focused on intra-psychic and inter-personal factors. It may be that a more social constructionist approach, that focused on issues of power and inequality would reveal other new and helpful ways of viewing interaction on the ward.

However a researcher's perspective is not a fixed entity. In the process of research, as new data emerges, the perspective of the researcher will change as this data is incorporated into his or her world view. This process is thought of as a process of 'reflexivity' – a consideration of the impact of the data on the researcher and thus on the process of the research itself. In this study the researcher was very much struck by the comment of one patient participant, early in the interview process, that she had no way of knowing whether or not she had been understood in the interview. The impact of this on the researcher was to make him work harder in subsequent interviews to establish a rapport with participants and also to reflect on the importance and meaning for patients of being understood.

Situating the sample

Readers need to be able to know about participants' backgrounds in order to both contextualise their comments and to judge the relevance of their comments to other persons and situations. In this study, a description of the participants was provided in terms of age, gender, diagnosis and for staff, grade. The Ward Atmosphere Scale (Moos, 1996) was also used to provide a description of the ward environment. However, the scale proved difficult for both patients and staff to understand, especially as many of the items seemed designed for an American audience. Also many of the patients found it too tiring to fill out and were reluctant to complete it. If more patients had been willing to complete the scale it might have been possible to carry out some statistical analysis of the results, however this was unfortunately not the case.

Grounding in examples

The reader of a qualitative study, especially one that utilises an interpretative phenomenological approach, needs to be able to understand where the researcher's interpretations have come from and to be able to make his or her own interpretations from the data. As such it is important that the researchers ideas are supported by plentiful examples of text. In this study examples of text are provided for all themes discussed.

Providing credibility checks

Elliott et al. (1999) suggest a range of methods for checking the credibility of the categories constructed in the analysis. In this study an additional analytic 'auditor' - a

researcher with qualitative experience - was provided with a range of unlabelled quotes and a list of categories, the results of which are reported in chapter two. Additionally, a third researcher audited themes being identified at a number of intervals during the analytic process.

Coherence

Elliott et al. (1999) contend that understanding should be represented in a way that “achieves coherence and integration while preserving nuances in the data” (p. 228) and that this understanding should fit together to form a story. In this study the overall aim was for the stories and accounts of both patients and staff to be condensed into an organised narrative of the experience of being a patient on an acute mental health ward. However at some level individual differences between accounts must necessarily be lost. In this instance it is for the reader to judge whether coherence has been achieved without the loss of important difference.

Accomplishing general vs. specific research tasks

This study had a specific research task: the description of specific instances related to feelings of safety on an acute ward. Elliott et al. (1999) suggest that when the research task is specific rather than general, the study must be systematic and comprehensive and address limitations of extending the findings to other instances. The limitations of extending the findings of this study to other instances have been discussed in the section, “Generalisability of findings”.

Resonating with the reader

Finally, Elliott et al. (1999) state that the finished manuscript of a qualitative study must “resonate” with readers, such that they are able to achieve an expanded understanding and clarification of the subject matter. It is the hope of this study that such a task has been accomplished.

Areas for Future Research

Two avenues of future research are suggested by this study: the first would involve verification of findings and the second, further exploration and discovery.

Verification

One potentially profitable avenue for future research might be to attempt to ascertain to what extent the accounts and experiences contained in this study are shared by other service users and staff. It might be extremely useful, in terms of planning of services, to know whether such concerns, expressed by patient participants in this study, as worries about male staff entering female sleeping areas, and anxieties generated by multi-bedded rooms were indeed more generally shared. In terms of staff members, agency staff, though employed temporarily, played an important part in the running of the ward and it would be useful to explore their experiences and beliefs. It might also be useful to compare perceptions of safety on other types of wards, such as, forensic locked wards, and mental health intensive care units.

Question that would seem relevant are: Does the higher level of staffing on an intensive care unit result in a greater feeling of safety? Does the type of fellow patient - forensic or not - influence feelings of safety? Do patients with more admissions feel

safer, or does negative experience of mental health wards result in them feeling less safe?

Further exploration and discovery

One theme that emerged from the interviews with staff was the idea of a ‘them and us’ attitude towards staff and patient relations. This would seem to be an important area for further investigation as it was linked by both staff and patients to feelings of safety. It would be interesting to be able to explore this in more depth, perhaps focusing on ways in which staff manage uncomfortable feelings in their work, such as fear of assault and the feelings associated with forcibly restraining patients and administering medication. One might hypothesise that such beliefs and attitudes would have great influence on their clinical practice and interaction with the patients in their care. As such, this research would seem to have clear clinical utility.

In this study issues of gender emerged as an important point of consideration with regard to feelings of safety. However other issues of difference that could be profitably explored might be with regard to sexual orientation - how safe do mental health wards feel for lesbian and gay service users, and with regard to ethnicity - what role does persons’ ethnicity play in their feeling safe.

Implications of the Study for Services

Perhaps the most worrying finding of the study was that many of the participants indicated that they did not feel safe on the ward. There was a sense, especially from female patients, that not only were they vulnerable to assault, but that staff were unable to protect them. The areas of concern that patients and staff identified

suggested a number ways in which services might be improved to make patients feel safer. These included:

The provision of Single Rooms for all Patients

Both staff and patients spoke of their concern that patients had to share rooms with other patients who might be behaving inappropriately. The lack of single room accommodation and the use of multi-bedded rooms is problematic, not only in terms of its effect on patients' anxiety and distress, but also in terms of its effect on staff morale, as staff must listen to patients' very real concerns about their safety in this respect and find themselves powerless to act.

Gender Appropriate Nursing

Female patients spoke of how uncomfortable they felt in having aspects of their nursing care that contained more intimate elements, such as the enforced administration of medication, performed by male staff. They also spoke of their concern with regard to male staff entering female sleeping areas. Some staff shared these concerns, however there was a sense from staff that staffing constraints made it difficult for them to act on the concerns. The compromise that existed on the ward was that female staff would attempt to attend female patients, if staffing gender ratios on that shift allowed and if the staff remembered. However such an approach is problematic for patients as they continue to feel unsafe and feel their concerns have been unheard and, as before, is also problematic for staff as they must listen to patients' requests for change and know that they are powerless to effect them. The adoption of more gender appropriate nursing, therefore, would have the effect of empowering both patients and staff.

Improving Patient/Staff Communication

Staff spoke of the need to talk to patients more and to give information, and patients spoke of the need to be listened to by staff and understood. Improvements in patient/staff communication would have the effect of beginning to meet these similar needs. One way that would allow staff to listen to patients, and encourage patients to talk to staff would be to empower staff to act on patients' concerns, for instance, in the ways discussed above.

Another way to help staff be able to listen to patients would be to provide a space for staff to reflect on their own, and patients', experience. Individuals admitted to acute mental health wards are, by definition, experiencing acute distress. The troubling emotions they project, and the feelings they evoke in staff, need to be managed in more appropriate ways than by simply 'not hearing' and staff have every right to expect to be helped with this management. Many of the staff participants interviewed spoke of feeling that the interview had been useful for their clinical practice, in helping them to reflect and think about their work. There was an idea in their comments that they might work differently back on the ward, with greater consideration for minimising patients' fears for their safety.

Staff Training

Since exploration of patients' experiences in mental health wards is a relatively unresearched area it is perhaps not surprising that patients' experiences figure little in staff training. One junior staff member commented, when asked to think if her own feelings of unsafety might find echo in her patients' feelings, that the interview experience had made her think in ways she had not been required to do in her training,

or in her subsequent work. In the interview she had been able to reflect that patients might feel unsafe when they first came in and didn't know anyone, as she did when a new unknown patient first arrived, something she had not thought of before.

As has been said earlier, persons experiencing acute distress evoke powerful and uncomfortable feelings in those in contact with them and training needs to incorporate two things. Firstly, an understanding and consideration of the experience of being a patient on a mental health ward and secondly, an understanding and consideration of the feelings evoked in staff members and the ways, both functional and dysfunctional, in which those feelings may be managed.

Consultation with Service Users

Two points were clearly made by patients interviewed in this study: the importance of single bedrooms and a desire amongst female patients for gender appropriate nursing. However staff were unable to act on these concerns, partly because there existed constraints, both financial and organisational, that were beyond staff's control to influence. Whilst there existed on the ward a community meeting in which patients were able to voice concerns, for the reasons mentioned above it was hard for staff to be able to act on the concerns raised. What would seem to be required is a formal process whereby patients' concerns can be heard at the level of service planning, and where decisions with regard to financial prioritising and organisational structure can be made. Without such a process patients will continue to speak but not be heard and experience the psychological difficulties consequent to that.

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Appendix 1: Letter of Ethical Approval

**BRENT MEDICAL
ETHICS COMMITTEE**

**CENTRAL MIDDLESEX HOSPITAL
TRUST OFFICE
ACTON LANE
PARK ROYAL
LONDON NW10 7NS**

31st May 2000

Mr Daniel Wood
117 Cloudesley Road
London
N1 0EN

**Tel: 020 8453 2195
Fax: 020 8961 0012
e-mail beryl.frost@cmh-tr.nthames.nhs.uk**

Dear Mr Wood,

Re: BEC 693 - Perceptions of safety and threat amongst inpatient users of an acute psychiatric unit and a secure forensic unit.

The Ethics Committee considered the following documents at their meeting on 30 May 2000:

- Completed Application form
- Patient Information Sheet
- Semi-structured interview schedule
- Ward Atmosphere Scale Form R
- Proposal for Research Dissertation

I am pleased to tell you your project was approved. It is assumed that any negative feed-back from the interview will be individually addressed. You may proceed on the understanding that the researchers will observe strict confidentiality over the medical and personal records of these patients. It is suggested that this be achieved by avoidance of the subject's name or initials in the communication data. In the case of hospital patients, this can be done by using the hospital record number and in general practice the National Insurance number of a code agreed with the relevant general practitioners.

It should be noted:

1. The Ethics Committee's decision does not cover any resource implications, which may be involved in your project.
2. The Ethics Committee should be informed of any untoward development or changes in protocol that may occur during the course of your investigations. Please quote your BEC Number in any correspondence.
3. Where research involves computer data, this may be subject to the Data Protection Act.
4. The general practitioners of any volunteers taking part in research projects should be aware of their patients' participation.

5. Every care is taken to obtain the volunteers' informed consent to participate in the research project with the necessary help being provided for volunteers with language
6. One of the conditions of approval is the provision of a short report when the study has been completed, and we would be particularly interested in receiving this. We would also like to know if it had been published in a journal. Perhaps you would be kind enough to let us have this information at the appropriate time.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'K. Ryan', with a long horizontal flourish extending to the right.

Dr Kate Ryan
Chairman

Appendix 2: Patient Information Notice

Research Study - Volunteers Needed

I'm a researcher trying to find out what it feels like to be a patient on a ward such as [redacted] Ward. This information is useful because it can suggest ways in which wards like [redacted] Ward can be made safer and more comfortable places to be.

If you agree to take part you will be asked to fill in a short questionnaire and to discuss what it is like to be a patient on [redacted] Ward. Your contribution will be anonymous - your name will not be used. What you say will not be passed on to the staff unless you ask for it to be.

If at any time you wish to stop taking part in the study you are free to do so.

If you would be interested in taking part, or would just like to have a chat about what it would involve, please sign your name below, or have a word with [redacted]

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.....

This study has been approved by the [redacted] Medical Ethics Committee and is being carried out in conjunction with University College London.

Daniel Wood
Clinical Psychologist in Training

Appendix 3: Staff Participant's Letter of Invitation

Dear Colleague

As you may be aware I am conducting a research project on [deleted] Ward which is intended to explore what it is like to be a patient on an acute mental health ward, such as [deleted] ward, with regard to feelings of safety. I have conducted a number of interviews with patients and now intend to interview some staff members. The central focus of these interviews will be staff understandings of patients' experiences, and the interviews should take no longer than 30 minutes. I shall be approaching staff members over the next few days to see if they would be prepared to be interviewed. I would like to stress that staff members are under no obligation whatsoever to take part in this study.

If you agree to be interviewed the interview will be recorded. However your contribution will be treated anonymously - your name will not be put on the answer sheet, or linked with anything you discuss. Your identity will remain entirely confidential, and what you say to me will not be discussed with your line manager or indeed any [deleted] Ward Staff.

This study has been approved by the [deleted] Medical Ethics Committee and it is being carried out in conjunction with the Department of Psychology, [deleted] and the Sub-Department of Health Psychology, University College London.

Daniel Wood
Clinical Psychologist in Training

Appendix 4: Patient Participant Information Sheet

Participant information Sheet

The aim of this study is to find out what it is like to be a patient on a ward such as [deleted] Ward. This information is useful for us because it can help to suggest ways in which wards like [deleted] ward can be made safer and more comfortable places to be.

If you agree to take part you will be asked to fill in a short questionnaire and to discuss what it is like to be a patient on [deleted] ward.

The conversation will be recorded. However your contribution will be treated anonymously - your name will not be put on the answer sheet, or linked with anything you discuss. Your identity will remain entirely confidential. What you say to me will not be passed on to ward staff unless you ask for it to be.

This study has been approved by the [deleted] Medical Ethics Committee and it is being carried out in conjunction with the Department of Psychology, [deleted] and the Sub-Department of Health Psychology, University College London.

Daniel Wood
Clinical Psychologist in Training

Appendix 5: Staff Participant Information Sheet

Participant information Sheet

The aim of this study is to explore what it is like to be a patient on an acute mental health ward, such as [deleted] ward, with regard to feelings of safety. I have conducted a number of interviews with patients and am now interviewing staff members. The central focus of these interviews is staff understandings of patients' experiences. I would like to stress that staff members are under no obligation whatsoever to take part in this study.

If you agree to be interviewed the interview will be recorded. However your contribution will be treated anonymously - your name will not be put on the answer sheet, or linked with anything you discuss. Your identity will remain entirely confidential, and what you say to me will not be discussed with your line manager or indeed any [deleted] Ward Staff.

This study has been approved by the [deleted] Medical Ethics Committee and it is being carried out in conjunction with the Department of Psychology, [deleted] and the Sub-Department of Health Psychology, University College London.

Daniel Wood
Clinical Psychologist in Training

Appendix 6: Participant Consent Form

CONSENT TO RELEASE RECORDINGS

The reason we are recording conversations is to better understand the ways in which talking can be helpful: we use the tapes to listen carefully and repeatedly to each conversation. When we publish our findings, it is often useful if we can include verbatim extracts from the conversations (with names and other identifying factors removed). We will not do these things without your consent which you may withdraw at any time in the future.

Please circle Yes or No for each statement below.

I give my consent for all or part of the transcript of my conversation to be published in scientific journals or books.

Yes

No

If you have any questions about anything on this form please ask.

Name (please print)

Signature

Researcher's name (please print)

Researcher's signature

Date

Appendix 7: Interview Transcript

Staff interview 6

I: Can you tell me what grade you are?

P: I'm an E grade.

I: And how long have you been working on the ward?

P: I've been here since the 2nd week in May.

I: So that's about ten months. And how long have you worked in mental health?

P: This is my first post upon qualifying. I finished my training in April.

I: As you know the aim of the study is to find out what it feels like to be a patient on the ward especially with regard to feelings of safety. I wondered what your idea of what it would be like to be a patient here is? What do you think it would be like to be a patient on the ward?

P: It's quite changeable, the dynamics seem to change week in and week out. And particularly if I was in a dorm, I think it depends on the particular mix of patients at one point in time. You might share with patients who were reasonably quite or you might share with someone who was quite manic or aggressive at that particular time.

I: And what do you think that would be like?

P: It might be quite frightening. I might be frightened to go to sleep and settle down. I imagine I might prefer my own room. That's the other thing about being on the ward, from what I understand, is stuff being stolen.

I: Your own belongings? What do you think it would be like for people for whom it's their first experience of mental health services?

P: Quite sobering, I think it can be quite frightening for patients when it's their first experience.

I: Can you think of any attributes of the patients themselves that might make it more or less frightening?

P: Well there's delusionary beliefs and it's occasionally a quite hostile environment. The probability is quite high that

something of your delusions will be re-enforced through the dynamics of the ward.

I: So there would be an interaction between your state of mind and what is going on. So you think it would be the people with delusions who would have the most...

P: Or people with a very serious state of depression.

I: How do you think they might feel?

P: I think it's the intrusiveness...the patients are quite intrusive. I think if you were very deeply depressed that's going to be very difficult for you, quite frightening. Because you're struggling to work with your own insecurities even without the presence of anybody else.

I: Do you think there's anything that you have to do as a staff member that might make patients feel unsafe?

P: Yes, a number of factors, once again that depends on the mental state of the patient, but I'll just run through a few example. Medication for one. You're not quite sure what the medication's doing to you or why it's been given to you, or quite what the motives are behind being given that medication and part of it's the approach as well, what staff give, whether they offer explanations or not for example, once again, medication. The other thing is you are being quite constantly observed, even if you're not on special levels of observation like level two, every fifteen minutes. You're checked every hour, someone's going around and checking. I mean that can be quite comforting as well to know that someone's watching what's going on. At the same time you could feel quite paranoid, it could swing the other way and could re-enforce those feelings.

I: So what do you think about the way that staff give medication...you talked a bit about how it might make patients feel unsafe?

P: I think it's lack of information, you're frightened if you don't know. And I think you might say that if you give them that information, about what the side effects are, they most definitely won't take it. They're less likely to take it than they were before. But I don't think that's the case, because I think if you're frightened, you're assuming worse case scenario anyway. And if you're told that the worse thing you're likely to experience is some nausea, headaches, and if you've already taken it a few times and you've not experienced it you might think, oh well, what was I frightened of?

I: So that's an idea about the effects of the medication being frightening. Have you ever seen staff members do anything that you think might be frightening for a patient?

P: I think there's some staff members who can be quite abrupt to a patient in their approach. If somebody's new they're not used to the environment. I mean, for example, people who smoke, I think to introduce the fact that you don't smoke, you smoke in the smoking room. If they see other patients smoking outside the smoking room they might think, oh well, maybe the staff don't...take a fairly liberal view on it. You know, despite having told me this. And so they might smoke and then a particular staff member might go in and be particularly harsh with them.

I: Do you think there's anything that you can do that makes patients feel more safe on the ward?

P: Yes, I think particularly when someone's first been admitted even more so if it's their first admission, it's just to try and allocate time to them and orientate them to the ward environment, show them around the room area, introduce yourself to them, as soon as you can let them know who they can approach. If you're going to be the named nurse it's good to know straight away that they can see the person, that they can approach. Even things really low-key, like making them a drink, introducing them to other patients you think they might get on with.

I: Making those sort of social connections for them?

P: Definitely, so they don't feel quite as much alone, and offering them the opportunity to make a phone call. Particularly as they're unlikely to... at that point they may not have any money on them or any other property.

I: When people talk about safety what seems to spring to mind is when someone first comes. Do you think there are aspects, there are things, that are still frightening for people who have been in services a while?

P: Yes I think if you receive a particular treatment you don't like you can be frightened of receiving it again.

I: So do you mean like a drug regime?

P: Yes it could be a drug regime, or it could be a particular care plan.

I: So experiences of the past?

P: Yeah.

I: I wanted to talk a bit about gender and I wondered whether you though mixed wards felt more or less safe to patients?

P: Less safe, I wouldn't say that's the only variable in terms of considering the mix of a ward, but in terms of safety, perhaps from a female point of view, not quite so sure from a male point of view. Maybe from a male point of view you'd feel safer if there was a mixture.

I: So for men you think it would feel safer if there was a mixture?

P: Yes.

I: What about for females, for women?

P: I think for women...may feel...particularly male patients who are quite disinhibited or lacking key social skills in terms of making relationships it can be quite frightening. And don't get me wrong, there's other female patients who can be quite intimidating as well. I think in terms of your sexuality, you feel that to be particularly vulnerable. And from what I've heard expressed for female patients that is the case. So I was going to say that you can feel a little safer in the fact that there's a locked female area and where only staff have access to the keys. Obviously that's not encouraging for patients integrating outside. If they feel that's the only area where they're safe.

I: But not all women are in the locked/

P: Not all women can have access, because there's only five beds.

I: So how are decisions made about who goes in there and who doesn't?

P: Decisions are usually made on people who are most vulnerable, like emotionally fragile as in decision of who goes in there, it tends to be based upon...it's kind of a shame for women who can assert themselves who would appreciate being in that area.

I: How do you think your own gender impacts on patients' feelings of safety, do you think it does?

P: I think it does and it's important that I demonstrate sensitivity in that area if I'm doing the hourly checks and going into a female-only area I'll knock. And then when you go inside where

the bays are there's a curtain, but there's a bit of wood on the side and you can knock on that and make your presence known. You can hear them any way and sometimes see their feet, so it's not necessary to look in every time. Depends on the patient concerned of course. But I'm aware that I could have a particularly frightening impact on somebody who's feeling particularly vulnerable.

I: OK, on some wards violent incidents do occur and I wondered what you thought might be the impact on a patient of experiencing violence from another patient?

P: Towards themselves or just observing violence?

I: A violent attack perhaps or some sort of violence that involves another patient.

P: And they fear for their own safety? I think it's the fear of hostility and not knowing quite what's going to happen next.

I: Do you think they feel protected by staff in those incident?

P: They ought to and staff aren't around in every incident. You know when you see something potentially starting off, I think staff do need to be there to 'nip it in the bud' as it were, try and divert them away from a communal area as sensitively as you can, not trying to exacerbate any potential violence. Because you've also got to consider the therapeutic relationship with that person concerned. Plus you've got to consider the other patients. It's a difficult balance sometimes.

I: Thinking of the other patients, I wonder what effect you think it might have on them to see violence on the ward, not toward them but witnessing it toward other people?

P: Just seeing it happen? Apparently it can be quite disturbing. None of us enjoy it. When I got out to nightclubs and occasionally fights break out it's not very pleasant. Usually if I was in a bar or a night club when that happened wouldn't necessarily fear for my own safety. Although I think my instinct as a mental health nurse is to get involved!

I: Sort it out.

P: Yes, try and sort it out. But I imagine from a patient perspective it is quite frightening, the level of unpredictability. And it's fear if they get aggressive...they think, how would I be treated if I became angry? If I was angry...particularly when they see patients being seized and pushed down on the floor. When the heavies come in, as it were. When they see four big

blokes holding someone down and dragging them to the seclusion room.

I: And what do you think people might think if they are...if restraint does happen? How do you think that might be experienced?

P: That can vary from individual as well. I mean individuals who are used to getting involved in fights. You know, subjectively, not be quite as traumatised as people who haven't experienced a lot of hostility before their mental illness. Because there's a number of patients who, when they're not mentally ill are naturally quite gentle. So to suddenly experience a retaliation, as it were, and sort of people coming down quite heavy on them, they might find it quite frightening. And the seclusion room – it's like a prison really.

I: I wonder what you think it might be like to be in the seclusion room at that point.

P: It's wondering quite what'll happen next. And relief – once you're in there the staff aren't onto you, the door's been locked, you know you're not going to have to face further restraint. It's quite what's going on as well – if you're psychotic and you're...it depends on the nature of your delusions that could...that's another variable.

I: So, with your delusions, what kind of a thing would it be that would make you more frightened?

I: Well if you're paranoid, you think people are out to get you, that kind of confirms it really.

I: Do you think there's things staff can do during restraint that can make it less frightening?

P: I think they can let them know why they're doing it and say, 'we're just going to put you there because we consider you, your threat to safety to other people at the moment and that you could end up getting in a fight yourself and getting hurt. Let them know why you're doing it - putting them in a seclusion room. I mean you're doing observations when they're in the seclusion room. For the first half hour you're checking every 10 minutes and then after half an hour you're checking every 15 minutes. As soon as it comes across as feasible that they'll be able to conduct themselves safely you let them out of the seclusion room.

I: I wonder, thinking about yourself, have there ever been times when you've felt yourself to be unsafe on the ward?

P: Yes, there have been occasions, mostly on night shifts because there's less staff. Particularly if I've been charge nurse for that shift. I realise my level of responsibility. There's been times when I've been the only regular member of staff on a night shift and if a patient is behaving aggressively and you're not confident in the other member of staff's ability to deal with it, that level of conflict...if you have that it's quite frightening.

I: That's if you're the only regular member of staff?

P: Yes...if the other staff are agency.

I: So that's to do with the make up of staff on the ward.

P: Yes definitely because I certainly feel less unsafe when I know I'm working with regular staff, or agency staff that I know are competent to deal with an aggressive incident. I feel then, well OK we'll ride it together, I know within a moment's notice they'll know how to respond, they'll be able to respond spontaneously and will be able to deal with the incident. If I'm not confident of that it's quite frightening.

I: Do you think the times when you have felt a bit unsafe or frightened, that that has any impact on patients?

P: I think it must do. I don't think that I can completely hide my feelings. It must come across somehow the way I come across. If I can pick it up in the patients I'm sure they can pick it up in me.

I: Do you think that would have any effect on them?

P: If they know they know that I'm frightened, if they know they can get a response, they may utilise that...to get the response that they want.

I: So that would be...they may...?

P: Take advantage of that.

I: Do you think it has any effect on how you work when you're feeling unsafe?

P: Yes, I'd say I become more defensive, I'd be much more likely to...to be an increased presence of staff if that happened I'd say...would be constantly, constantly observed. That would have an effect on them because that would be, hang on, they're expecting something to happen here. Whether inadvertently that may make it more likely to happen, or less likely to

happen...you can only make a decision there and then...and hope that it's the right one.

I: Do you think there's anything about the physical layout of the ward that might make people feel more safe, or less safe?

P: Definitely, it's quite confined, for example in the day room there aren't enough spaces for everybody to sit at the table to eat. So either people eat their meals quickly, people in the front of the queue, or they're sitting in the lounge area.

I Do you think there are parts of the ward that don't feel safe?

P: I think if you go down the corridors...the layout is quite good in terms of the corridors, because you can stand outside the staff room and you can see down every corridor, there's no hidden corners. In terms of the communal area, it's safe in that respect, so in that way it's quite a good design.

I: How about the bedrooms? Do you think the bedroom configuration is OK?

P: Well if they all had their own rooms I think it would be safer. Corridors where you could see down each corridor and you knew that everybody had their own room. That would be safer, such as...there's another ward where although everyone has their own room you can't see down every corridor, because there's a communal room in the way. Yes that makes it a bit less safe, the fact that once you go inside the dorms there's four beds, four patients.

I: We've talked a bit about patients being threatened or feeling threatened, do you think that has any impact on the recovery process?

P: Yes...I think that if someone's paranoid you're trying to reassure them that their paranoia is not founded, when in actual fact some of the paranoia may be founded
And you've got to work around that. It's quite difficult to get a perspective particularly if the dynamics are shifting. You might say, oh, it's quite safe today but half an hour after you discussion, you find another incident occurs. You might think you're back to square one. What you try and do is get them where they're safe where you can start sending them on leave, where they can experience time off the ward, and learn to disassociate that and learn that this is a mental health ward and that's what happens here but it is actually safer outside. I am actually more likely to be safe than not safe when I'm outside. I am...statistically I am much more likely to go to the shops and not be beaten up, than will be beaten up.

I: We've talked a bit about gender, do you think ethnicity has any impact on whether people feel safe or not?

P: Yes, I'd say so, I think there can be a lack of understanding of people's culture. I think some people's culture, they do have a tendency to express themselves more abruptly, more bluntly than the people of other ethnicities.

I: So that might make some people feel less safe than others?

P: Yes.

I: What do you think would be the most frightening aspect of being a patient on a mental health ward?

P: Fear of being bullied.

I: Being bullied by other patients?

P: Yes.

I: And do you think there's stuff staff can do to prevent that?

P: I should think so, a presence always has an impact. I usually find that when there's a member of staff in the day room, particularly when it's a more experienced member of staff, that things are less likely to happen. Patients can feel more assured of feeling safe.

I: Well thank you very much for talking about this, I just wondered how it's felt thinking about these things?

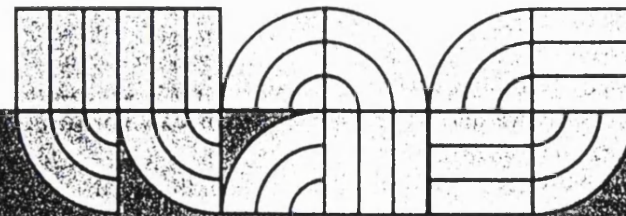
P: In a way I think it's been quite helpful. Just being able to open up and reflect back what can be frightening for a patient or even for myself. An awareness of that...and I can consider that when I'm back on the ward and look at ways to minimise that, people's fears for their safety.

Appendix 8: Ward Atmosphere Scale , Form R

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.

WARD ATMOSPHERE SCALE FORM R

RUDOLF H. MOOS, PH.D.



INSTRUCTIONS

Read the statements in the booklet. They are the same as those in the original Ward Atmosphere Scale. For each statement, mark the number on the scale that best describes the ward. The numbers are 1 through 5. 1 means "never" and 5 means "always".

Do not make any marks on the booklet.



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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.

Appendix 9: Interview Schedule for Patient Participants

Interview Schedule for Patient Participants

Getting to know the participant

The purpose of this section was to gain some basic demographic information about the participant and to develop rapport. The section began with a brief restatement of the aims and objectives of the study, confidentiality and anonymity, and a reminder that the participant was able to withdraw consent at any time.

Can you tell me how old you are?

How long have you been on the ward?

How have you been spending your time here?

What's it been like for you on the ward?

Safety and Security

The aim of this section was to move the focus towards discussion of issues of safety, threat and security.

As you know the aim of this study is to find out how it feels to be a patient on Shore ward specifically with regard to feelings of safety. In what ways does the unit feel safe or not so safe for you?

When do you feel more safe or less safe?

If you've felt unsafe, why do you think this was?

Experience of Arrival

The purpose of this section was to explore participants' feelings when they first arrived on the unit, and find out if those feelings changed over time.

Did you feel safe or unsafe when you first arrived?

Did this feeling change over time?

What was it that made things feel more or less safe?

Was it your first experience of a mental health ward?

What were you expecting it to be like? / Was it like you expected it to be?

Can you tell me anything that happened that made you feel a bit better when you first arrived?

Did anything happen to make you feel frightened or worried?

Other Residents

The aim of this section was to find out how participants felt about the other residents of the unit and whether this had an impact on participants' feelings of safety or threat.

How did you feel when you first met the other residents here?

How did they seem to you? Did your impression of the other residents change as you got to know them?

Who was the first person who talked to you?

Did talking to them make you feel better or worse?

Did anyone help you to feel a bit better? What did they do?

*This is a mixed sex ward. How do you feel about sharing the ward with *men / women. Do you think you would prefer to be on a single sex ward?*

How do you think it would be different? How would you feel?

On wards like people sometimes become angry or violent. Have you seen this happen? Can you tell me exactly what happened?

What did you think?

How did it make you feel?

What did you do?

Staff

The purpose of this section was to discover how participants experienced the staff.

What was your impression of the staff when you first arrived? Did it change over the next few weeks?

Did anyone do or say anything to make you feel better? What was the most helpful thing they did or said?

Was there anything they did or said that made you feel frightened or worried, or was unhelpful?

Did you ever witness any angry, threatening or violent behaviour from staff?

How did that make you feel?

*This is a mixed ward with male and female staff? How does that feel? Would you prefer the staff to be all *female/male?*

Specific events

This section was designed to explore any actual experiences of violence

Have you ever been assaulted or threatened here? Did you report it?

Have you ever witnessed anyone else being assaulted or threatened here? How did this make you feel?

What advice would you give to someone coming on to the ward for the first time?

What could be done to make things feel safer here?

The Physical Environment

This section was designed to explore how participants felt about the physical environment on the ward, such as ward design and layout, security, and bedroom configuration.

Is there anything about the building that makes you feel more or less safe?

Are there any parts of the building where you don't feel safe?

How could the building be improved to make people feel more safe?

Closing the Interview

The aim of this section is to thank the participant for their participation and to provide an opportunity for them to express any concerns that they may have or clarify any points they have made.

Thank you very much for talking to me.

How has it felt to discuss these things?

Is there any thing that you said that you feel I didn't quite understand?

*term used dependent on gender of participant

Appendix 10: Interview Schedule for Staff Participants

Interview Schedule for Staff Participants

Getting to know the participant

The purpose of this section was to gain some basic demographic information about the participant and to develop rapport. The section began with a brief restatement of the aims and objectives of the study, confidentiality and anonymity, and a reminder that the participant was able to withdraw consent at any time.

Can you tell me what grade you are?

How long have you been working on this ward?

How long have you been working in mental health?

Staff beliefs with regard to Patients' feelings of Safety and Security

The aim of this section was to encourage staff to reflect on the experience of being a patient on the ward with regard to issues of safety, threat and security.

As you know the aim of this study is to find out how it feels to be a patient on the ward, specifically with regard to feelings of safety. What do you think it would feel like to be a patient on this ward?

Do you think patients feel safe here?

What do you think it might be like for patients for whom this is their first admission, or first experience of mental health services?

What do you think might be the most frightening aspect of being a patient here?

Do you think that there is anything that you have to do as a staff member that might make patients feel unsafe?

Can you think of anything that you've seen other staff members do, either here or elsewhere, that you think might make patients feel unsafe?

*Is there anything that you can do to make patients feel more safe?
How do you think that might make them feel more safe?*

Impact of Gender

The purpose of this section was to explore staff's views with regard to mixed gender wards and also to encourage them to reflect on the impact of their own gender on patients' feelings of safety.

Do you think mixed wards feel more or less safe to patients?

How about male/female patients?

What is it about such wards that makes male/female patients feel more/less safe?

How do you think the gender of a patient impacts on how they feel on the ward with regard to safety?

How do you think your gender impacts on a patient's feeling of safety?

Do you think this is the same for male/female patients?

Specific events

This section was designed to explore what staff believed was the impact on patients of either experienced or witnessed violence.

What do you think is the effect on patients of experiencing violence from other patients on the ward?

What do you think staff can do to ameliorate or lessen this effect?

What do you think is the effect on patients of seeing other patients become violent or angry, or witnessing staff restrain other patients?

What do you think is the effect on patients of being restrained by staff? How do you think patients feel when this happens?

Do you think they find it frightening?

Is there anything staff can do to make it less frightening?

Staff feelings of safety

The purpose of this section was to find out if staff felt safe on the ward and to explore this in terms of transference and counter-transference.

Are there times when you yourself feel unsafe on the ward?

Are there times when you've felt unsafe on other wards?

When you feel like this do you think it has any effect on how you work?

When you feel like this do you think it has any effect on the patients you're working with?

The Physical Environment

This section was designed to explore how staff felt about the physical environment on the ward, such as ward design and layout, security, and bedroom configuration.

Do you think that there are aspects of the design and layout of the building that might contribute to making patients feel more or less safe?

Do you think patients feel more or less safe in single or multi-bedded rooms?

How do you think the building could be improved to make patients feel more safe?

Closing the Interview

The aim of this section was to thank the participant for their participation and to provide an opportunity for them to express any concerns that they may have or clarify any points they have made. Because of the sensitivity of the issues discussed, particular care may need to be taken to detect any sense that participants have that their work may have been scrutinised or criticised during the interview process. If this is the case it may be useful to explore these feelings at this point.

Thank you very much for talking to me.

How has it felt to discuss these things?

Is there any thing that you said that you feel I didn't quite understand?