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The Use of Coercive Measures in a High Secure Hospital:

Expressions of Institutional and Emotional Work

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MNursSci (Hons), RMN

Thesis submitted to the University of Nottingham
for the degree of Doctor of Philosophy

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*'My greatest desire when I become a doctor is to give people back their
freedom.'*

Sabina Spielrein (1885-1942)

ABSTRACT

This thesis examines the use and implications of using coercive measures within a high secure hospital, where those contained are identified as ‘mad, bad and dangerous’. High secure hospitals are unique environments where challenges are often faced in balancing care with safety and security. The use of coercive measures; namely, restraint, seclusion, rapid tranquillisation and segregation, are considered unavoidable necessities in preventing and/or limiting harm. Yet coercive measures are deemed ethically, morally and professionally controversial. Staff working in high secure hospitals are healthcare professionals not prison officers, and those contained are patients not prisoners. Nonetheless, both staff and patients are expected to abide by institutionally prescribed rules, boundaries and methods of containment. Little is known with regard to the impact and implications that coercive measures have upon patients or staff. This study therefore seeks to explore patient, staff and environmental factors that might influence variations in attitudes and experiences towards the use of coercive measures within Rampton National High Secure Hospital.

The study employs a sequential mixed methods design, conducted in three stages. Stage one examines the rates, frequencies and demographic characteristics of patients experiencing seclusion and/or rapid tranquillisation across Rampton Hospital over a one year period. Stage two uses standardised questionnaires to elicit and analyse staff and patient attitudes towards aggression (ATAS), containment measures (ACMQ) and hospital environment (EssenCES) across four male wards within the Mental Health Directorate. Stage three uses a constructivist grounded theory approach to conducting semi-structured interviews with staff across the four wards, analysed against the background of institutional and emotional work theories. A pragmatic view is taken towards a mixed methods design being both complementary and advantageous to developing this area of knowledge, while the combined theories of institutional and emotional work allow for the study of complex interactions between institutional values and expectations, and individuals’ emotions and actions.

Findings from hospital level data revealed that younger, newly admitted females were those most likely to experience coercion within this hospital. Reasons for this were attributed to younger patients being physically fitter

and therefore perceived as being a greater threat. Less is known with regards newly admitted patients; their potential triggers, risks and most efficient ways of de-escalating them as individuals. Reactions to violence are associated with social expectations of gender and so violence from females may elicit greater reactions than violence from males. Furthermore, Rampton Hospital is the only National High Secure Service for Women in England and Wales, thus accommodating those females considered most dangerous nationally.

Comparisons of staff attitudes towards aggression (ATAS) across four wards indicated that aggression was viewed as being significantly more destructive on the pre-discharge ward, in comparison with the admissions, ICU or treatment ward. Reasons for this might be due to differences in staff expectations or preparedness for aggression on each of the four wards, particularly since aggression on the pre-discharge ward may hinder patient progression to a lesser secure environment. Results from the ACMQ showed discrepancies between staff and patient perceptions of the least acceptable containment measures, creating interesting dilemmas for using 'the least restrictive methods'. The EssenCES questionnaire established that patients experienced the hospital environment as more supportive and cohesive than staff; suggesting interesting dynamics within hospital where staff are purported to control and contain.

Finally, findings from the staff interviews uncovered a complex interplay between the personal feelings of staff and their professional roles. Staff use bravado and machismo as ways of masking their personal fears and anxieties, whilst detachment and desensitisation are used as ways of coping. Staff sought justification for their actions through accommodating institutional values, however, the expectations of healthcare professionals to conduct security measures clearly presents challenges, tensions and conflicts, requiring both institutional and emotional work in maintaining institutional values, control and order.

While this thesis has made a start on generating new insights into the unique environment of the high secure hospital, and has used a novel approach of combining institutional and emotional work theories, more research is required into examining staff and patient attitudes regarding the least restrictive methods and the implications this will have for practice. The internal dynamics within high secure hospitals warrant further attention,

examining, for instance; i) what it means for staff to be working in an environment where patients feel more supported by being contained than staff do when containing them; ii) what methods of support can be put in place for staff experiencing conflict between their personal feelings and professional roles, and iii) whether anything can be done to relieve the tensions of healthcare professionals expected to care, coerce and contain.

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ACRONYMS AND ABBREVIATIONS

ACMQ	Attitudes Towards Containment Measures Scale
ATAS	Attitudes Toward Aggression Scale
AVPU	Alert Voice Pain Unresponsive Scale
DoH	Department of Health
DSPD	Dangerous and Severe Personality Disorder
ESRC	Economic and Social Research Council
EssenCES	Essen Climate Evaluation Schema
HSH	High Secure Hospital
HSPSCB	High Secure Psychiatric Services Commissioning Board
ICU	Intensive Care Unit
MDT	Multi-Disciplinary Team
MHA	Mental Health Act
NA	Nursing Assistant
NHS	National Health Service
NIC	Nurse in Charge
NICE	National Institute of Clinical Excellence
NOMS	National Offenders Management Service
NRESC	National Research Ethics Services Committee
OT	Occupational Therapist
PD	Personality Disorder
PRN	Pro re nata
R&D	Research and Development
RC	Responsible Clinician
RCN	Royal College of Nursing
REC	Research Ethics Committee
RT	Rapid Tranquillisation

SHA	Strategic Health Authority
SHSA	Special Hospitals Service Authority
SN	Staff Nurse
SUI	Serious Untoward Incident
SW	Social Worker
TL	Team Leader
UK	United Kingdom
USA	United States of America
WAS	Ward Atmosphere Scale
WM	Ward Manager

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CHAPTER 1: INTRODUCTION

PART 1: BACKGROUND

Coercive measures are considered controversial practices, particularly within healthcare settings, and especially when conducted by healthcare professionals. Prior to exploring what has been investigated already, by way of examining the sociological literature, history of high secure hospitals and conducting a literature review of empirical studies previously conducted, I would first like to reflect upon the personal reasons why I became fascinated by this area of study, most notably the values and experiences that have drawn me towards this area of research.

Firstly, it is important to first acknowledge my role as a registered mental health nurse. I have a background of working in community-based rehabilitation settings and a strong interest in sociological perspectives of mental health. This interest stems from the community context in which the mental health service from where I began my career was provided, a personal background and upbringing that span several cultures, and having been inspired by social thinkers throughout my nursing education. My understanding is that the rehabilitation services were set up as 'halfway houses', for individuals not yet ready to live fully independently and requiring differing levels of support. My role, along with other team members' who were also healthcare professionals, was to try to 'rehabilitate' individuals to a point of being able to as independently as possible.

Another aspect of what drew me towards this area of working, was the ethos of person-centeredness; understanding the person as an individual and having, what I perhaps naively thought, the luxury of time to spend getting to know those in our care. What I began to realise however, was that perceptions of time might be very different between patients and clinicians, perhaps influenced by how time was spent within these organisations as well as how the notions of time were conceptualised and experienced (see Chandley, 2007). A perhaps even bigger question I had during this time was what 'rehabilitation' actually meant, what the expectations were and how this concept might be defined from clinical, patient, societal and organisational perspectives.

With increasing pressures to accept 'riskier' patients into rehabilitation services due to closures of acute inpatient beds, I also began questioning whether or not our roles were veering towards containment within the community as the ethos of the service evolved to meet the demands of structural service changes. I began to question my role as a mental health nurse, what that was, what it meant and whether I was indeed delivering the philosophies and standards of care that had led me towards a career in nursing in the first place or instead, whether I was inadvertently being forced into becoming an agent of social control. Being placed in a position of power and authority was a facet of my work that I felt particularly uncomfortable with. Whilst, at times, this position allowed me to positively advocate for patients, there were also times when this role and accompanying responsibilities meant that difficult decisions had to be made. Perhaps one of things I found most challenging about this role were the subtle and sometimes more obvious practices of coercion, for example, encouraging patients to take their medication, assessing patients for capacity and being involved in the processes of formal detention resulting in transfer to acute inpatient services, whereby the process of rehabilitation would have to begin all over again. I wondered whether other clinicians might question their roles in a similar way, if at all, and what environments might lend themselves to such questions being brought to the fore. I became increasingly aware of the influences and interactions between values, cultures, actions and environments, even though I might not have thought about these ideas precisely in these ways until I embarked on this PhD.

In the course of that I was caused to begin to think more about the environment of high secure hospitals, where the structures and routines seemed, to me, to be at the polar opposite of the open door, community-based rehabilitative setting I had grown familiar with. These high security hospital environments were still considered hospitals and still managed on a day to day basis by healthcare professionals, most predominantly by mental health nurses, who would have begun their careers through training not too dissimilar from my own. The coercive practices within these environments however, would be much more pronounced, most notably in the forms of high fences, locked gates and multiple layers of physical, relational and procedural security measures.

Thus, what has drawn me to this investigation of coercive measures in high secure hospitals is my interest in trying to understand how individuals come to behave in certain ways – why are patients coerced in high secure hospitals? Why do healthcare professionals perform such actions? What are the cultures within these environments? How might individuals experience not only being accommodated or working in high secure hospitals, but how might they experience conducting the security measures that seem to conflict with philosophies of care? How do individuals seek justifications for such actions? These were just some of the questions I had at the beginning of this study, and which have come formalised as research questions in the course of it. Some of the background and contexts to them can be found in sociological and social psychiatric literature that is reviewed. Some are clarified and explored through conducting the study itself, and further questions result.

PART 2: CONTEXT

Throughout history, individuals, or groups of individuals, have been labelled different or other (Becker, 1963; Lemert, 1951). These differences are often identified through appearances, beliefs or behaviours that depart from social norms and as a result are considered deviant, rule-breaking or non-conformist (Becker, 1963; Lemert, 1951). These individuals are those whom Lemert (1951) would consider 'primary deviants'. Through processes of labelling, the notions of 'deviants' and 'outsiders' are created and those individuals subsequently stigmatised and marginalised from mainstream society. Examples of these include, 'the mad' who have traditionally been confined in asylums and psychiatric institutions and 'the bad' who are incarcerated within prisons. Those who are segregated become 'secondary deviants' (Lemert, 1951). For those continuing to deviate within prisons and psychiatric institutions, the term 'tertiary deviants' can be applied.

Neither psychiatric institutions nor prisons are considered adequate places of containment for those who are 'mad, bad and dangerous'. The discipline of forensic psychiatry therefore seeks ways to accommodate and manage these 'tertiary deviants' through the provision of secure psychiatric hospitals. In England and Wales, secure hospitals are divided into low, medium and high levels of security, reflecting the assessments of risk and dangerousness presented by those accommodated within. Low secure hospitals accommodate those who pose a 'significant danger to themselves or others' (Rutherford & Duggan, 2007). Medium secure hospitals accommodate those who pose a 'serious danger to the public' (Rutherford & Duggan, 2007). High secure hospitals accommodate those who pose a 'grave and immediate danger to the public' (Rutherford & Duggan, 2007). As the level of security increases, the emphasis therefore shifts from that of the individual towards the safety and interests of society. It is the high secure hospital environment that will form the focus of this thesis.

The institution of forensic psychiatry and organisation of secure psychiatric hospitals present many challenges. The pluralistic discipline of forensic psychiatry represents a meeting point between legal and medical paradigms. These paradigms with their disparate histories and competing priorities frequently create tensions and conflicts for those working within. The precarious balances of care and containment; treatment and security, safety

and control, are frequently debated and well documented within the literature (Alty & Mason, 1994; Kaye & Franey, 1998; Kontio et al., 2010; Prinsen & Van Delden, 2007; Tardiff, 1984; Vassilev & Pilgrim, 2007). The lived experiences of those working within these environments however, are far too often neglected. Healthcare professionals are expected to manage and contain 'tertiary deviants' via the use of coercive measures. These controversial methods represent the greatest sanctions legally imposed upon individuals already accommodated within extremely regimented and restrictive environments. With emphases currently placed on patient autonomy and individual human rights, the use of coercive measures conflicts with these ideals. The expectations of healthcare professionals to impose these sanctions are juxtaposed with their professional duties to care (Alty & Mason, 1994; Tardiff, 1984). Furthermore, a number of international guidelines have called for a reduction and even elimination in the use of such methods (American Psychiatric Association et al., 2003; National Mental Health Working Group, 2005; NICE, 2005; Queensland Government, 2008). The notions of deviance, the environments in which deviants are accommodated and the experiences of staff expected to contain these individuals each form central contributions towards this thesis.

Definitions of forensic psychiatric patients, secure hospital provisions and uses of coercive measures differ widely internationally. These will be briefly introduced here and then elaborated on in subsequent chapters. For the purposes of this thesis, forensic psychiatric patients will be considered those who are deemed 'dangerous, violent or having criminal propensities' (Mason, 1993: 413) and who have usually 'interfaced with the law at one level or another' (Mason, 2006: 3). High secure psychiatric hospitals will be considered those organisations with security measures in place to accommodate forensic psychiatric patients 'where a lesser degree of security would not provide a reasonable safeguard to the public' (Nottinghamshire Healthcare NHS Trust, 2007: 2). Coercive measures will encompass the explorations of restraint, seclusion, segregation and forced medication via rapid tranquillisation. Restraint will be considered in two parts; physical restraint, whereby a patient is held by at least one member of staff; and mechanical restraint where a device, such as a belt, is attached to a patient; both with aims to restrict patient movement (Department of Health, 2008; NICE, 2005). Seclusion will be considered the placement of a patient in a locked room that has been specifically designed for this purpose (Department

of Health, 2008; NICE, 2005). Segregation is considered the longer term placement of a patient alone in a locked room specifically designed for this purpose (Department of Health, 2008; NICE, 2005). Finally, forced medication is considered the administration of a drug causing rapid tranquillisation via intramuscular injection against a patient's will (NICE, 2005).

High secure hospitals will be the context of this thesis whilst secure hospital literature will be drawn upon where levels of security are not defined. While there are overlaps in forensic psychiatry between prison and hospital settings, it should be made clear from the outset that this thesis will focus on hospital provisions only; where those accommodated are patients, staff are healthcare professionals and care should be at the forefront of service delivery. The use of coercive measures within high secure contexts therefore represent the greatest deprivation of physical liberty towards those accommodated within hospitals settings. Forensic psychiatry as an institution espouses its own set of rules, values and beliefs based on legal and medical paradigms. Through these frameworks, the use of coercive measures is justified and legitimised through emphases on safety, security and duty of care to prevent harm to others. Secure hospital organisations provide the physical context in which such practices may be conducted, while the interrelations between the institution, organisation and individuals influence the internal dynamics, most notably the environment within them.

High security hospitals have also been considered the modern day total institution, closed off from the outside world (Goffman, 1964). Although studies of institutions and organisations are well established, related theories have not been applied to the high secure hospital setting. Theories of institutional and emotional work will provide a basis for which to study the complex discipline of forensic psychiatry; specifically, the organisational arrangements of a high secure hospital and the challenges and experiences of healthcare professionals working within it. Through this novel approach within this unique environment, new knowledge and insights may be sought in studying patient, staff and environmental factors that might influence variations in the attitudes and use of coercive measures. For the purposes of this thesis, Rampton High Secure Hospital will be the institution under study. Rampton is one of three national high secure hospitals in England and Wales, for which details of its history and composition will be provided later in this chapter and elaborated on in Chapter 5.

The interrelationships between the institution, organisation, staff and patients provide interesting observations for ways in which actions and emotions influence practice; providing opportunities for studying how institutions and organisations may be created, disrupted or else maintained (Fineman, 1993; 2008; Hochschild, 1983; Lawrence, Suddaby & Leca, 2009). This thesis aims to explore these factors using a sequential mixed methods design.

The following sections will explore theories and concepts of social deviance through the notable works of Becker (1963), Lemert (1951) and Scheff (1966; 1984; 1999). A history of high secure services in England and Wales will be outlined detailing the inception of high secure services, changes and developments in their structure and governance, along with current policies and legislations for the indications of using coercive interventions (Department of Health, 2008; NICE, 2005). A literature review will be presented, illustrating research on the topic specific to secure hospital services (Hui, Middleton & Völlm, 2013). From this, gaps in knowledge will be identified and research questions drawn. A comprehensive overview will be given to the theories of institutional and emotional work with details of their relevance and applications to forensic psychiatry and the high secure hospital context. Further chapters will detail the mixed methods design of this study, findings, ethical issues and study limitations. Finally, discussions of these findings will be discussed using the theoretical framework of institutional and emotional work, conclusions drawn and indications for further research suggested.

PART 3: DEVIANCE, DEVIATION AND DEVIANTS

Individuals and groups of individuals identified as 'deviants' in various cultures and societies have been loci for systems designed to provide order and social control (Cohen & Scull, 1983; Mayer, 1983). Historically, sociological studies have rested heavily upon the idea that deviance provokes measures designed to restore social control (Cohen & Scull, 1983; Lemert, 1967). This study however, considers these notions as reciprocal, that deviance can lead to social control, but that social control can also lead to deviance (Lemert, 1967). In considering the reciprocal nature of these concepts, equal importance is placed towards the studies of those considered deviant, as well as those enforcing social control.

Throughout history, different groups of individuals have been considered 'deviants' by different cultures and societies at different points in time (Foucault, 2001). As such, the study and identification of deviants has influenced the design of systems used to maintain social order (Cohen & Scull, 1983; Mayer, 1983; Pilgrim, 2007; Pilgrim & Rogers, 2003; Vassilev & Pilgrim, 2007). Factors influencing the identification of deviants have included differentiations in appearance, behaviours, social status, employment, language, values and beliefs. Some of the most notable designations of deviant status in recent history have included racial segregation, religious distinctions, divisions between the deserving and undeserving flanked by social class and status, alongside distinctions between the well and the unwell instituted via leper colonies, epileptic colonies and lunatic asylums. In identifying deviants, methods of social control are most often applied, either through coercive force or via social rules, norms and sanctions (Mayer, 1983).

The relations between deviance and social control, therefore allow questions to be asked concerning i) who are considered deviant and requiring control, ii) why individuals are considered deviant and requiring control, iii) how individuals are assessed as deviant and subsequently controlled, and iv) what effect these have upon those considered deviant and those who are enforcing social control (Mayer, 1983). This section will begin to explore some of these questions through focusing upon the notion of deviance specific to the patient population within high secure hospitals in England. These include both mentally disordered offenders as well as those with mental health problems who are deemed too violent and dangerous to be accommodated elsewhere

(Nottinghamshire Healthcare NHS Trust, 2007). It will first outline definitions and theoretical considerations of deviance largely through the works of Edwin M Lemert (1951) and Howard S Becker (1963). This will be followed by an exploration of notions of labelling theory, including their effects and limitations. Finally, and more specifically, notions of deviance will be applied to the high secure hospital population in relation to societal reactions, social order and control.

LABELLING THE 'DEVIANT'

The sociological study of deviance allows for the study of individuals or groups of individuals within their wider social systems. As such, the study of the social and cultural context in which deviance is identified becomes as important as the study of individuals themselves. Areas of interest thus include: i) the emotions that deviants evoke within their social audience; ii) the relations between the individual, their social audience and their social context; and iii) the resulting societal reactions to such deviants (Lemert, 1951; Scheff, 1999). The notion of deviance may be defined as the departure from, or 'violation' of, any given social norms (Adler & Adler, 2006; Lemert, 1951). Deviance therefore represents an 'infraction of some agreed-upon rule' (Becker, 1963: 8). Such rules may be formal or informal (Adler & Adler, 2006; Lemert, 1951). Indeed digressions from social norms may be more easily identified than the actual rules and norms of a society themselves (Lemert, 1951). These may include nonconformity to widely-held societal beliefs, traditions, customs, written or spoken language, including; accent, dialect or syntax, behaviours, or style of dress (Scheff, 1999).

The individual, their audience, their context and their situation each have influences and implications for the consequences of deviance. Social reactions to deviance may vary depending upon the extent of nonconformity and the perceived risks and threats associated with these (Becker, 1963; Cockerham, 2003). The context of deviance may invoke differing reactions, depending upon whether the individual is amongst other people of similar mind-sets, attitudes and beliefs, or what might be happening more widely in the society at the time (Becker, 1963; Lemert, 1951; Scheff, 1999). Societal reactions towards deviance may be heightened during periods of social sensitivity or perceived vulnerability. Social reactions towards deviance may also depend

upon who executes such behaviours, as well as who is, or feels, threatened by them (Becker, 1963; Cockerham, 2003; Scheff, 1999).

INDIVIDUAL, SITUATIONAL AND SYSTEMATIC DEVIATION

Lemert (1951) distinguishes between three types of deviation, namely, individual, situational and systematic deviation. These will be considered in turn, before exploring the concepts of primary, secondary and tertiary deviance.

Lemert describes individual deviation as a 'personal phenomenon' (1951). That is, deviation emanating from within the person, resulting from biological mutations or hereditary conditions. Lemert (1951) highlights that individual deviation may result from an individual's 'distributive and personally delimited context', referring to the interactions between the individual's personal dispositions with that of their environment, thus emphasising the relational components between the self, others and their social context (Lemert, 1951: 37; Young, 1945).

Situational deviation, in contrast, is characterised by the 'impact of forces in the situation external to the person or in the situation of which the individual is an integral part' (Lemert, 1951: 37). Thus, deviant behaviours arising from situational deviation are thought to result from circumstantial changes. An example of this might be that of a usually law-abiding citizen who, in extreme poverty, has to steal in order to support their starving family. Given that this type of deviation is dependent upon situational forces, once the individual's situation changes and they can afford to feed themselves and their family again, it is assumed that their behaviour would return to normal (Lemert, 1951).

Related to situational deviation is what Lemert (1951) terms 'cumulative situational deviation'. Lemert (1951) draws upon the example of individuals stealing towels, coat hangers and dressing gowns from hotels, recognising that such behaviour occurs frequently, even amongst those who would not normally steal. Since this behaviour occurs so readily, such deviation is recognised as being both situational and cumulative, considering the amount of individuals involved as well as the frequency in which it occurs. This type of deviation occurs with such regularity within this specific situation that there

becomes an associated degree of informal rules, allowing this to be somewhat accepted and indeed expected, even though the same behaviours would not be acceptable elsewhere. The numbers of people who engage in deviant behaviours, as well as the circumstantial context in which such behaviours occur, are therefore key factors in distinguishing cumulative situational deviation.

Systematic deviation, as identified by Lemert (1951), is both systematic and organised, referring to the way that deviants come to recognise and acknowledge the existence of others similar to themselves. Lemert proposes that this form of deviation may contribute towards the creation of deviant subcultures, whereby individuals who self-identify with a particular form of deviancy become integrated with each other and create their own social rules among themselves, analogous to those found within wider society.

PRIMARY, SECONDARY AND TERTIARY DEVIANCE

Primary deviance is most closely related to situational deviance, and refers to the behaviours that others perceive to be strange but are interpreted as being atypical of the one's usual character and 'true' self. These may be rationalised either as the individual having an 'off day', or a result of the individual's situation at the time (Cockerham, 2003; Lemert, 1951).

Secondary deviance, in contrast, is considered to be influenced by both individual and systematic deviation. These nonconventional patterns of behaviour occur so frequently that they are interpreted as being typical and characteristic of that individual's true self, and so the individual is labelled 'deviant' (Lemert, 1951). In becoming recognised and labelled as 'deviant', the individual is stigmatised and marginalised from mainstream society (Cockerham, 2003; Lemert, 1951). Social reactions towards the individual, as well as individual instincts to find a place of belonging act as motivational forces, creating places where similar individuals co-habit and where deviants become less noticeably deviant within the community. Secondary deviants as defined by Lemert (1951) are therefore those individuals whom the 'deviant label' has been applied with certainty and for whom this label has resulted in a socially ascribed role.

In developing Lemert's (1951) ideas that there are levels of deviance, the term tertiary deviance will be used in this thesis to describe those who continue to be identified as 'deviant' and non-conformist even amongst those for which the 'deviant' label and status has already been assigned. Tertiary deviants are those who are considered deviant even within an already 'deviant community' and whose behaviours continue to remain non-conformist amongst deviant rules.

DEVIANCE AND SOCIAL CONTEXTS

In his book, 'Outsiders', Becker (1963) emphasises the key role of culture and societal context in the constructions of deviance, explicating that social rules concerning deviance are not cross-culturally uniform. In studying a group of drug users, Becker proposes that even though people who use drugs are largely rejected as deviants within Western society, the same behaviours in other societies are acceptable and indeed even encouraged as spiritual experiences.

The second key tenet of Becker's (1963) work is social audience and context. Here, Becker (1963) explicates the subtle distinctions between 'rule-breaking' and 'deviance'. Rule-breaking encompasses all deviations from social norms, whilst deviance refers only to those acts that have an audience and can therefore be labelled (Becker, 1963: 9). Accordingly, the term 'deviant' in turn refers 'to whom[ever] the label has successfully been applied' (Becker, 1963: 9). For Becker, rule-breaking and deviance may therefore fall into four categories:

- i) 'the falsely accused deviant', who is rule-abiding but whose actions are wrongly perceived as being deviant;
- ii) 'the conforming', who is rule-abiding and correctly perceived to be rule-abiding;
- iii) 'the pure deviant', who is both rule-breaking and perceived as deviant, and;
- iv) 'the secret deviant', who may be better termed the secret rule-breaker, since only they are aware of their rule-breaking behaviours and as such cannot be labelled deviant.

DEBATES OVER DEVIANCY THEORY

The most notable critique of the theories of labelling developed by Lemert (1951) and Becker (1963) has been put forward by Walter Gove (1970; 1975a; 1975b; 1982). Gove's critique has three major components:

- i) The individual and society: Labelling theory focuses too much upon those conditions external to the individual, and therefore gives too much emphasis to social interpretations and reactions.
- ii) Stigma: Being labelled does not result in as intense or lasting stigma as labelling theory would suggest.
- iii) Social status: People of lower social status are not more likely to be labelled (Gove, 1970; 1975a; 1975b; 1982). Gove proposes instead that deviance is more readily identified amongst the upper classes as a result of the upper social strata having less tolerance of such deviant behaviours.

The first part of Gove's critique is generally deemed to hold more weight than the latter two arguments (Cockerham, 2003). However, these three strands of Gove's critique will be considered in turn.

THE INDIVIDUAL AND SOCIETY

The dynamics of labelling highlight the mutual influences and relations between the individual and their society. Through abiding to rules, individuals reiterate, reaffirm and reinstate social norms, whilst through punishments for rule-breaking, consequences are created to maintain social order (Scheff, 1999). The negative feelings associated with non-conformity, such as embarrassment, guilt, and fear of punishment, can be so strong as to deter individuals from behaving in ways other than those that are socially prescribed (Bell, 1967; Scheff, 1999). Furthermore, punishments are not limited to actual social sanctions, but may also include imagined social sanctions; those sanctions which the individual places upon themselves through what they believe to be expected of them (Bell, 1967; Scheff, 1999). Real or imagined social rules, expectations, conformity and self-control therefore all act towards providing social sanctions and means of social control in directing individual behaviour and maintaining social order (Bell, 1967; Scheff, 1999).

STIGMA

The notion that labelling does not hold lasting effects with regards to stigma and marginalisation is largely unsubstantiated. Indeed, studies have consistently found, particularly with regards to mental health and those with long-term mental health problems, that stigma can be particularly prevailing (Link et al., 1997; Link & Phelan, 1999; Phelan et al., 2000; Rogers & Pilgrim, 2010; Rosenfield, 1997). The ongoing negative perception of labelled individuals was demonstrated in a seminal study by Rosenhan (1973). In Rosenhan's study, pseudo-patients diagnosed with schizophrenia (i.e. fake sufferers) admitted themselves into hospital and deliberately behaved 'normally', yet staff still perceived and documented them as behaving strangely. Ironically, it was 'genuine' patients that recognised the pseudo-patients as 'frauds' more readily than the staff.

SOCIAL STATUS

Similarly, Gove's proposal that individuals of higher social status are more likely to be labelled is not without its flaws. Often, historically, greater judgements have been made upon the poor, and the poor have often suffered greatly from labelling. There was immense shame and humiliation associated with signing up to the workhouses via the Vagrant and Pauper Acts, and the further shunning of those deemed 'undeserving' as a result. Moreover, those with mental health problems, often find themselves unemployed and in poor housing conditions (Rogers & Pilgrim, 2010). As such, those who are labelled often become increasingly isolated, avoided, discriminated against and socially devalued (Cockerham, 2003; Rogers & Pilgrim, 2010). These negative societal reactions often become so embedded within the individual that the person who is labelled 'deviant' comes not only to think less of themselves, but also grows to be expectant of rejection, as will be further explored in examining modes of social order and control (Cockerham, 2003; Rogers & Pilgrim, 2010; Scheff, 1999).

APPLYING DEVIANCY THEORY TO FORENSIC PSYCHIATRY

The three main sociological perspectives of deviance will be presented in this section, as outlined by Adler and Adler (2006). These perspectives will then be applied to the legal and medical aspects of forensic psychiatry and the

challenges considered with regard to managing and accommodating deviants within high secure hospitals.

ABSOLUTIST, RELATIVIST AND SOCIAL POWER PERSPECTIVES ON DEVIANCE

The absolutist perspective views deviance as 'objective facts' that exist regardless of social norms, customs and traditions. This perspective views deviance as being constant to both time and place. Furthermore, the absolutist perspective views deviance as being an essential part of any positive functioning society, being critical to a society's continued existence but which is independent of individual thought or questioning (Adler & Adler, 2006). The notion of deviance here is therefore viewed as something intrinsic and innate; such values exist before societies are formed and permeate over time across all cultures.

The relativist perspective, in contrast, regards deviance as being constructed by societal norms, values, rules and laws and are thus defined by time and place. The relativist view holds that there are no constant, absolute or universal rules that define deviance. Instead, such rules and sanctions are based upon social reactions to deviant behaviours and are therefore progressive and evolving, with varying sets of rules between individual social groups (Becker, 1963; Lemert, 1951; Scheff, 1966; 1967; 1999).

Finally, the social power perspective asserts that rules surrounding notions of deviance are not arbitrarily formed but rather selectively created and applied in serving the personal and political interests of those with greatest social power (Adler & Adler, 2006; Foucault, 1991; 2001; 2003; Quinney, 1970). Whilst recognising that conflicts occur between groups within a society, this viewpoint posits that sets of rules are constructed and determined by the dominant group over their subordinates, through which, personal interests are reflected (Foucault; 2001; 2003; Quinney, 1970). Whilst this chapter has so far focused mainly on the relativist perspective through the works of Becker (1963), Lemert (1951) and Scheff (1999), and to a degree on the social power perspective through discussions of maintaining social order and control, it is here that the absolutist perspective will also be explored with regards to examining deviance within forensic psychiatry.

The positioning of forensic psychiatry stems from two separate vantage points. These are (a) law and criminology, associated with moral principles of right and wrong, and (b) psychiatric systems associated with normality and abnormality, health and illness. These are often at odds. While both crime and mental health problems are both perceived as violations of social norms, the attributions of cause and resulting social reactions to these are somewhat different; 'deviance that is seen as *wilful* tends to be defined as crime; when it is seen as *unwilful* it tends to be defined as illness' (Conrad, 1981: 107). There is also a difference between social responses to crime and to people with mental health problems. The criminal is deemed responsible for their actions and is punished with the goal of motivating them towards conventional behaviours, while the person with mental health problems is deemed irresponsible for their actions and treated with the goal of altering their conditions that prevent such conventionality (Conrad, 1981).

The legal aspect of forensic psychiatry might be seen as representing the absolutist perspective in its approach to deviance. The force of legal judgement over deviance derives from a universalistic notion of morality – the idea that there are moral values that are unchanging over time and geographical space, and that all individuals are born with at least some degree of recognising right from wrong.

Nonetheless, the legal consequences of such crimes, such as the processes of sentencing, are necessarily 'relativist', as systems of punishment are socially prescribed and socially constructed, not only varying between societies (e.g. not all societies use capital punishment), but also often varying in different times and places within each society. For instance, the conditions, regimes and sanctions are different between prisons, as are the expectations of prisoners.

The psychiatric strand of forensic psychiatry, in contrast with the legal strand, is largely considered relativist. That is to say, it places emphasis on social interactions and relations between the individual and society. Psychiatry from a relativist perspective reflects a continuum spanning from the 'normal' to the 'abnormal', and subsequently the extent of deviance where 'abnormality' is apparent.

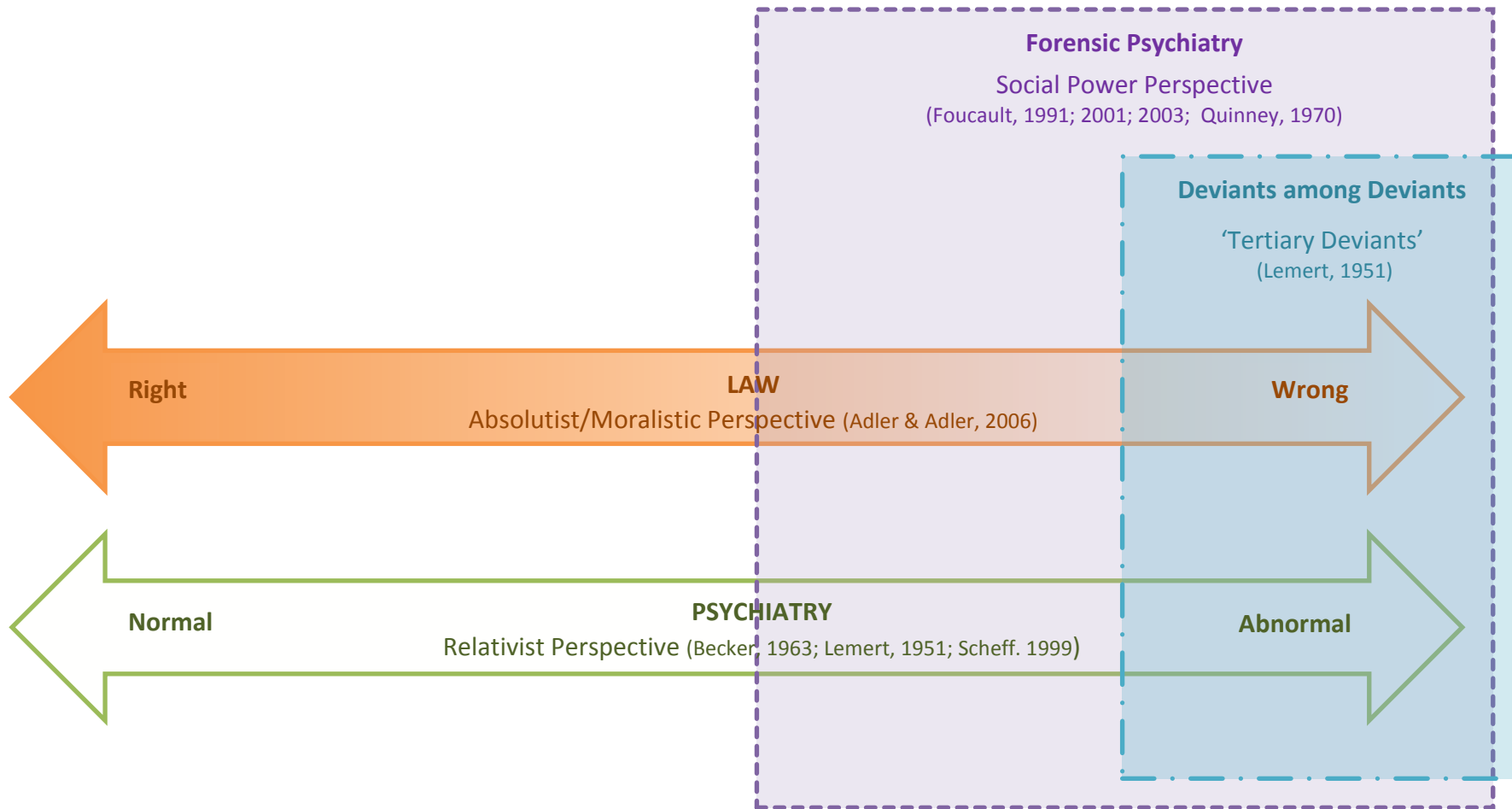
DEVIANCE IN FORENSIC PSYCHIATRY

Forensic psychiatry, and, more specifically forensic psychiatric systems, are where those who are doubly deviant – deviant from both legal and psychiatric perspectives – are housed and accommodated. Forensic psychiatry and forensic psychiatric systems therefore represent deviance at several different levels:

- i) The forensic psychiatric population does not fit completely into either legal or psychiatric systems. Instead, it covers both.
- ii) The degree of deviance is both ascertained by and reflected in the levels of security at different forensic psychiatric hospitals.
- iii) The most extreme form of deviance within forensic psychiatric services is represented by those who break rules within high secure hospitals.

The formal labelling of ‘forensic psychiatric patients’, alongside the physical segregation of such patients within such secure institutions, therefore shapes what Lemert (1951) refers to as secondary deviance, creating a subculture whereby socially constructed rules to manage deviants apply, and deviants who break those rules may be found (Becker, 1963). Whilst social rules and sanctions govern such secondary deviants within forensic psychiatric systems, those deviants who continue to non-conform and break rules within this deviant subculture may be considered ‘tertiary deviants’. Such primary, secondary and tertiary levels of deviance along with the different sociological perspectives and vantage points of forensic psychiatry are represented diagrammatically in Figure 1: Applying Deviancy Theory to Forensic Psychiatry. It is this population of tertiary deviants within the field of forensic psychiatry that will form the main focal point of this thesis.

FIGURE 1: APPLYING DEVIANCY THEORY TO FORENSIC PSYCHIATRY



PART 4: HIGH SECURE HOSPITALS IN ENGLAND

Reflecting the identification and ensuing needs for the placement of individuals who could not be accommodated in either prisons or conventional mental health settings, high secure hospitals were developed in order to accommodate those considered both 'mad and bad'. Rather than focusing on matters concerning responsibility and justifiability, for which there is already an extensive literature, this section will focus upon the development, ownership and governance of high security hospitals in England. The institution and organisation of the three special hospitals, Broadmoor, Ashworth and Rampton, will form the main focal point of this section and will explore the history of forensic psychiatry in England and Rampton Hospital in particular.

Broadmoor, Ashworth and Rampton each have their own unique histories, and their differences perhaps reflect the difficulties in developing institutions that accommodate deviants who do not readily conform to pre-existing institutions. This section will begin by providing a brief historical overview of each of these hospitals before exploring the developments of the hospitals since the advent of the Mental Health Act 1959 and the Special Hospitals Services Authority. Notable reports, inquiries and ensuing legislative documents will be explored. Finally, this section will focus on the current ownership, management and governance of Rampton Hospital, the organisation that has provided the context for this thesis. Studying the history and development of high secure hospitals provides insight into why and how these institutions became established in the social control of deviants. Exploration of changes to the Mental Health Acts enables deeper understanding of some of the wider socially evolving attitudes towards those contained. Finally, findings from the investigations, reports and inquiries into these services, unveils prior inherent working cultures and reasons for some of the contemporary forms of governance, management and practice.

BROADMOOR, ASHWORTH & RAMPTON PRIOR TO THE MENTAL HEALTH ACT
1959

BROADMOOR

The placement of mentally ill offenders has long been a topic of debate, particularly since these individuals do not automatically conform to the traditional institutions of criminal or psychiatric systems (Bartlett, 1993; Hamilton, 1985; Parker, 1985). During the late eighteenth and early nineteenth centuries, asylums were deemed to lack the security provisions required to accommodate 'criminal lunatics'. Therefore many of these patients were confined in prisons (Parker, 1985). Simultaneously, prisons were criticised for the mixing of both criminals and the insane, such that the mixing of the deviant 'bad' and the deviant 'mad' was viewed as 'a serious evil' (Bartlett, 1993; Hamilton, 1985: 85; Parker, 1985). The development of a new institution designed to accommodate those deemed both 'mad' and 'bad' was therefore required.

Broadmoor, situated on the Surrey-Berkshire border, was commissioned to be purposefully built as a 'Criminal Lunatics Asylum', and was formally opened in 1863 (Black, 2003; Hamilton, 1985; Parker, 1985). It was owned and governed by the Home Office, who controlled all admissions and discharges (Black, 2003; Hamilton, 1985). In 1949, the Board of Control for Lunacy and Mental Deficiency (by this time under the Ministry of Health) took over the management of Broadmoor Hospital under the provision of the Criminal Justice Act 1948 (Hamilton, 1985). However, all admissions and discharges to and from the hospital remained under Home Office control (Hamilton, 1985). Thus the dual management of Broadmoor by both health and legal departments had begun.

The types of patients admitted to Broadmoor were, however, all 'offenders' up until the Mental Health Act 1959. These offender patients were admitted under three categories; 'guilty but insane', 'insane on arraignment' or 'time-serving prisoners' (Black, 2003). 'Guilty but insane' patients were those who were successful in their insanity plea during trial and were thus detained at Her Majesty's Pleasure. Someone who was insane at the time of the trial would be considered 'insane on arraignment' and therefore detained at Her Majesty's Pleasure, theoretically until the person was considered fit to stand trial, although in practice this rarely happened as patients were most often

detained until deemed fit for release (Black, 2003). These two classifications were often referred to as 'pleasure patients' since both groups were detained 'until Her Majesty's Pleasure be known' (Black, 2003; Parker, 1985). Time serving prisoners were those who had already been sentenced but later found to be unsuitable for prison for reasons of 'mental illness' and so transferred to Broadmoor from prisons rather than the courts (Black, 2003). 'Time serving prisoners' were often referred to as 'convicts' or 'time men or women' (Black, 2003; Hamilton, 1985; Parker, 1985).

So, within an institution for offender patients, distinctions were still clearly made which tended to separate the deviant 'mad' from the deviant 'bad'. The two groups were completely separated to accommodate differences in management and treatment regimes. As Parker (1985: 23) says: 'the HMP cases were found to be ideal patients, treatable and well-behaved, whose crimes were a result of their insanity. In contrast the convicts were disruptive, many were dangerous, they required constant supervision, and their insanity was thought to result from their criminal lifestyles'. As such, the attitudes towards pleasure patients and towards convicts appeared to be as divided as the patients themselves, and the development of an institution to accommodate those considered 'doubly deviant' was fraught with new and different challenges by those continuing to deviate from institutional rules, norms and expectations (Parker, 1985).

ASHWORTH

Ashworth, the newest of the three high secure hospitals, was formerly two separate hospitals; Moss Side and Park Lane. These were the only high secure hospitals never to have been directly managed by the Home Office. Moss Side, located just north of Liverpool was purchased by the Board of Control in 1914 and intended for 'violent and dangerous mental defectives' similar to those patients admitted to Rampton (Bartlett, 1993; Hamilton, 1985). Between 1914 and 1918, however, Moss Side was controlled by the War Office for shell-shocked patients (Bartlett, 1993), and between 1920 and 1933, Moss Side was leased to the Ministry of Pensions to accommodate the 'epileptic colony', another group whom society identified as deviants during that time (Bartlett, 1993; Hamilton, 1985). It was therefore not until late 1933 that the hospital was reopened and became firmly established as a State

Institution for Mental Defectives under the management of the Board of Control.

The Park Lane part of Ashworth, opposite Moss Side Hospital, was not built until after the introduction of the Mental Health Act 1959. Opening in 1974, having faced much local opposition (Bartlett, 1993), it was originally intended to accommodate psychopathic and mentally ill patients. It was not until 1989 that Moss Side and Park Lane Hospitals were amalgamated under the Special Hospitals Services Authority to form Ashworth High Secure Hospital (Bartlett, 1993).

RAMPTON

Rampton Hospital was originally constructed with the intention of serving similar purposes as Broadmoor. The types of patients accommodated at Rampton, however, were quite different to those at Broadmoor, almost from the very beginning. Rampton Hospital is situated in the North Nottinghamshire countryside, near the town of Retford. Rampton opened on 1 October 1912 as a Criminal Lunatic Asylum to alleviate some of the pressures on Broadmoor, since, by this time, Broadmoor was full to capacity (Hamilton, 1985; Parker, 1985).

Originally owned and managed by the Home Office until 1920, Rampton was then passed over to the management of the Board of Control for Lunacy and Mental Deficiency under the Mental Deficiency Act 1913, becoming a 'state institution for mental defectives with dangerous and violent propensities' (Hamilton, 1985: 87). This marked the beginning of two main differences between Broadmoor and Rampton; the former accepting only offender patients of 'normal intelligence' and the latter accepting both offender and non-offender patients as well as those of 'subnormal intelligence' (Bartlett, 1993; Street & Tong, 1960).

Patients at Rampton could therefore be admitted or transferred via courts, prisons or other mental institutions (Street & Tong, 1960). Up until the Second World War, all staff were required to live on site and women had to resign upon marriage, creating a particularly insular community (Nottinghamshire Healthcare NHS Trust, 2007). With the National Health Service Act 1946, the Ministry of Health became the new owners of the

institution in 1948, and for the first time, Rampton became officially recognised as a hospital despite still being managed by the Board of Control (Parker, 1985; Street & Tong, 1960).

THE MENTAL HEALTH ACTS 1959 AND 1983

THE MENTAL HEALTH ACT 1959

The Mental Health Act 1959 had a huge impact on the reform of mental health services as well as the patients admitted to the three high secure hospitals. The language shifted from that of 'lunatics' to 'mental' and 'psychiatric patients' (Black, 2003). Broadmoor, Rampton and Ashworth were no longer referred to as asylums or institutions, but instead became recognised as 'special hospitals' (Bartlett, 1993; Nottinghamshire Healthcare NHS Trust, 2007; Parker, 1985). The Mental Health Act 1959, in addition, outlined four categories of 'mental disorder' in the course of defining how diminished responsibility would be classified, namely, 'mental illness', 'subnormality', 'severe subnormality' and 'psychopathy' (Mental Health Act, 1959, Black, 2003).

Subsequently, the Homicide Act 1957 and the Mental Health Act 1959 worked alongside one another in addressing the outcomes for patients. Patients were no longer deemed 'guilty but insane' or detained 'until Her Majesty's Pleasure be known'. Instead, under the new Acts, a verdict would be reached in court as to whether or not a person was of diminished responsibility. It was only then, after a verdict had been reached, that a classification of mental disorder would be decided upon (Black, 2003). If evidence of disorder was found, it would likely result in a hospital order rather than a prison sentence (Black, 2003). If the patient were considered likely to pose further dangers to the public, a 'restriction order' could be placed upon the person's discharge such that the authority for discharge would be restricted to being upon a Home Office decision rather than hospital authority alone (Black, 2003).

Convicted prisoners could still be transferred to the special hospitals, comparable to the old legislation of 'time' patients. However, these prisoners could now also be subject to Home Office restrictions. Furthermore, people awaiting trial could be transferred to psychiatric facilities including special hospitals for periods of assessment. With the development of regional secure

units, the transfer of civil patients into and out of special hospitals was further facilitated. Thus, all three special hospitals now admitted offender ('criminal') and non-offender ('civil') patients, of either 'normal' or 'subnormal intelligence'. Similarly, the language of patients changed from pleasure patients and time serving prisoners or convicts to civil and criminal patients, and so too did the types of patients accommodated in each of the three special hospitals, creating, at least in theory, a more uniform patient population across all three hospitals (Bartlett, 1993).

THE MENTAL HEALTH ACT 1983

The Mental Health Act 1983 served to lessen the divide between mental illness and what had been termed 'mental deficiency', since these were now both set out under one Act. All four categories of patients moved from the courts, prisons and other psychiatric hospitals could then be admitted to any of the three secure hospitals. The Act consolidated such changes in legislation, focusing further on patients' rights and the intention not to compulsorily detain unless absolutely necessary (Black, 2003; Boardman, 2005; Mental Health Act, 1983). Furthermore, the Board of Control was abolished and the three special hospitals were placed under the management of the Ministry of Health, now the Department of Health (Parker, 1985).

Although concerns surrounding the special hospitals having too much of a custodial emphasis never ceased, the management of the organisations at least appeared to move towards a healthcare agenda (Evans & Oyeboode, 2000; Gunn, 1994; Higgins, 1996). Changes in ownership, governance and language therefore contributed towards subtle shifts in institutional values, practices and management of such deviants. Finally, during the same period, regional medium secure units were proposed and established, to accommodate those considered less violent and dangerous and requiring lower levels of security.

REPORTS & INQUIRIES SHAPING HIGH SECURE SERVICES

Reports, inquiries and legislation have all served to influence and transform the face of high secure forensic mental health services. Throughout the past few decades, several reports and inquiries have had transformational effects on high secure services. These have most notably included the Ashworth

Inquiry and Boynton Reports, alongside investigations into the deaths of three patients at Broadmoor following restraint. The Ashworth Inquiry is perhaps the most monumental inquiry of all those conducted within high secure services to date and was certainly the most extensive inquiry of its time (Kaye & Franey, 1998).

THE ASHWORTH INQUIRY

The Ashworth Inquiry, also frequently referred to as the Fallon Inquiry, was conducted amidst allegations by a former patient of corruption on the Personality Disorder Unit (PDU) at Ashworth Hospital (Fallon, Bluglass & Edwards, 1999). Amongst these allegations were ‘the misuse of drugs and alcohol, financial irregularities, possible paedophile activity and the availability of pornographic material on the Unit’ (Fallon, Bluglass & Edwards, 1999: iii). Alarmingly, these allegations were found to be largely accurate with hospital policies being ignored, security procedures being ‘grossly inadequate’, staff malpractice, neglect over a child’s protection, and senior managers being both ‘out of touch’ and ‘totally unable to control this large institution’ (Fallon, Bluglass & Edwards, 1999: iii). Indeed, amongst the Inquiry’s recommendations was that Ashworth be closed.

THE BOYNTON INQUIRY

The Boynton Inquiry was conducted in 1980 at Rampton Hospital. This Inquiry was conducted following the screening of the film ‘The Secret Hospital’, in which allegations were made of the ill-treatment of patients by staff (Boynton et al., 1980). Upon this report, Rampton was criticised as possessing an ‘institutional inertia’, being outdated and too custodial in manner (Boynton et al., 1980). In particular, the hospital was criticised for its strict rigidity in discipline and routines, its overemphasis on security rather than therapy, and its lack of patient integration (Boynton et al., 1980). In short, Rampton Hospital was criticised for being too closed and isolated and having too great an emphasis on containment. A later follow up report ‘Prejudice and Pride’, conducted ten years after the Boynton Report, found conditions to be much improved (Dick et al., 1990).

THE BROADMOOR DEATHS

The three patients who died at Broadmoor Hospital between 1984 and 1993 were young Afro-Caribbean men; Michael Martin (1984), Joseph Watts (1988) and Orville Blackwood (1991) (Kaye & Franey, 1998). All had been involved in struggles during restraint, and each was forcibly medicated and subsequently placed in seclusion where they died (Kaye & Franey, 1998; SHSA, 1985; 1990; 1993). Whilst these are the most notable patient deaths related to the use of coercive measures within high secure hospitals, they are by no means the only patient deaths associated with the use of restraint and seclusion (SHSA, 2003). These patient deaths sparked mass debates surrounding the use of coercive measures and the levels of risks involved with such practices (Paterson et al., 2003).

What resulted from these reports was the tightening of institutional controls, policies and governance surrounding such practices. Recommendations were made for appropriate staff training into restraint, seclusion, rapid tranquilisation and resuscitation. Explicit rules, regulations and indications were outlined with regards to when these controversial sanctions can and should be used. Furthermore, staff were to closely monitor patients not only during restraint but also after the administration of rapid tranquillisation and whilst in seclusion. The experiences of being under scrutiny by inquisitive media and under obligation to answer to government authority can be assumed to have made strong contributions to institutional roles, work and practices.

HOSPITAL POLICIES ON THE USE OF COERCIVE MEASURES

Inquisitive media, deaths involving the use of coercive measures, public inquiries, and moral and ethical debates have each led to detailed and thoroughly monitored policies and procedures governing the use of coercive measures. Each of the three high secure hospitals have their own local policies on the use of coercive measures, reflecting national guidelines (Department of Health, 2008; 2011; NICE, 2005) and recommendations outlined from those Reports and Inquiries (SHSA, 1985; 1990; 1992; 1993; 2003).

Due to the levels of security and bureaucracy in place to maintain the security arrangements of each of these hospitals, the researcher was only privy to those hospital policies in which this study is located. It is these policies, in place during the time of data collection, for the uses of restraint, seclusion, segregation and rapid tranquillisation that will now be summarised in turn.

RESTRAINT

Restraint is broadly divided into two types, namely; physical or mechanical; each with the purposes of restricting patient movement. Physical restraint is where a patient is held by at least one member of staff, whereas mechanical restraint involves the use of a device, such as a belt (Department of Health, 2008; NICE, 2005). The types of holds and mechanical devices may vary between countries. In England and Wales however, patients are not allowed to be tied to furniture where mechanical restraints are used.

The use of restraint, as set out by the hospital, is divided into policies relating to physical restraint, mechanical restraints, and the use of handcuffs. Interestingly, the policy on physical restraint comes under the umbrella of 'preventing, minimising and managing aggressive and violent behaviour' (Nottinghamshire Healthcare NHS Trust, 2012a), with a separate policy titled 'post restraint procedure' (Nottinghamshire Healthcare NHS Trust, 2011a). The hospital policy outlines that 'the purpose of physical restraint is primarily to take immediate safe control of a dangerous situation by containing or limiting the patient's freedom' (Nottinghamshire Healthcare NHS Trust, 2012a: 7). The type of physical intervention 'must amount to a proportionate, legal, acceptable, necessary and reasonable response to the circumstances' (Nottinghamshire Healthcare NHS Trust, 2012a: 8); with the most common reasons for restraint cited as; 'physical assault, dangerous threatening or destructive behaviour and non-compliance with mandated treatment' (Nottinghamshire Healthcare NHS Trust, 2012a: 7). Staff are required to undergo levels of training identified by their managers with annual updates being a mandatory requirement.

The post restraint procedure outlines that a physical assessment of the patient by a junior doctor must be conducted as soon as possible after the event and any injuries must be recorded (Nottinghamshire Healthcare NHS Trust, 2011a). An incident form must be completed, all staff involved in the

restraint procedure recorded and details of the incident documented in the patient's notes (Nottinghamshire Healthcare NHS Trust, 2011a). Any injuries sustained must be followed up appropriately (Nottinghamshire Healthcare NHS Trust, 2011a).

Mechanical restraints are defined in hospital policy as being 'the application and use of specialised materials or therapeutic aids designed to significantly restrict the free movement of an individual, with the intention of preventing injury' (Nottinghamshire Healthcare NHS Trust, 2012b: 2). In addition, mechanical restraints are identified as 'the most restrictive possible level of response to actual violence' (Nottinghamshire Healthcare NHS Trust, 2012b: 2). Three situations are outlined for their use:

- i) Exceptional and unexpected circumstances, such as emergency situations;
- ii) Short term use, such as planned transfers and reintegration, and;
- iii) Long term use; planned use where 'patients' behaviours cannot be managed in less restrictive ways' (Nottinghamshire Healthcare NHS Trust, 2012b: 5).

Where the use of mechanical restraint is planned, the Responsible Clinician (the consultant psychiatrist or occasionally another clinician holding legal responsibility for that patient under the Mental Health Act) must make a formal application to the Executive Manager, a second opinion must be obtained from another Clinical Directorate and all staff involved to be trained appropriately in their use and physical observations and monitoring of the patient.

The main use of handcuffs is identified as being while patients are 'on leave of absences from the hospital', where handcuffs are 'applied as a safeguard against a serious threat of harm to the public, patients or staff' (Nottinghamshire Healthcare NHS Trust, 2011b: 1). Different types of handcuffs are identified, and patients must only be handcuffed to a member of staff of the same gender (Nottinghamshire Healthcare NHS Trust, 2011b). Staff are to be appropriately trained, risk assessment plans are to be in place, and handcuffs carried at all times, even if not applied, where patients are on leave of absence (Nottinghamshire Healthcare NHS Trust, 2011b). Where handcuffs are applied, this must be documented (Nottinghamshire Healthcare NHS Trust, 2011b).

SECLUSION

Seclusion is defined as the placement of a patient in a locked room that has been specifically designed for this purpose (Department of Health, 2008; NICE, 2005). Hospital policy dictates that seclusion should normally take place in specially designated seclusion room, used as a last resort and for the shortest time possible (Nottinghamshire Healthcare NHS Trust, 2012d). The decision to seclude and to terminate seclusion may be made by the Responsible Clinician, Nurse in Charge or the Site Manager, however, 'throughout the period of seclusion, a suitably skilled professional will be readily available within sight and sound of the seclusion room' (Nottinghamshire Healthcare NHS Trust, 2012d: 3).

Patients must be reviewed every two hours by two nurses; one of whom was not directly involved in the decision to seclude, and every four hours by a doctor or approved clinician (Nottinghamshire Healthcare NHS Trust, 2012d). If the period of seclusion lasts longer than fourteen days, an Independent Review should take place, a specific management plan developed and the use of longer term segregation considered (Nottinghamshire Healthcare NHS Trust, 2012d).

SEGREGATION

Segregation is defined as the placement of a patient in a locked room which may either be the patient's bedroom or where greater restrictions deemed necessary, within a room designed specifically for this purpose. The use of longer term segregation was a relatively new intervention within the hospital, outlined as a revised section within the hospital policy on seclusion at the time of data collection. The policy for longer term segregation remains a joint policy with seclusion to date, however, provides clearer guidelines than before (Nottinghamshire Healthcare NHS Trust, 2013). The indications for using segregation are outlined as 'for a small number of patients who are not responsive to the short term management of violence and aggression' (Nottinghamshire Healthcare NHS Trust, 2012d: 9). Where segregation is used, a management plan must be developed and agreed upon by the Seclusion Monitoring Group within the hospital (Nottinghamshire Healthcare NHS Trust, 2012d). The policies outlined above therefore highlight the levels of institutional control surrounding staff training, expectations and requirements in the event of coercive measures being necessitated.

RAPID TRANQUILLISATION

Rapid tranquillisation is considered to be the administration of medication, via intramuscular injection, against a patient's will (NICE, 2005). The principles for the use of rapid tranquillisation are outlined as a 'strategy used to manage severely disturbed behaviour [where] other strategies, such as de-escalation, time-out, seclusion or oral medication, have failed' (Nottinghamshire Healthcare NHS Trust, 2012c: 2). The decision to administer rapid tranquillisation must be in consultation between a senior nurse and a doctor and the site manager should also be informed (Nottinghamshire Healthcare NHS Trust, 2012c). Physical observations including blood pressure, respiratory rate, pulse and temperature, and levels of consciousness, as determined using the AVPU scale must be monitored and recorded at least every thirty minutes during the first hour then hourly and all staff must receive annual training in hospital life support and monitoring of patients post-rapid tranquillisation (Nottinghamshire Healthcare NHS Trust, 2012c).

RECENT DEVELOPMENTS

THE SPECIAL HOSPITALS SERVICE AUTHORITY

In 1989, the management of all three high secure hospitals in England was taken over by the Special Hospitals Service Authority (SHSA) (Bartlett, 1993; Higgins, 1996). This occurred amidst concerns surrounding the hospitals' organisational structures and lack of common aims and outcomes (Bartlett, 1993; Department of Health, 1992; Evans & Oyeboode, 2000; Higgins, 1996; SHSA, 1995). The SHSA brought about changes to the management structures of the hospitals, from one of predominantly hierarchical arrangement to one of general management, with emphases being placed on improved communication between different staff tiers and professional groups (Evans & Oyeboode, 2000; Higgins, 1996; SHSA, 1995). Multidisciplinary working was highlighted and patient interests were brought to the fore (SHSA, 1995).

In particular, priorities were placed on changing the culture and milieu of the hospitals from one of custody and containment to one of clinical care and treatment (Evans & Oyeboode, 2000; Higgins, 1996; SHSA, 1995). The over-containment and misplacement of individuals within high secure services was further addressed through recognising the need to lessen the isolation of high secure hospitals through better integration with wider services and the

appropriate transfer of patients to less secure services where possible (Bartlett, 1993; Evans & Oyebode, 2000; Higgins, 1996; SHSA, 1995).

NHS MANAGEMENT AND THE PURCHASER-PROVIDER SPLIT

At the same time, the management of NHS services was evolving. In 1991, NHS services in England went from being directly managed by health authorities to becoming the responsibility of individual NHS Trusts, thus emphasising the purchaser-provider split (Abbott, Procter & Iacovou, 2009; Boardman, 2005; Higgins, 1996). The High Secure Psychiatric Services Commissioning Board (HSPSCB), which superseded the SHSA in 1996, in effect became the 'purchaser' of high secure services. The HSPSCB, located within the NHS, was formed with clear aims to align high secure services with mainstream NHS services (Higgins, 1996).

Continuing the recommendations of the SHSA, the HSPSCB reiterated the need for transparency between all services within the NHS, and in particular the integration of high secure services with wider NHS agendas. Each of the three hospitals were to become separate and independent 'providers' being individually responsible for the local management of their hospital, whilst the HSPSCB would be responsible for the coordination and oversight of all three hospitals located within the wider NHS (Higgins, 1996). Broadmoor was to fall under the jurisdiction of London NHS Strategic Health Authority, Rampton under East Midlands NHS and Ashworth under the North West NHS (DoH, 2008). Respecting these policy developments, Rampton Hospital became part of the new Nottinghamshire Healthcare NHS Trust in 2001 (Nottinghamshire Healthcare NHS Trust, 2007).

SECURITY OBLIGATIONS

All three hospitals continue to be independent service providers under local NHS Trusts whilst being overseen by commissioners, however, while continuing to work within national NHS policies, the three high secure hospitals have mandatory security obligations and as such have not completely escaped the prison and legal systems (Department of Health, 2008; 2010a; 2011). Despite high security hospitals being outlined as serving the purpose of providing a 'distinct and separate environment from prisons' (Department of Health, 2010a: 1), their security standards must conform to

Category B prison standards drawn up by the National Offender Management Service (NOMS) (Department of Health, 2008, 2010).

To ensure that these security arrangements are maintained appropriately, these security arrangements are audited annually by the prison service (Department of Health, 2008; 2010). Due to the patients that high secure hospitals contain, the hospitals are also required to work closely with the HM Prison Service, Ministry of Justice and police (Department of Health, 2008). While the hospitals ethos should be therapeutic, emphases continue to be placed upon risk, prevention of absconsion, public protection, physical, relational and procedural security, such that a degree of overlap remains between the institutions of care and containment (Boardman, 2005; Department of Health, 2000; 2008; 2010a; 2010b; 2011). Despite a series of reorganisations and changes of emphasis, the very nature of their clientele has ensured that the high secure hospitals remain delicately balanced between the ideologies of healthcare and those of custodial security.

This emphasis on security necessitates a highly structured environment with everyday reminders of the patient's status as someone forcibly confined to an institution. Unsurprisingly, not all patients accept this readily or all of the time. As explored in the previous chapter, not everyone automatically conforms to social norms and values. For those who fail to comply with institutionally prescribed rules, regimes and practices, further sanctions are created to manage such circumstances. Within a high secure hospital context, these include the use of coercive measures, specifically restraint, seclusion, segregation and forced medication. These increasingly extreme measures, sanctions and consequences are designed to manage 'deviant deviants', and they often raise fears, concerns and anxieties regarding safety, clinical, ethical and moral dilemmas. As patients become increasingly challenging in their behaviours, greater sanctions are required. As sanctions become greater, however, the risks and governance of such practices become more demanding and increasingly controversial.

This chapter has outlined the notions of labelling theory as applied to deviants, and the history and developments of three high secure hospitals in England. The identification of deviants and subsequent social responses to containing such non-conformists via high secure hospitals have been mutually reinforcing. These hospitals have developed in response to an identified need

to accommodate those deemed criminal (on the basis of a lawful conviction) but too mentally disordered to be accommodated in prison, and those deemed mentally disordered but too dangerous or violent to be accommodated in conventional mental hospital settings. Of necessity, the high secure hospitals are eminently custodial institutions and as a result their necessary regulations can sometimes challenge the tolerance of some patients. When this happens in these settings there is no further setting to turn to, and challenges to the authority of the institution have to be accommodated in-house, if necessary by resort to physical restraint, tranquillizing medication or confinement. In effect these are ultimate sanctions applied in response to deviant behaviours amongst an already highly deviant sub-population.

While studies suggest that staff experience strong emotional responses to working with violent patients, few studies have examined the emotional effects upon staff who are called upon and expected to use such coercive methods (Sequiera & Halstead, 2004). The conduct of such measures thereby offers an opportunity to study those institutional provisions put in place for those deemed highly deviant within a highly structured set of rules governed by institutional and organisational contexts. The following chapter provides a review of literature to date which has already considered the use of coercive measures such as restraint, seclusion and involuntary medication in such settings.

CHAPTER 2: INSTITUTIONAL AND EMOTIONAL WORK

So far, the notion of deviance has been examined with regards to recognising 'difference'. While some differences might be beneficial and indeed unproblematic, others are viewed as having negative impacts upon society and thus having negative consequences not only for those deviant individuals but also for those around them. An example of this has been the identification of those who are deemed 'mad, bad and dangerous', requiring high secure provisions in order for them to be contained. Within high secure hospitals, there is a recognition that some patients still fail to conform to those highly organised sets of rules, structures and boundaries. As a result, coercive measures are employed as the greatest sanction.

The literature review revealed that the majority of studies have focused on the demographics of those patients who continue to challenge institutional boundaries and that variations occur in the prevalence of coercive measures between different settings. Context therefore appears an important factor in the use of coercive measures, and, moreover, in the considerations of coercive measures as a transient process: that is, the influences that go beyond patient characteristics and extend towards staff actions and emotions, institutional expectations, rules and values, organisational environment and ward atmosphere. It is proposed here that one of the ways of addressing such personal, professional and wider contextual experiences is through the combined theoretical frameworks of institutional and emotional work.

The tasks faced by high secure hospitals include the containment of individuals who have proved themselves uncontainable in either prison or mental health settings. As such, alternative arrangements are sought through the uses of security, containment and coercive measures within high secure hospitals. These place emotionally demanding expectations upon the workforce, and require a highly institutionalised set of arrangements. Studies of institutional work and of emotional work are not new to the study of organisations but they are rarely studied explicitly in tandem. This chapter aims to bring together the disparate concepts of institutional and emotional work, viewing these concepts as relevant to the study of coercive measures within high secure hospitals. Meanwhile, it proposes that emotions, actions

and institutions operate as interactive and recursive determinants of an organisation's activities.

This chapter will seek to bring together these ideas by, firstly, examining the concept of 'institutional work' in exploring the recursive interactions between actions and institutions (Lawrence & Suddaby, 2006; Lawrence, Suddaby & Leca, 2009). Secondly, theories of 'emotion work' will be explored, examining the efforts required in managing emotions within an organisation (Hochschild, 1983; Bolton; 2005; 2009; Fineman, 1993; 2008). Thirdly and finally, attempts will be made at combining these theories. This will enable a nuanced exploration of the recursive interactions between emotions, actions, institutions and organisations, thereby providing a framework from which to examine the influences, actions, emotions and experiences of those working and residing within high secure hospitals, particularly in relation to the use of coercive measures as a necessary expedient in response to 'tertiary' deviance.

DEFINITIONS: INSTITUTION, ORGANISATION AND ACTORS

Whilst there are no universally accepted definitions, and differences in definitions often reflect different standpoints and interests, the terms 'institution' and 'organisation' are at times used interchangeably within the literature. In the context of this chapter it is proposed that organisations may be studied broadly at three different levels; namely at the levels of the institution, organisation and actors. While these levels have been made distinct for ease of navigating and understanding these concepts, they are inextricably linked with each affecting the other.

INSTITUTION

For purposes of clarification, use of the term 'institution' here will refer to the 'rules, norms and cultural beliefs' (Scott, 2001: 49) that hold both enabling and constraining influences on behaviour (Lawrence & Suddaby, 2006). Institutions are specific to a socio-environmental context, place and time, whilst providing 'stability and meaning to life' (Scott, 2001: 48). Where the institution may be considered somewhat abstract; relating to ideologies, philosophies and belief systems, the organisation provides a physical

structure in encompassing, being permeated by and associated with such ideologies.

ORGANISATION

An organisation has been defined as a 'social structure created by individuals to support the collaborative pursuit of specified goals' (Scott & Davis, 2007: 11). In this sense, organisations are regarded as having a 'relatively fixed structure of authority, roles and responsibilities that [are] independent of the personal characteristics of those filling the roles at any particular time' (Handel, 2003: 2). Actors, either individually or collectively, are therefore those living and working within institutions and organisations, whose actions may reveal those institutionally held values, beliefs and norms.

ACTORS

Each organisation, however, may vary greatly in structure. That is to say, whilst organisations have formal structures, goals and rules, informal social relations (personalities or styles of interpersonal engagement) and institutionally held beliefs exist that may influence the workings of an organisation through individual autonomy, agency, personally held characteristics, values and beliefs (Handel, 2003).

At a micro socio-relations level, the emotions and actions of actors may therefore serve to create, maintain or disrupt institutions and organisations (Fineman, 1993; Lawrence, Suddaby & Leca, 2009). As Fineman (1993) states: 'feelings contribute to, and reflect, the structure and culture of organizations. Order and control, the very essence of the 'organization' of work, concern what people 'do' with their feelings' (Fineman, 1993: 9). Emotions and actions are thus inseparable entities, tied into organisational fields and institutional contexts, since one ultimately affects the other. While studies of emotions in organisations (Fineman, 1993; 2008) and actions in institutions (Lawrence & Suddaby, 2006; Lawrence, Suddaby & Leca, 2009) have emerged, rarely have each of these concepts been explicitly studied together within a single arena.

DEVELOPMENTS IN INSTITUTIONAL THEORY

Institutional theory examines the interplay between actors, agency and institutions (Lawrence, Suddaby & Leca, 2009). The varying degrees of influence and importance placed on actors, agency and institutions, however, have ranged considerably over time. DiMaggio & Powell (1991) distinguish between old institutionalism and new (neo-) institutionalism in addressing such shifts in perception. These distinctions may be best understood in terms of relations between actors and the organisation (old institutionalism), and relations between the organisation and the institutional environment (new institutionalism) (DiMaggio & Powell, 1991; Hirsch & Lounsbury, 1997).

Old institutional theory largely viewed organisations as 'closed systems' where influences outside of the organisation were rarely considered, if at all (DiMaggio & Powell, 1991; Hirsch & Lounsbury, 1997). Furthermore, old institutionalism emphasised the role of organisational influences and constraints upon individual action. From this perspective, individuals were viewed as 'committed actors' working completely under the powers and influences of the organisation (DiMaggio & Powell, 1991; Hirsch & Lounsbury, 1997). This approach therefore largely focuses upon micro-level studies, examining the internal dynamics inside single organisations, while studying the informal social networks and relations within them (Hirsch & Lounsbury, 1997).

New institutionalism, in contrast, largely views organisations as being influenced by their environments (DiMaggio & Powell, 2009; Hirsch & Lounsbury, 1997), thus viewing organisations as 'open systems' influenced by factors beyond the organisation itself (Handel, 2003). Organisations from this perspective are viewed as being largely constrained by institutional forces; being confined to institutional systems, rules and norms (DiMaggio & Powell, 2009; Hirsch & Lounsbury, 1997). Organisations from this perspective are viewed as formal structures with emphases placed upon studying the common characteristics of organisations that enable them to exist and prevail, despite institutional influences, forces and pressures (DiMaggio & Powell, 1991). Macro-level analyses of organisations are therefore popular amongst new institutional studies (Hirsch & Lounsbury, 1997).

Whilst such distinguishing features of old and new institutional perspectives have been drawn upon for ease of comparison, rarely are such extreme and polemic ideas as simplistic or transparent as these theories might suggest. Furthermore, what this somewhat oversimplified and polemic outline of old and new institutional theories aims to draw attention towards, are the possibilities of studying organisations and institutions at multiple levels. Both old and new institutional theories, however, have their own fundamental flaws. Whilst old institutionalism has been criticised for placing too much emphasis on organisational pressures upon actors whilst discounting the wider influences outside of the organisation (DiMaggio & Powell, 1991; Hirsch & Lounsbury, 1997), new institutionalism has paradoxically been criticised for placing too much emphasis on institutional pressures on organisations whilst neglecting the actors working within them (Battilana & D'Aunno, 2009; DiMaggio & Powell, 1991; Hirsch & Lounsbury, 1997; Zucker, 1983). What both perspectives neglect or perhaps give insufficient consideration towards, however, are those concerning individual agency, particularly in terms of explaining organisational and institutional change (Battilana & D'Aunno, 2009; Lawrence, Suddaby & Leca, 2009).

The concept of agency within institutional theories has been of particular importance and relevance when attempting to explain institutional and organisational change (Battilana & D'Aunno; 2009; Holm, 1995). Without agency, questions are raised with regards to the possibilities of change, and indeed how the creation or disruption of institutions can occur (Lawrence, Suddaby & Leca, 2009). The notion of individual agency was brought to the fore through the concept of 'institutional entrepreneurship' in attempting to address how institutional change might occur (Eisenstadt, 1964; 1980; DiMaggio, 1988). The idea of institutional entrepreneurship introduces the concept that individual 'leaders' may be supported by other actors in bringing about institutional and organisational change (Eisenstadt, 1964; 1980; DiMaggio, 1988). The idea that certain individuals might have greater agency than others, however, is subject to much criticism, and critics have been dubious of this notion, particularly since actors are suddenly transformed from 'cultural dopes' into idealised 'heroic actors' (Lawrence, Suddaby & Leca, 2009; DiMaggio & Powell, 1991). Indeed, one of the enduring debates in institutional theory relates to how much influence actors, organisations and their institutional environments have upon one another (Battilana & D'Aunno, 2009; Lawrence & Suddaby, 2006; Lawrence, Suddaby & Leca, 2009).

Lawrence & Suddaby (2006) propose the concept of institutional work in attempting to balance and overcome, or at least pacify such debates and disputes whilst bringing together both old and new institutional perspectives.

INSTITUTIONAL WORK

Lawrence and Suddaby (2006) highlight a recursive relationship between institutions and actions in exploring how institutions are created, disrupted and maintained (Lawrence & Suddaby, 2006; Lawrence, Suddaby & Leca, 2009). The concept of institutional work is based on 'a growing awareness of institutions as products of human action and reaction, motivated by both idiosyncratic personal interests and agendas for institutional change or preservation' (Lawrence, Suddaby & Leca, 2009). As such, attention is drawn to three key elements in characterising institutional work from other institutional theories: i) 'the study of institutional work would highlight the awareness, skill and reflexivity of individual and collective actors'; ii) it would generate 'an understanding of institutions as constituted in the more and less conscious action of individual and collective actors'; and iii) it would adopt an approach that would suggest that 'we cannot step outside of action as practice - even action which is aimed at changing the institutional order of an organizational field occurs within sets of institutionalised rules' (Lawrence & Suddaby, 2009: 220). The notions of agency, intentionality and effort will therefore be considered in relation to what Lawrence & Suddaby (2006) consider 'institutional work'.

AGENCY

One of the key questions emanating from the studies of institutions and organisations is how it is possible for actors to have agency when they are so apparently defined by the institutions of which they are a part. In seeking to manage and overcome this apparent 'paradox of embedded agency' (Seo & Creed, 2002), Lawrence, Suddaby & Leca (2009) refer to the works of Batillana & D'Aunno (2009) in distinguishing between determinist (structuralist) and voluntarist (agentic) schools of thought. Where the determinist perspective views individuals as being products of their environments; internalising and being conditioned by institutional norms and values; a voluntarist perspective conversely attributes actors properties of self-directed individuals; free-will,

autonomy and the ability to change their social contexts (Astley & Van de Ven, 1983; Batillana & D'Aunno, 2009; Burrell & Morgan, 1979). At their most extreme, a determinist perspective would view individuals' actions as complete products of their social systems, whilst an extreme voluntarist perspective would view social systems as being complete products resulting from individual action (Batillana & D'Aunno, 2009). Displacing such polarised perspectives, the theory of institutional work instead adopts an alternative relational perspective in finding a 'middle ground' for agency (Lawrence, Suddaby & Lawrence, 2009). According to this view of institutional work, individuals are embedded within their social context whilst simultaneously being able to respond to situational occurrences (Batillana & D'Aunno, 2009; Emirbayer, 1997). Thus while individuals may be confined to their institutional contexts to a certain extent, they are not confined entirely. Neither do they have absolute agency or free-will in their actions.

Through engaging a relational perspective, individuals are not only perceived to be shaped by their environments but by engaging in institutional work, individuals may then also shape those institutions in which they are located (Batillana & D'Aunno, 2009; Berger & Luckmann, 1967; DiMaggio & Powell, 1991). In this sense, institutions are viewed as being both simultaneously constraining and enabling with regards to individual action, (Lawrence, Suddaby & Leca, 2009). Unlike either the determinist or voluntarist perspectives, rather than viewing institutions and actions as *opposing* forces, institutional work, while adopting a relational perspective, advocates that one *presupposes* the other (Batillana & D'Aunno, 2009; Lawrence, Suddaby & Leca, 2009). In doing so, the concept of institutional work highlights the recursive nature between institutions and individual action, broadening the scope of institutional studies through relocating the traditionally narrow focus on outcomes, to being inclusive of the actions, processes and sequences of events that lead to such transformations (Lawrence & Suddaby, 2006). In relating these ideas to the use of coercive measures in high secure hospitals, questions are broadened from whether or not coercive measures are used, to what are the institutional rules of the organisation, what are the expectations of staff and patients, how do staff and patients know these rules and how do they respond to them, what training do staff have in learning such values, who uses coercive measures, who are they used on and why are they used, if at all.

INTENTIONALITY

The theory of institutional work encompasses the study of 'all human action that has institutional effects' (Lawrence, Suddaby & Leca, 2009: 13). This notion proposes that institutional work may be attributed to all actions that either have direct or indirect consequences in transforming institutions, that institutional work may encompass actions that are either intentional or unintentional and that such actions may have the intended or unintended effects of creating, maintaining or else disrupting institutions (Lawrence & Suddaby, 2006; Lawrence, Suddaby & Leca, 2009). Here, Lawrence et al (2009) introduce the work of Emirbayer & Mische (1998) who outline three different types of agency, namely; iteration, practical evaluation and projectivity, drawing parallels with the possibilities for creating, maintaining and disrupting institutions (Batillana & D'Aunno, 2009; Lawrence, Suddaby & Leca, 2009).

Iteration is associated with the past and is 'manifested in actors' abilities to recall, to select, and to appropriately apply the more or less tacit and taken-for-granted schemas of action that they have developed through past interactions' (Emirbayer & Mische, 1998: 975). The processes of iteration are therefore largely associated with actions that are most often taken for granted; a form of practice Emirbayer & Mische (1998) refer to as 'habitual action'. The institutional work approach posits that this process is intentional given that iteration still requires thought and imagination on behalf of the actor (Lawrence, Suddaby & Leca, 2009). Cognitive processes are required in order to select an appropriate action from a series of possible habits and routines previously enacted (Batillana & D'Aunno, 2009; Emirbayer & Mische, 1998; Lawrence, Suddaby & Leca, 2009). Iterative actions based on routines therefore account for both agency and intention with regard to institutional work.

Emirbayer & Mische's (1998) second strand of agency, namely practical evaluation, is orientated to the present, and lies in the 'contextualisation of social experience' (Emirbayer & Mische, 1998: 994). This dimension involves self-reflection and deliberation in response to current challenges, demands, ambiguities and dilemmas faced by the actor (Emirbayer & Mische, 1998). As such, practical evaluation requires problem-solving abilities that may or may not have intentional effects. The third and final strand of agency proposed by

Emirbayer & Mische (1998) is that of projectivity. Projectivity is orientated towards the future and involves 'imaginative engagement' and 'hypothesisation of experience, as actors attempt to reconfigure received schemas by generating alternative possible responses to the problematic situation they confront' (Emirbayer & Mische, 1998: 984). This dimension takes into account actors' hopes, fears, anxieties and desires regarding the future, and proposes that when faced with problems that taken-for-granted habits cannot solve, actors adopt a reflexive stance and 'project' themselves into the future in attempting to find appropriate solutions (Emirbayer & Mische, 1998). Again, this form of agency relates to institutional work since it draws upon the notion of intentionality in terms of what actors hope to achieve and what actors actually achieve.

Through outlining these three strands of agency, actions may therefore be viewed as holding different degrees of intentionality, self-consciousness and reflexivity. Institutional work may be seen to manifest in different ways given the complexities of actions, intentionalities and differing temporal orientations (Batillana & D'Aunno, 2009; Emirbayer & Mische, 1998; Lawrence, Suddaby & Leca, 2009). Through highlighting actors as thinkers, the focus of traditional institutional theories shifts in giving prominence to the aspect of 'work' as a focal point of study (Lawrence, Suddaby & Leca, 2009). In addition, through establishing the view that all actions have institutional effects, Lawrence & Suddaby (2006) highlight the influences of action involved in creating, maintaining and disrupting institutions. Not only do actors have agency therefore, but through the processes of cognition, actors influence change whether intended or not. In the context of conducting coercive measures in a high secure hospital, actors' intentionality will be reflected in how they go about their tasks, and therefore how their tasks are fulfilled, and detectable in their reflections upon conducting them.

EFFORT

Lawrence, Suddaby & Leca (2009) also direct institutional researchers towards the notion of 'effort' as a specific and discriminate area of study with the potential for adding a further dimension to 'other forms of institutionally related action' (15). They posit that 'the notion of work connects effort to a goal, and thus institutional work can be understood as physical or mental

effort done in order to achieve an effect on an institution or institutions' (Lawrence, Suddaby & Leca, 2009: 15).

EFFORT AND INSTITUTIONAL PLURALISM

It is possible that within the context of forensic psychiatric work, greater effort is required, given the tensions and potential conflicts arising from institutional pluralism. Kraatz & Block (2009) define pluralistic organisations as those with 'more than one institutionally ascribed identity and more than one societally sanctioned purpose' (Kraatz & Block, 2009 :71). Institutional pluralism is of particular relevance to the field of forensic psychiatry, given the dual institutions of legal and psychiatric systems within a single organisation. They further outline that 'pluralism in the institutional environment has the effect of creating *persistent internal tensions* within the individual organisation itself. Contending logistics penetrate the pluralistic organisation, and different people within its boundaries project different identities and purposes upon it' (Kraatz & Block, 2009 :71) Not only do staff have to work between their self and organisational identities, but also between the identities of the two institutions that their organisation is located between.

THE 'THREE PILLAR' MODEL

The effort required in working within such organisations and pluralistic institutions has been analysed in Scott's (1991) 'three pillar' model. The model outlines a useful framework from which to explore different mechanisms that both constitute and support institutions. This framework highlights the different mechanisms involved in constructing and maintaining institutions, and also indicates the varying degrees and types of effort required in overcoming taken-for-granted beliefs, values and assumptions (Lawrence, Suddaby & Leca, 2009). The three pillars are the regulative pillar, the normative pillar and the cultural-cognitive pillar, each of which will now be considered in turn.

THE REGULATIVE PILLAR

The regulative pillar is concerned with the ways in which institutions constrain and regularise behaviour. Scott (1991) states that 'regulatory processes involve the capacity to establish rules, inspect others' conformity to them,

and, as necessary, manipulate sanctions – rewards and punishments – in an attempt to influence future behaviour’ (Scott, 1991: 52). As such, these processes may function through informal mechanisms, such as stigma, marginalisation or exclusion of deviants, or they may be highly formalised and involve the assignment of actors to specialised roles, such as through the formal labelling of deviants and through sanctions enforced via psychiatric and legal systems (Scott, 1991).

The primary mechanism of control according to the regulative pillar is through coercion (DiMaggio & Powell, 1983). Behaviour is regulated as a result of ‘force, fear and expedience’ (Scott, 1991: 53). The use of authority is most commonly applied in this instance in imposing will and ensuring compliance, such that the use of seclusion and restraint may be considered regulative mechanisms within high secure hospitals (Scott, 1991).

THE NORMATIVE PILLAR

The normative pillar emphasises rules ‘that introduce a prescriptive, evaluative and obligatory dimension into social life’ that include both values and norms (Scott, 1991: 54). Values are considered to be concepts that are preferred or desirable (Scott, 1991). Norms on the other hand, specifically outline how things should be done (Scott, 1991). Since certain values and norms are only seen as applicable to actors in certain positions, normative mechanisms may be specific to individual roles within institutions (Scott, 1991).

Moreover, with such prescribed roles, come the responsibilities and expectations of how actors, especially those in specially assigned roles, are supposed to behave (Scott, 1991). Scott outlines that ‘normative systems are typically viewed as imposing constraints on social behaviour... but, at the same time, they empower and enable social action. They confer rights as well as responsibilities, privileges as well as duties, licenses as well as mandates’ (Scott, 1991: 55). As such, actors in prescribed roles may be afforded the rights to engage in activities and actions that would otherwise be forbidden in other circumstances, roles or situations (Hughes, 1958; Scott, 1991). The training of healthcare staff working within high secure hospitals in the use of coercive measures, for example, would, in most circumstances be considered at odds with the healthcare profession. Within the institution of forensic

psychiatry and organisation of high secure hospitals, however, different values and norms are seemingly applied.

THE CULTURAL-COGNITIVE PILLAR

Finally, the cultural-cognitive pillar focuses upon ‘the shared conceptions that constitute the nature of social reality and the frames through which meaning is made’ (Scott, 1991: 57). Actors are seen to interpret and assign meaning to external stimuli (Scott, 1991). Cultural-cognitive mechanisms include both ‘individual mental constructs’ as well as shared meanings (Scott & Davis, 2007: 260), making it possible for individuals to interact (Berger & Luckmann, 1967; Scott, 1991; 2007): ‘To understand or explain any action, the analyst must [therefore] take into account not only the objective conditions but also the actor’s subjective interpretation of them’ (Scott, 1991: 57). In this instance routines are followed because as actions are repeated they become habitualised and as such are taken for granted (Scott, 1991; Scott & Davis, 2007), or, put another way, actions become institutionalised (Lawrence & Suddaby, 2006).

So, not only is effort required in constructing individual meanings while processing shared understandings, but, also, actors are required to question taken for granted routines if they are to challenge institutions. Whilst the use of coercive measures might have been unquestioned in the past and thus regarded acceptable methods of control, it is the questioning of such methods has resulted in changes in training, practices and legislation in attempts to reduce their use. The cultural-cognitive pillar may therefore be viewed as a series of individual and collective meanings and actions; enabling teamwork and shared understandings with regards to role and philosophies of care. Numerous inquiries have resulted in careful reviews which have developed thinking, policy and practice in a way that Scott would understand as the cultural-cognitive pillar.

EMOTION WORK

The concept of institutional work provides a useful and insightful framework for exploring individual and collective action, as the physical actions of actors are important considerations in creating, maintaining and disrupting institutions. However, exercising coercive measures in the context of high secure hospitals is emotionally demanding, and concepts of emotion work are

important in exploring the feelings associated with performing such tasks, particularly within the field of healthcare (Bolton, 2000; Fineman, 1993; 1996; 2003; James, 1989; 1993; Theodosius, 2008). Combining the two sets of concepts, therefore, will enable a fuller understanding of emotions and actions as ‘institutional work’.

THEORIES OF EMOTION WORK

The ideas of Arlie Russell Hochschild are often cited as seminal to the study of emotion work. Hochschild distinguishes between the ‘private’ and ‘public’ presentation of emotion, akin to the works of Erving Goffman concerning the presentation of self (Goffman, 1959). Whereas Goffman uses the analogy of theatre and stage to explore every day interactions – front stage to describe the visible social actions where a performance takes place; backstage where real feelings and hidden interactions may be revealed – Hochschild instead uses the concepts of emotion work and emotional labour to describe the efforts required in presenting oneself in ways that are socially acceptable and indeed desirable within private and public spheres. She uses the term ‘emotion management’ to describe ‘the management of feeling to create a publicly observable facial and bodily display’ (Hochschild, 1983: 7).

EMOTION WORK AND EMOTIONAL LABOUR

Hochschild’s distinction between emotion work and emotional labour is based on context. Hochschild proposes that emotion work takes place in the private realm such as at home, while emotional labour is sold as a commodity and takes place specifically in the context of the workplace. The management of emotions is learnt through ‘feeling rules’; learning how one is supposed to behave in certain contexts and thus requires individuals to act in ways that may be different to what they actually feel. Emotion work and emotional labour are therefore seen as being greatly influenced by organisational rules and individual perceptions of organisational demands upon them.

SURFACE ACTING AND DEEP ACTING

Hochschild distinguishes between ‘surface acting’ and ‘deep acting’. She defines surface acting as the superficial display of emotions using ‘the ability to deceive others about how we are really feeling without deceiving

ourselves' (Hochschild, 1983: 33). Deep acting in contrast is where individuals induce feelings through imagination in a way that such feelings become deceptive to 'ourselves about our true emotion as we deceive others' (Hochschild, 1983: 33). Using the language of institutional theory, deep acting may therefore be considered the process of becoming 'institutionalised' as an individual internalises institutional values, norms and beliefs.

Hochschild warns, however, that either type of acting can be uncomfortable for the individual; superficial acting, as a result of the inauthentic nature of one's actions, and deep surface acting, as a result of the self-induced alienation and estrangement from one's genuine personal feelings and emotions. Drawing upon the works of Karl Marx in *Das Kapital*, Hochschild pursues her line of enquiry through the lens of industrialist capitalism. Actors are seen to be highly constrained by their organisations, emotional labour is performed in light of organisational expectations. Furthermore, emotional labour is sold for a wage and, as such, is viewed as a commodity. As a result, emotional labour, according to Hochschild, is a form of manipulation and exploitation of workers (Hochschild, 1983).

CRITIQUES

Hochschild's theory has been critiqued on multiple accounts since its inception. Nevertheless, it provides a useful starting point whilst taking into account its limitations. Firstly, Bolton (2000; 2005; 2009) has warned of the fallacies of jumping aboard the 'emotional labour bandwagon' (Bolton, 2005: 53). Secondly, Hochschild has been criticised for placing too much emphasis on the organisational control of emotion whilst giving too little recognition to the relevance of individual agency (Bolton, 2005). Thirdly, the applicability to the healthcare profession has been questioned.

MEANINGS OF 'EMOTION WORK'

Bolton's critique of the 'emotional labour bandwagon' was in part due to the multiple meanings and definitions ascribed to the term 'emotion work'. While studies of emotional labour often cite Hochschild's works, their conceptions and analyses have not always been truly representative of Hochschild's theory (Bolton, 2009).

Hochschild used the term 'emotion work' specifically to refer to the effort required in trying to 'work on' or 'to manage' an emotion or feeling (Hochschild, 1979: 561). This managerial notion of effort is comparable to the effort outlined in the discussion of institutional work. It may be argued that managerial intentionality is also a component of emotion work, since the actor is attempting to induce a desired feeling either in themselves or for the purposes of visual display for others. Hochschild defines the effort required in managing emotions as 'how people *try to feel*' (Hochschild, 1979: 560). She distinguishes this from the actions relating to how such managed emotions are displayed, referring to actions as 'how people *try to appear to feel*' (Hochschild, 1979: 560). It is the former rather than the latter that Hochschild was particularly interested in (Hochschild, 1979).

ACTORS VERSUS ORGANISATIONS

In particular, Hochschild's concept of emotion work emphasises conflict between workers and the organisation in which they work. This dualistic comparison of actors versus organisations is considered to be far too simplistic whilst discounting the wider institutional influences beyond the organisation. Actors and organisations may not necessarily have such competing and conflicting ideas and be at such odds with one another. Moreover, such a dichotomy does not account for those actors who enjoy their work and who do not see their work as being as arduous and alienating or requiring as much emotional effort as Hochschild's concept might lead one to believe.

APPLICABILITY TO THE HEALTHCARE PROFESSION

Finally, Hochschild's theory of emotional labour was developed through studies with flight attendants, leading to questions surrounding the applicability of this theory to other professions. For instance, Bolton (2005) uses the example of factory workers. Workers who deal with objects rather than people will ultimately have a different relationship with their work with regards the requirements and expectations of their emotional displays (Bolton, 2005). While positive emotional displays may be desirable in factory work, it is certainly not as much of a necessity as with the work of flight attendants (Bolton, 2005).

Indeed, the healthcare profession is often considered more complex in nature than other professional roles, not only because it requires the management of personal emotions but also that of others' emotions (Bolton, 2009; James, 1989; 1993; Theodosius, 2008). If emotional labour is sold as a commodity, further questions are also raised with regards the genuineness and legitimacy of paid care and how staff manage their personal and professional selves when required to both care and contain (Bolton,2000; Gray, 2009). In drawing links between institutional and emotional work, these critiques will be further explored with regards to 'redefining' emotion work within the context of this study.

(RE-)DEFINING EMOTION WORK

Hochschild's definition of emotional labour refers to the challenges faced by individuals in conforming to organisational expectations. However, it is proposed here that this concept, whilst taking into account individual agency, should also be expanded to encompass organisational and institutional influences and expectations. In doing so, it is hoped that justice will be given to Hochschild's work, whilst simultaneously drawing parallels with institutional work in bringing together these concepts within a single framework of study.

A COMBINED APPROACH

In bringing together the theories of emotion work and institutional work, it is proposed that both of these notions are equally important, especially as emotions can often affect actions and vice versa (Fineman, 1993). This combined institutional and emotional work approach offers a much broader scope than the simple dichotomy between actors and organisations. Furthermore, by including the concept of institutional work, emotion work is no longer confined to the organisation alone, but instead is also seen to be influenced by wider environmental and institutional factors. By taking into account emotions in the study of institutional work, the notions of effort and intentionality are also highlighted, because of the emphases on emotions and actions as 'work'.

Given that Hochschild's theory of emotion work has been developed in palliative care but often criticised for not taking into account the full complexities of healthcare work, it is hoped that this combined approach will address some of these shortfalls. Through viewing institutions and organisations as having both enabling and constraining effects of emotions and actions, emotion work within this context not only encompasses staff management of their emotions in accordance with organisational and institutional expectations but also the emotions of colleagues and patients. Emotion work in this context may as such be viewed as being not only the management of personal feelings, but also the displays of professionalism. For example, managing one's own personal fears and anxieties, whilst instead using taught skills to deescalate and manage confrontational situations instead of fighting or fleeing.

DISSONANCE OVER RULES AND EXPECTATIONS

Institutional-emotional work may also be in response to managing self and others' emotions and actions as well as the expectations of others at individual, organisation and institutional levels:

- At an individual level, staff are expected to maintain the safety of patients, colleagues and the public.
- At an organisational level, staff are expected to abide by the rules, boundaries and security measures in place within the specific hospital setting.
- At an institutional level, staff are expected to uphold the values, philosophies and beliefs of the institution.

Where dissonance occurs between the values, beliefs and expectations of the individual, organisation and institution, institutional and emotional work is likely to occur. This influences the degrees of work and effort conducted by staff, subsequently resulting in the creations, disruptions or else maintenance of institutions (Lawrence, Suddaby & Leca, 2009).

Within the context of a high secure hospital both staff and patients are expected to behave in ways that abide by institutional rules. With regards to patients, they are expected to conform to the rules, boundaries and structures of the institution which require them to behave in non-violent

ways. Where patients deviate from these rules however, staff are required to respond to such incidents. Despite staff's own personal emotions, fears and anxieties in being confronted with such violent situations, they are expected to control these personal emotions, instead, remaining calm whilst trying to deescalate and maintain control of the situation through their professional roles and institutional expectations. Where coercive measures are required these would have to be applied using appropriate holds as trained and deemed acceptable by the organisation, all whilst maintaining the safety standards of the institution.

Given the scope of a combined institutional-emotional framework, this study will take an interest in the workings of the institution at multiple levels. In doing so, different aspects of emotion and institutional work will be examined, while taking into account institutional influences. These will be in the context of the work required by the individual between their personal and professional self, such as their experiences and actions of conducting coercive measures; the relationships between the self and other professionals, through individually perceived roles, identities and expectations; the self and patients, in terms of attitudes, relationships, experiences and perceptions; and the self and institutional values and expectations, through bringing together and examining each of these factors more broadly. By considering the use of coercive measures from this perspective the social world of forensic psychiatry, within which they are conducted, has to be explored.

The following chapter will provide a review of literature to date which has already considered the use of coercive measures such as restraint, seclusion and involuntary medication in such settings. In conducting and presenting this literature review, previous research and current questions will be elucidated with a view to formulating specific research questions for this study, framed against the background of social theory as it might be applied to this context.

CHAPTER 3: LITERATURE REVIEW

The aim of this chapter is to examine the prevalence and factors associated with the use of coercive measures within secure settings. Particular attention will be given to the rates, frequencies and durations of coercive measures used within forensic psychiatry, the characteristics of those secluded and restrained, possible predictors and indicators of using coercive measures, and staff and patient attitudes and experiences. The use of coercive measures remains a controversial method of practice within forensic psychiatry. Ethical and moral debates surrounding the use of such measures are compounded by the need to balance care, safety and security.

Despite such tensions, limited research has been conducted in this area, and this literature review has been conducted in order to clarify current knowledge concerning the management of challenging behaviour and expressions in such settings. These are behaviours that might be identified as tertiary deviance: behaviours that fail to conform to the expectations of institutions explicitly provided to accommodate those who have already proved themselves too challenging to accommodate in institutions narrowly for the 'bad' (prison) or for the 'mad' (hospital).

DEFINITIONS

COERCIVE MEASURES

The term 'coercive measures' has multiple definitions within the literature, creating confusion and difficulties in drawing comparisons for those wishing to examine this topic (Davison, 2005; Jarrett, Bowers & Simpson, 2008). For the purposes of this literature review, this term will encompass the uses of restraint, seclusion and involuntary medication.

RESTRAINT

The term 'restraint' is defined in two ways; the use of physical restraint, where a patient is held by at least one member of staff; and mechanical restraint, where a device, such as a belt, is attached to a patient; both with aims of restricting patient movement (Department of Health, 2008; National Institute of Clinical Excellence (NICE), 2005). 'Seclusion' will be considered as

the placement of a patient alone in a locked room that has been specifically designed for this purpose (Department of Health, 2008; NICE, 2005), and 'involuntary medication' as the administration of rapid tranquillisation via intramuscular injection against a patient's will (NICE, 2005).

VOLUNTARY AND INVOLUNTARY

As a consequence of on-going discussions surrounding 'truly voluntary' or 'covertly involuntary' uses of oral medication (Currier, 2003, p. 60), the decision was made to examine rapid tranquillisation only as a measure of involuntary medication, since the direct act of a staff member administering intramuscular medication against a patient's eliminates such ambiguities. Furthermore, whilst it is recognised that rapid tranquillisation may be administered either orally or parenterally, all identified papers focus solely on intramuscular administration.

FORENSIC PSYCHIATRY

Forensic psychiatry has been defined as the sub-speciality of psychiatry that 'deals with patients and problems at the interface of legal and psychiatric systems' (Gunn & Taylor, 1993, p. 1). Forensic psychiatric inpatients are generally those who have been deemed 'dangerous, violent or having criminal propensities' (Mason, 1993, p. 413) and who have usually 'interfaced with the law at one level or another' (Mason, 2006, p. 3). Thus, those who are considered deviant within mainstream criminal and psychiatric systems require yet another set of institutional rules and boundaries. Patients who are admitted to forensic psychiatric settings however, depend largely on the legal framework of the country.

While some countries detain only those patients found not guilty by reason of insanity or of diminished responsibility in such settings, other forensic psychiatric systems also allow the detention of those who are not manageable in other settings or who pose a particular risk to the community (Department of Health, 2008; Gunn & Taylor, 1993). Secure hospitals may therefore detain mentally disordered offenders as well as non-offenders for assessment, diagnosis, treatment and risk management (Bluglass & Bowden, 1990; Chiswick, 1995; Mason, 2006). In order to achieve a balance between

the need for focus upon settings that provide for those who have challenged both conventions of the law and those of mental stability, and the need to accommodate the variety of such settings across different jurisdictions, forensic psychiatry has been chosen as the service setting of this review, as detailed below.

DEBATES AND DILEMMAS

The uses of restraint, seclusion and involuntary medication are sensitive and controversial areas of practice despite their longstanding traditions within psychiatry (Alty & Mason, 1994; Gunn & Taylor, 1993; Tardiff, 1984). Such practices have been largely influenced by dominant philosophical beliefs, as well as being embedded within the social, political and cultural norms of the time (Alty & Mason, 1994; Soloff, 1984). Currently, the use of coercive measures as a means to maintain safety and security is juxtaposed with the ideals of patient autonomy and individual human rights. As a result, the use of coercive measures has been increasingly challenged.

A number of international guidance documents have called for a reduction and even elimination in the use of such methods (American Psychiatric Association, American Psychiatric Nurses Association & National Association of Psychiatric Health Systems, 2003; National Mental Health Working Group, 2005; NICE, 2005; Queensland Government, 2008), and involuntary treatment practices have faced opposition while viewed as infringements of liberty (The MacArthur Research Network, 2004; National Association of State Mental Health Directors, 2002). Some authors have described the use of coercive measures as 'an embarrassing reality' for psychiatry (Soloff, 1979, p. 302). The use of coercive measures have also been suggested as having paradoxical effects in provoking further violent and aggressive behaviours (Daffern, Mayer & Martin, 2003; Goren, Singh & Best, 1993; Morrison et al., 2002; Patterson & Forgatch, 1985; Thomas et al., 2009). With few alternative interventions currently available, these conflicts have posed great dilemmas for those working in high secure hospitals responsible for the care, treatment and safety of both psychiatric patients and the public.

Despite such dissonance, limited empirical research has been conducted in this area. Findings from general psychiatry indicate that there has been little

consistency in research findings relating to the prevalence of coercive measures (Raboch et al., 2010; Steinert & Lepping, 2009; Steinert et al., 2009). Cross cultural comparisons indicate widespread differences in the numbers of patients and number of times patients are subject to coercive measures (Steinert et al., 2009). Similarly, differences have been found in the frequencies and durations of different types of coercive interventions used (Raboch et al., 2009; Steinert et al., 2009).

Such variations have been apparent in the practice of coercive measures both within and between different psychiatric settings, indicating a lack of standardisation (Raboch et al., 2010; Steinert & Lepping, 2009; Steinert et al., 2009). Where empirical findings have been limited on the prevalence and factors associated with using coercive measures in psychiatry as a whole, even lesser attention has been given to the use of coercive measures within the specialist division of forensic psychiatry, which is the professional “home” of those employed by high secure hospitals.

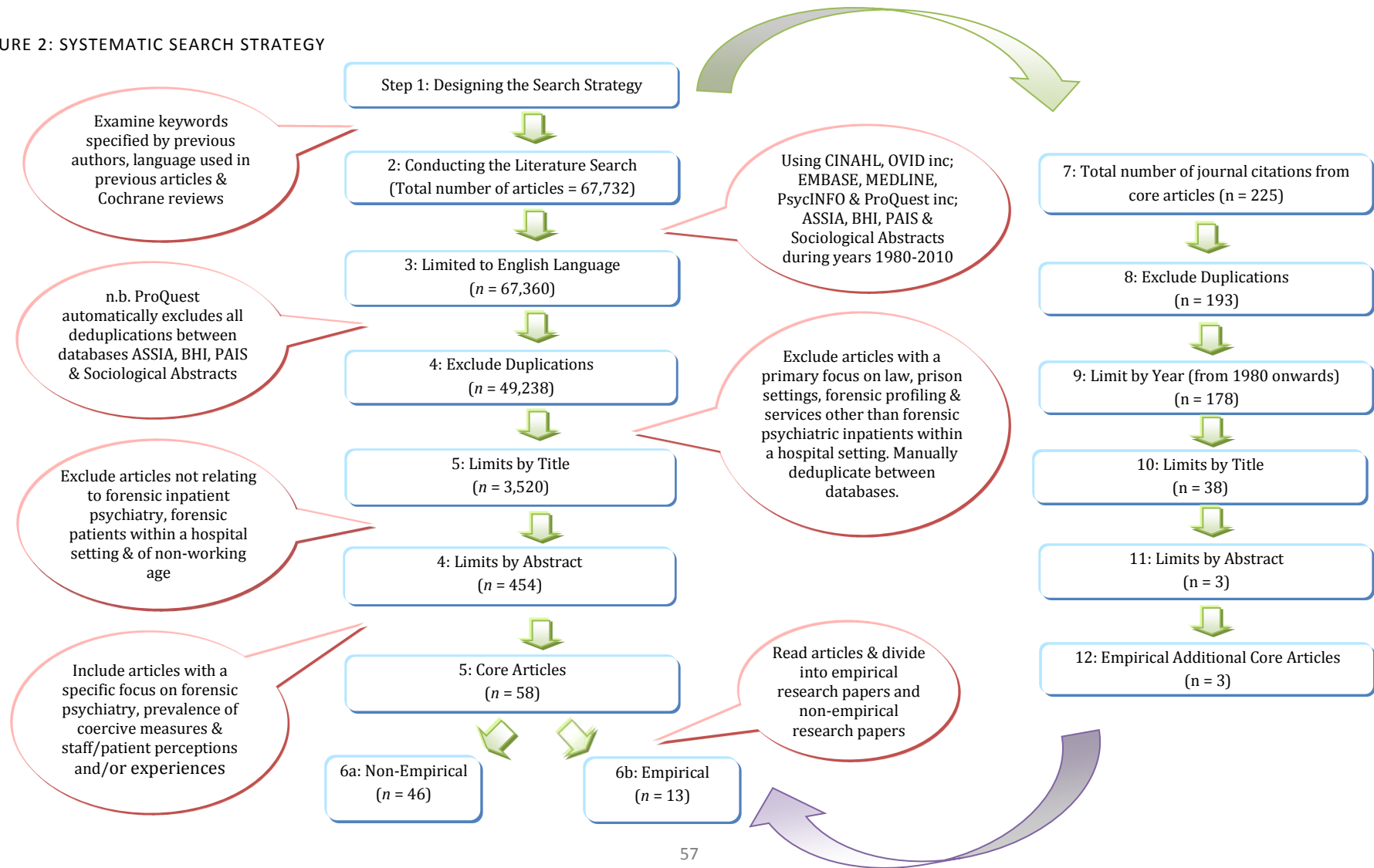
METHOD

A systematic literature search was conducted using electronic databases ASSIA, BHI, CINAHL, EMBASE, PAIS, PsycINFO, MEDLINE and Sociological Abstracts. All articles published from January 1980 to July 2013 were included. In the UK, distinctions are made between secure and conventional psychiatric establishments. Forensic psychiatry is practiced across a range of specialised secure hospitals, specialised medium secure units and what are otherwise considered generalised medium secure units. However, in other countries lesser distinctions are made in terms of levels of security. As a result, the term forensic psychiatry was used in covering all of these eventualities. The main headings relating to ‘forensic’ and ‘psychiatry’ or ‘mental’ or ‘nursing’ were combined with groups of subheadings relating to categories of coercion, restraint, seclusion, involuntary medication, violence and aggression. The search terms ‘forced medication’ and ‘rapid tranquillisation’ were also included alongside ‘involuntary medication’ since these are often used interchangeably within the literature. ‘Involuntary treatment’, however, was not used since this term tended to draw out papers on the legal aspects of patient detention.

A total of 69,241 citations were elicited using this method. The inclusion and exclusion criteria for this review were based on study design, themes of the papers and population samples. Papers were included on the basis that they reported empirical findings using either qualitative and/or quantitative methods. These criteria excluded the majority of citations which were opinion papers, reviews, debates and discussion based articles. Papers were also included on the basis of having a focus on healthcare and being conducted within hospital settings as opposed to prison environments. Papers with themes relating to incidence, prevalence and indicators for using coercive measures were included. Papers exploring themes relating to staff and patients attitudes and experiences of coercive measures were also included. Papers reporting solely on the pharmacological aspects of rapid tranquillisation, however, were excluded. With regards to population samples, this review included studies of forensic psychiatric inpatients of working age (18-65 years) while excluding general psychiatric or community forensic psychiatric settings.

Papers were initially limited through processes of de-duplication and to English language publications only (see Figure 2: Systematic Search Strategy). Remaining citations were further excluded by title and then by abstract. Following all exclusions by title and by abstract only thirteen empirical research papers remained. The citations from these thirteen articles were then reviewed using the criteria outlined in Figure 2: Systematic Search Strategy. This resulted in a further three articles included for review. Despite a large number of citations being elicited at the start of this review, this surprisingly small number of articles was a result of many papers having been excluded through either not being empirical or not having a specific focus on the prevalence of coercive measures. Many articles were also excluded as a result of having not been conducted in relation to forensic psychiatric patients or within forensic psychiatric hospital inpatient settings, where reports of general and forensic populations could not be distinguished, or having a legal rather than healthcare focus. Sixteen papers form the basis of the following discussion.

FIGURE 2: SYSTEMATIC SEARCH STRATEGY



FINDINGS

PREVALENCE OF COERCIVE MEASURES

Amongst the papers reviewed, ten papers focus solely on seclusion, three on restraint and seclusion in combination, two on the uses of restraint, seclusion as well as involuntary medication in comparison, and one on restraint alone. These studies reported varying rates, frequencies and durations of restraint and seclusion. Rates of seclusion have been found to be comparably higher than those of restraint, both by Heilbrun, Rice and Preston (1995) in the United States and by Paavola and Tiihonen (2010) in Finland.

Other studies reported between 29.6% and 35.3% of all patients having been secluded over a one year period within the UK (Mason, 1998; Pannu & Milne, 2008), 44% of patients having been secluded over two year period within Australia (Thomas et al., 2009) and 27.7% of patients having been secluded over a two and a half year period in Canada (Ahmed & Lepnurm, 2001). Whilst the proportions of patients involved in episodes of seclusion appear to vary, differences in study duration as well as the terminology surrounding seclusion need to be taken into consideration.

DEMOGRAPHIC INDICATORS

GENDER

A total of seven studies were reviewed in relation to gender and the use of coercive measures. All of these studies were conducted retrospectively using patient and hospital records.

Comparisons of these findings suggest that females are likely to be restrained or secluded more often than males (Ahmed & Lepnurm, 2001; Mason, 1998; Paavola & Tiihonen, 2010; Pannu & Milne, 2008). Males tend to be restrained for longer periods than females (Heilbrun et al., 1995), however, there are some discrepancies as to whether males (Mason, 1998) or females are secluded for longer periods (Pannu & Milne, 2008). Findings also suggest that females tend to be restrained or secluded as a result of self-harm, whilst male patients tend to be restrained or secluded a result of harming others (Ahmed & Lepnurm, 2001; Paavola & Tiihonen, 2010).

AGE

Four studies report findings on age. All four of these studies present a consensus that younger patients tend to be secluded more often than older patients (Ahmed & Lepnurm, 2001; Beck et al., 2008; Pannu & Milne, 2008; Thomas et al., 2009). Younger patients tend to be secluded for longer periods (Pannu & Milne, 2008). Younger patients also tend to be restrained and secluded, in combination, most often (Beck et al., 2008). There have been no studies, however, that reported age in relation the use of restraint exclusively.

ETHNICITY

Perhaps surprisingly, to date, there have been few studies examining the use of coercive measures between different ethnic groups (Benford Price, David & Otis, 2004; Pannu & Milne, 2008). Only two papers from this review examined ethnicity in relation to the use of coercive measures. A study, conducted by Benford Price et al., (2004), within a maximum security facility in the United States, found that Asian and Black patients were secluded disproportionately more often, while the opposite was found for Hispanic and White patients.

Pannu and Milne (2008) reported similar findings from a high security hospital in the UK, with Asian and Black patients secluded more frequently. Neither of these study findings, however, reached statistical significance (Benford Price et al., 2004; Pannu & Milne, 2008). In addition, these two studies used different categories for grouping ethnic groups, thus, the scope for comparing these findings is somewhat limited.

CLINICAL INDICATORS

DIAGNOSIS

Only four studies examine patient diagnoses, each in relation to the use of seclusion. There appeared to be a general consensus between these studies that patients with a primary diagnosis of 'mental illness' were secluded most often. However, comparisons between these studies are challenged by inconsistencies in the categorisation of patient diagnoses.

LENGTH OF ADMISSION

A study conducted by Beck et al (2008) was the only study, of all those reviewed, which examined length of admission in relation to the use of coercive measures. Findings from this study revealed that patients were most likely to be restrained or secluded during their first two months of admission and that these patients would be restrained or secluded on average between two and six times per month during this period (Beck et al., 2008). Findings from this study suggested that after the first two months of admission, rates of restraint and seclusion were likely to decrease. The durations of using such interventions, however, were not reported.

INDICATIONS FOR THE USE OF COERCIVE MEASURES

Eight papers examined reasons for the use of coercive measures; seven of these were reasons in relation to the use of seclusion only and one in relation to a combination of using both seclusion and restraint. One of these papers focused solely on violence and aggression as indicators for the use of coercive measures (Thomas et al., 2009), one paper examined dangerousness towards self and others (Paavola & Tiihonen, 2010), while a further paper reported findings of 'difficult or disruptive behaviour' being the main reason for using seclusion, without citing other possible alternatives (Lehane & Morrison, 1989, p. 55).

The remaining five papers included much more detailed categories for analysis, citing patient and ward characteristics including; agitation/disorientation, aggression, deterioration in mental state, disruptive/threatening behaviour, suicide/self-harm, timeout, violence towards staff and/or other patients, violence towards property and ward culture as reasons for using seclusion or restraint (Ahmed & Lepnurm, 2001; Heilbrun et al., 1995; Keski-Valkama, Koivisto, Eronen & Kaltiala-Heino, 2010; Maguire et al., 2012; Pannu & Milne, 2008). Findings from these studies suggest violence and aggression (Heilbrun et al., 1995; Keski-Valkama et al., 2010; Pannu & Milne, 2008), and suicide and self harm (Ahmed & Lepnurm, 2001) as the main indicators for using seclusion and/or restraint. Such conjectures, however, should be made with some caution given the inconsistencies in grouping of indicators for the use of coercive measures between studies and the different legal frameworks permitting or prohibiting the use of such measures in particular circumstances.

PATIENT PERCEPTIONS OF COERCIVE MEASURES

Two papers explored patient views of seclusion. Keski-Valkama et al. (2010) interviewed patients from both forensic and general populations to compare their experiences and perspectives. Grant et al. (1989) explored comparisons between patient and staff views of the least restrictive measures.

EXPERIENCES OF PATIENTS FROM FORENSIC AND GENERAL POPULATIONS

Keski-Valkama et al. (2010) conducted interviews with patients post-seclusion and again, at follow up, six months later. Interestingly, forensic patients viewed their experiences of seclusion as punishment more often than patients in general settings. Most patients recognised a need for seclusion, citing actual or threatening violence as a justification, along with agitation/disorientation or the patient's own will. Reasons for the need for seclusion did not differ between forensic and general patients. The majority of patients overall, however, perceived seclusion negatively and around one third of patients were confused over the reasons why they were secluded, even six months later.

Around half of all patients suggested that alternative methods would have been more effective interventions for them rather than seclusion. The majority of patients believed that resting in one's own room, verbal de-escalation, medication and activities such as listening to relaxing music, would have helped. Staff-patient interactions and debriefing were found to be limited and the investigators suggested that continued interaction during periods of seclusion may alleviate patient anxieties and promote better relationships and understanding (Keski-Valkama et al., 2010).

PATIENT AND STAFF VIEWS OF THE LEAST RESTRICTIVE MEASURES

Grant et al. (1989) included forty patients in their study. (The views of staff included in the study will be explored in a later section.) These patients were divided into twenty who were 'experienced' with coercive measures, having been involved in at least three coercive incidents over the previous year, and twenty who were 'inexperienced', having not been involved in any coercive incidents over the previous year. All patients were male. Each participant was asked to complete a questionnaire, outlining four separate incidents relating to self-harm and suicide, violence towards another patient, violence towards

staff and non-compliance. Nine coercive techniques were presented, ranging from 'light' to 'heavy', singular and as a combination of techniques. Techniques presented included removal of personal clothing, physical restraint, mechanical restraint, seclusion, and rapid tranquillisation either by mouth or by intramuscular injection.

Participants were asked to rate each of these techniques in terms of restrictiveness and aversion. Both 'experienced' and 'inexperienced' patients agreed that mechanical restraint was most restrictive, followed by seclusion, rapid tranquillisation via injection, rapid tranquillisation via mouth, loss of personal clothing and finally physical restraint. Overall, 'experienced' patients rated the coercive techniques as being less restrictive than those who were 'inexperienced' (Grant et al., 1989). 'Experienced' patients also rated 'heavier techniques' as being more acceptable than 'inexperienced' patients, although it was unclear whether this was a result of habituation from having experienced coercive measures or whether 'heavier' techniques were actually less unpleasant than they appeared (Grant et al., 1989). Patient exposure to coercive measures therefore appears to have some influence on the perceptions of their use.

STAFF PERCEPTIONS OF COERCIVE MEASURES

The literature on staff perceptions points towards tensions between those who 'authorise and govern', on one hand, and, on the other hand, those who 'do', or are expected to 'do', with regards to administering coercive measures. Inherent conflicts appear to emerge between professional roles and personal ethics. Rather than being able to draw homogenous conclusions from these studies, what apparently emerges instead are the heterogenous views of staff, which may be influenced by personal and professional beliefs, gender and education.

Six studies explored staff perceptions in relation to the use of coercive measures. Four studies adopted questionnaire designs, one to survey the attitudes of doctors regarding the use of seclusion in the UK (Exworthy, Mohan, Hindley & Basson, 2001), one to explore staff opinions and preferences of using seclusion, restraint and medication in the United States (Klinge, 1994), one to explore staff perceptions of the least restrictive

measures in Canada (Grant et al., 1989) and another to explore staff attitudes and perceptions pre and post measures aimed at reducing seclusion in Australia (Maguire et al., 2012). A further two studies adopted interview methods, one study used semi-structured interviews to explore the psychological effects of nursing staff using restraint and seclusion in the UK (Sequiera & Halstead, 2004), and a further study used focus group interviews (Mason, 1993a).

ATTITUDES OF DOCTORS REGARDING THE USE OF SECLUSION IN THE UK

Exworthy et al (2001) used a postal survey to explore consultants', specialist registrars (i.e. doctors training to become consultants in their chosen specialty), and non-training grade doctors' (within the UK system these are doctors who have chosen not to continue training to consultant or full GP status) views of seclusion. Findings indicated that seclusion was generally not perceived as a form of punishment. The majority of respondents supported the continued use of seclusion to prevent harm to others, even though there was ambiguity surrounding any therapeutic benefits. Interestingly, respondents who had roles in authorising the use of seclusion were significantly more likely to view seclusion as having some therapeutic benefits, than those who did not have roles in authorising seclusion. Possible reasons for this, however, were not explored further within this particular study.

STAFF PREFERENCES OF USING SECLUSION, RESTRAINT AND MEDICATION IN THE US

Klinge (1994), compared staff preferences of using restraint, seclusion and medication through a 40-item questionnaire. The study was conducted within a maximum security in the United States. Respondents included psychiatrists, psychologists, social workers, rehabilitation therapists, nurses and nursing assistants. The majority of respondents (63%) preferred the use of medication over seclusion or restraint, and a majority of 65% of respondents preferred the use seclusion over restraint where medication was not an option.

Reasons for using medication over any other coercive intervention were that medication was less physically restrictive, that medication would allow patients to continue participating in interactions in communal areas with staff and other patients and that medication had longer lasting effects. Reasons for

not choosing medication, however, were that seclusion and restraint lead to immediate control, medication administered by injection can be particularly invasive and that restraint and/or seclusion provide more opportunities for the patient to regain control on their own. The main reason for using seclusion was that this intervention was effective in allowing the patient to release more energy; whilst rationales for restraint were that this intervention is more effective in reducing injury to all involved. Staff with greater levels of education believed that coercive interventions were overused. Female staff also believed that patients experienced restraint or seclusion as positive attention whilst male staff believed this was a negative experience for patients. The investigators from this study concluded that both gender and education affected staff perceptions and decision-making, reasons for such decisions appear to be based on perceptions of invasiveness, with staff appearing to opt for the least restrictive measures possible (Klinge, 1994).

STAFF PERCEPTIONS OF THE LEAST RESTRICTIVE MEASURES IN CANADA

In a study conducted by Grant et al. (1989) the views of staff working with males in a maximum security hospital were explored, with regards the least restrictive interventions. Thirty-eight staff were included in the study, divided into nineteen who were 'experienced' front-line psychiatric attendants and twenty who were 'inexperienced', including six occupational therapists, five recreation staff, four psychologists, and four social workers. All but one of the experienced staff were male, while ten of the 'inexperienced' staff were female.

Both experienced and inexperienced staff viewed mechanical restraint as being most restrictive, followed by seclusion. 'Experienced' staff rated rapid tranquillisation via injection as being next most restrictive followed by loss of personal clothing, whilst the opposite was found for 'inexperienced' staff. Agreement resumed for both 'experienced' and 'inexperienced' staff that rapid tranquillisation via mouth was the second least restrictive followed by physical restraint being the least restrictive.

Overall, no significant differences were found between staff of both genders (Grant et al., 1989). 'Experienced' staff rated the coercive techniques as less restrictive than those who were 'inexperienced' (Grant et al., 1989).

'Experienced' staff also rated 'heavier techniques' as more acceptable than 'inexperienced' participants (Grant et al., 1989). Staff however, indicated that the effectiveness of 'heavier' techniques declined as the number of controls increased, indicating a point of saturation in the effectiveness of using coercive measures (Grant et al., 1989). Staff did not think that 'heavier' techniques were effective in preventing future incidents (Grant et al., 1989). It is unclear, however, whether differences between 'experienced' and 'inexperienced' staff were due to exposure to coercive interventions or to professional roles.

STAFF ATTITUDES AND PERCEPTIONS PRE AND POST MEASURES AIMED AT REDUCING SECLUSION IN AUSTRALIA

Maguire et al (2012) conducted a study into staff attitudes pre- and post- a national project aimed at reducing the use of seclusion at one hospital in Australia. The study included the use of three questionnaires; 1) the Confidence in managing Inpatient Aggression Survey (Martin & Daffern, 2006) which requests staff to rate their own and colleagues perceptions of safety and confidence in dealing with aggressive patients within the hospital; 2) the Heyman Staff Attitudes towards Seclusion Survey (Heyman, 1987) which asks staff to rate the validity of certain behaviours leading to the use of seclusion as well as ratings of seclusion on their wards as being therapeutic, punitive or necessary for safety; and 3) the Essen Climate Evaluation Schema (Schalast et al., 2007) which requires staff to rate the social and therapeutic atmosphere of their wards.

Findings indicated that following the project, frequencies and durations of seclusion were reduced within the hospital. However, the number of patients who were secluded remained similar. Despite reductions in the numbers of seclusion episodes, there were no significant differences in staff confidence. Staff did, however, score seclusion as being more therapeutic after implementation of the project. The reason for this was attributed to staff being less complacent with regards the use of seclusion following national scrutiny and initiatives.

PSYCHOLOGICAL EFFECTS OF NURSING STAFF USING RESTRAINT AND SECLUSION IN THE UK

Sequiera and Halstead (2004) conducted 17 semi-structured interviews with nurses and nursing assistants within 96 hours of them having been involved in restraining and secluding a patient. Staff reported feelings of anger and anxiety surrounding the use of restraint and seclusion. Staff reported anxieties with regards to hurting the patient, getting hurt themselves, as well as others getting hurt in the process. Feelings of anxiety were reported to reduce with familiarity, however, many staff reported continued anger and frustration at patients not responding to less restrictive interventions as well as injuring others. Interviewees cited low morale as being associated with the repeated use of coercive interventions. In addition, female nurses in particular expressed conflicts between the uses of restraint and seclusion with their role as a nurse. Those physically administering coercive measures therefore appear to have negative experiences of using these measures. Some staff described being 'hardened' to using restraint and seclusion although were ambivalent regarding the idea of receiving additional support.

CONFLICTS RESULTING FROM DECISION MAKING IN THE USE OF SECLUSION

Mason (1993a) identified five areas of conflict resulting from decision making in the use of seclusion. These came from 1) external pressures stemming from negative perceptions of both seclusion as well as the forensic psychiatry as a discipline, 2) seclusion as a necessary clinical intervention, 3) control elicited through seclusion, 4) dangerousness as a rationale for using seclusion and 5) a perpetuation of seclusion practices resulting from a 'macho culture' (Mason, 1993a). These findings appear to relate to the cultures and philosophies of working amongst the organisation as well as between the personal and professional views of staff.

DISCUSSION OF THE LITERATURE REVIEW

It is apparent that there is a lack of empirical research on the use coercive measures, specifically within forensic psychiatry. The use of different definitions and methods between the research studies reviewed restricts the scope for meaningful comparisons. However, several observations are particularly worth noting. Variations have been found with regards to rates and frequencies of using coercive measures, ranging from 27.7% to 44% of

patients having being secluded with forensic psychiatric settings (Ahmed & Lepnurm, 2001; Pannu & Milne, 2008; Thomas et al., 2009). This appears consistent with findings from general psychiatric literature where rates of coercive measures range from 21% to 59%, (Raboch et al., 2010). Due to such vast variations in findings across all studies, however, it remains unclear whether coercive measures are used more commonly in forensic or general psychiatry; and specifically whether coercive measures are used more frequently amongst secondary or tertiary deviants within society.

Reasons for such differences in the use of coercive measures might result from socio-cultural differences, including how each type of coercive measure is perceived (Bowers et al., 2007; Klinge, 1994; Soloff, 1984), variations in cultural norms and preferences (Bowers et al., 2007; Soloff, 1984; Steinert et al., 2009) as well as differences in local, national and international policies (Maguire et al., 2012; Raboch et al., 2010; Steinert & Lepping, 2009; Steinert et al., 2009). Indeed, there are varying legislative restrictions for the use of coercive measures between countries, depending on the type of coercive measure as well as the circumstances warranting patient restriction (Steinert & Lepping, 2008). In the UK, for instance, mechanical restraint is used only in exceptional circumstances and does not allow patients to be tied to furniture (Department of Health, 2008). However, in other countries, such as Finland, mechanical restraint most often involves the tying of patients to a bed (Raboch et al., 2010; Steinert & Lepping, 2008). Such differences in legislation, restraint methods and practices are likely to alter perceptions of acceptability as well as perceptions of what might be deemed the 'least restrictive' intervention (Bowers et al., 2007; Raboch et al., 2010; Steinert & Lepping, 2008). Such differences in legislations and ensuing practices also serve to highlight the different institutions between different societies in managing those labelled deviant.

Perhaps implicit to such variations, are also the differences in methods and meanings associated with the terms seclusion and restraint. Studies have consistently reported variations in definitions of these terms, such that physical restraint techniques and training may vary between services (Ching, Daffern, Martin & Thomas, 2010; Davison, 1995; Parkes, 1996). Seclusion may or may not be recorded depending on whether the door is open or locked (Ching et al., 2010; Davison, 1995; Mason, 1993b). Whether or not episodes of seclusion are recorded may also depend on whether the intervention was

elected by the patient or staff (Ahmed & Lepnurm, 2001; Mason, 1993b), whether seclusion was viewed as 'time out' or quiet time alone (Ahmed & Lepnurm, 2001; Mason, 1993b), or whether the patient was isolated in their own room or a room specifically designed for this purposes of seclusion (Mason, 1993b). Furthermore, the concepts of seclusion, night-time confinement and longer term segregation are not always clearly distinguished (Ahmed & Lepnurm, 2001; Department of Health, 2008; Mason, 1993b). Such differences in interpretations, meanings and understandings of these terms will ultimately alter reported research findings on the prevalence of coercive measures between settings.

DEMOGRAPHIC & CLINICAL INDICATORS

Age, gender and length of admission all appear to have some influence on the prevalence of using coercive measures. Findings reveal that younger, newly admitted patients are likely to be secluded, or secluded and restrained in combination, more often than those patients who are older and who have been admitted for a longer period (Ahmed & Lepnurm, 2001; Beck et al., 2008; Pannu & Milne, 2008; Thomas et al., 2009). There are perhaps several reasons for this. Those patients who are newly admitted are likely to be most acutely unwell. Both patients and staff are most likely to feel threatened during this initial period of admission, since staff are still getting to know the patient, while patients are still getting to know the staff and ward routine. Staff are also perhaps most likely to feel threatened by those who are younger and most physically fit (Ahmed & Lepnurm, 2001). More research, however, is required into substantiating such hypotheses. Further research is also required regarding age, gender and length of admission in relation to the use of restraint alone.

Categorisations of ethnicity, diagnoses and indicators for the use of restraint and seclusion have been particularly inconsistent. While some differences have been found between studies, these are largely inconclusive. If findings are to be comparable between studies, greater standardisation is needed in terms of how variables are arranged categorically. Since many of the studies were conducted retrospectively, perhaps this also points towards the need to standardise recordings of hospital data. Similar styles of data recording, would enable cross-analyses to be conducted more effectively.

Whilst there has been some research conducted into reducing violence and aggression as an adjunct to reducing the use of coercive measures (Ching et al., 2010; Daffern et al., 2003; Davison, 2005; Fluttert, Van Meijel, Nijman, Bjørkly & Grypdonck, 2010), findings suggest that the use of coercive measures have not been restricted to violence and aggression alone. Reports suggest that violence, aggression, suicide and self-harm may all be primary indicators for the use of coercive measures (Heilbrun et al., 1995; Keski-Valkama et al., 2010; Pannu & Milne, 2008). Other indicators, however, have also been cited to a lesser degree, which require further exploration (Heilbrun et al., 1995; Keski-Valkama et al., 2010; Pannu & Milne, 2008).

So far, little attention has been given to whether certain types of behaviour are more likely to lead to a certain types of coercive interventions being used. Similarly, little attention has been given to whether certain coercive measures may be more effective in managing certain disruptive behaviours. Given the controversies surrounding the use of coercive measures, such research would be important in providing necessary rationales and justifications for using coercive interventions.

PATIENT & STAFF PERCEPTIONS

The finding of only two studies exploring patient experiences of using coercive measures are, in themselves, revealing of the direction further research might follow. Whilst it is particularly interesting to note that forensic patients perceive experiences of coercive measures more punitively than general psychiatric patients, there has been a lack of exploration as to why this might be and whether such findings are restricted to this study only or whether such perceptions are held by forensic patients generally. Similarly, while 'experienced' patients appear more accepting of coercive interventions than 'inexperienced' patients, reason for this need to be explored. Through exploring patient attitudes and experiences, patient preferences may be taken into account in the event of coercive interventions being required.

With regards to staff experiences and perceptions of using coercive measures, those who authorise appear to view the therapeutic benefits of coercive measures positively, whilst those who are expected to employ coercive interventions appear to view such practices with fear, anxiety, anger and even

resentment (Exworthy et al., 2001; Klinge, 1994; Sequeira & Halstead, 2004; Whittington & Mason, 1995). These findings appear to point towards tensions between those who 'authorise and govern' with those who 'do' or are 'expected to do'.

Whilst inherent conflicts emerge between professional role and personal ethics, rather than being able to draw homogenous conclusions from these studies, what emerges instead are the transient heterogeneous views of staff, which appear to alternate between personal and professional expectations and ideologies. Such varied responses from staff are not dissimilar to the views of Whittington and Mason (1995), who propose that perspectives on seclusion are usually far more complex than those of simply being either for or against. Further research is required into this area in order to better understand the experiences leading to and resulting from the use of coercive measures. Greater understanding is also required with regards to the impacts and influences these different perspectives may have on interdisciplinary working, staff and patient roles, actions and policies governing such coercive practice.

REVIEW LIMITATIONS

The search strategy for this literature review was limited to specific healthcare and sociological databases and so articles relating to this subject, but not included within these databases, will inevitably have been missed. The search terms used for this review were carefully selected in formulating this search strategy. However, these search terms will ultimately influence those articles extracted from the literature and the subject matter within. This study has also been limited to hospital inpatient settings only and so the practices of coercive measures amongst forensic patients within prison or community settings will inevitably have been excluded. Moreover, it is recognised that different definitions of coercive measures exist, as do different forensic psychiatric settings both within and between countries, further compounding the already complex nature of this review (Mason, 1993b; Raboch et al., 2010; Steinert & Lepping, 2009).

CONCLUSIONS AND IMPLICATIONS FOR FURTHER THEORETICAL DEVELOPMENT

In conducting this review, limited research has been found on the use of coercive measures within forensic psychiatry. The majority of research so far has focused on the use of seclusion and restraint, with little attention being given to the use of involuntary medication. Younger patients and those who were newly admitted tended to be those patients secluded most often. A common theme throughout many of these studies however, has been a lack of coherence between research strategies and more significantly, a lack of research into this important area. Without such research, a lack of evidence will persist, with constant questions emerging as to why coercive measures are used and how they are justified.

As such, the discipline and practice of forensic psychiatry experience continuing dilemmas around the competing imperatives of patient autonomy and the needs to maintain safety. This literature review has been important in identifying existing gaps in research and areas for developing knowledge. This review has, in particular, highlighted questions as to how staff experience working within such an emotionally charged environment using such contentious practices. The institutional arrangements by which challenging patients are contained, governed and managed under these circumstances might provide some insights into this. The following chapter develops those lines of enquiry by making reference to theories of institutional work and governance, and how these might interact with the emotional work implicit in carrying out tasks such as physically restraining another or implementing forced tranquillisation.

CHAPTER 4: RESEARCH QUESTIONS

As a result of the literature review, it is apparent just how limited the published research has been concerning the use of coercive measures within forensic psychiatric services. Reports have tended to focus on patient demographics and characteristics while little is known about staff perceptions with regards to using coercive measures and particularly how, why and when decisions are made regarding such practices. Likewise, little is known about how staff attitudes relate to wider institutional factors including ward atmosphere and practice. There is evidence of variations in the use of coercive measures between different settings, which appear to reflect institutionally specific phenomena such as ward atmosphere. Previous studies have had distinct foci and different methods of reporting resulting in disparities within the literature along with ambiguous and inconclusive findings. Published studies have tended to focus on factors immediately resulting in the use of coercive measures rather than viewing the employment of coercive measures as a process involving a complex series of interactions contextually located within an institutional setting. It is proposed that a combined theory of institutional and emotional work allows greater emphases to be placed on the importance of studying the use of coercive measures as a process; in turn allowing the explorations of context specific phenomena, such as ward function as well as staff and patient characteristics which may each affect the prevalence of such measures being used. These proposals can be clarified in the following way:

OVERALL OBJECTIVE

- To explore patient, staff and environmental factors that might influence variations in the attitudes towards, and use of, coercive measures across different wards and patient groups
- To analyse how patient, staff and environmental factors might reflect and inform theory concerning the governance and conduct of an organisation obliged to use them.

SPECIFIC HYPOTHESES

- Coercive measures are likely to:
 - Be used more frequently in wards of greater acuity.

- Be experienced more by patients who are younger, more recently admitted and female, as opposed to older, longer-stay male patients.
- Variations amongst staff in attitudes towards aggression and the use of coercive measures will be influenced by their gender, professional role and experience, and the type of ward on which they work.
- The use of coercive measures is likely to be accepted more:
 - By staff, compared with patients.
 - By staff and patients working and residing on those wards where coercive measures are used more frequently.
- The acceptability of different types of containment measures will be influenced by whether or not staff and patients have experienced their use.
- ward atmosphere (cohesion, therapy and safety) is likely to be perceived more favourably by staff than by patients.
- Staff and patient perceptions of ward atmosphere will be influenced by ward function.

CONTEXTUAL ANALYSIS

- A broadly constructivist grounded theory approach will be taken to investigate how institutional and emotional work contribute to staff members' approaches to the use of coercive measures
- A specific focus will be upon how staff manage their personal emotions, professional roles and institutional demands placed upon them when working in a high secure environment
- The relationships between staff, patients and the institution will be explored as processes, while staff experiences will be analysed individually and collectively

CHAPTER 5: SETTING

Rampton High Secure Hospital is a specialist hospital providing high secure services, and also the National Dangerous and Severe Personality Disordered (DSPD) Service for Men, National High Secure Healthcare Service for Women, National High Secure Learning Disability Service, and National High Secure Deaf Service. The hospital contains some of the most dangerous secondary and tertiary deviants within the country, and has the capacity to accommodate approximately 350 patients, deemed to be 'dangerous, violent and often [having] criminal tendencies' (Nottinghamshire Healthcare NHS Trust, 2012d). The patients accommodated in this hospital have been assessed to 'present a grave and immediate danger to the public' and who could not be safely contained within a place of lesser security (Nottinghamshire Healthcare NHS Trust, 2007: 2).

The overall structure of Rampton Hospital is illustrated in Table 1: Structure of Rampton Hospital. The hospital is divided into six directorates, including Mental Health, Learning Disabilities, Personality Disorder, Dangerous and Severe Personality Disorder (DSPD), Women's Service and Deaf Service. The Mental Health directorate is by far the largest of these, with 110 beds, whilst the Deaf Service is the smallest having only 10 beds.

Patients at Rampton may be admitted from prisons for periods of assessment, via courts, or other hospitals of lesser security. The average length of stay at the hospital is seven and a half years. At the end of their stay, patients are usually either transferred back to prison or to places of lesser security (Nottinghamshire Healthcare NHS Trust, 2007b). The daily care of patients is undertaken by around 1000 nursing, medical and allied healthcare professionals. Allied healthcare workers include psychologists, social workers and occupational therapists, all forming part of the internal dynamic and environment of the institution.

TABLE 1: STRUCTURE OF RAMPTON HOSPITAL

Directorate	Number of Wards	Ward Type(s)	Number of Beds
Deaf Service	1	Admission/Assessment/Treatment	10
DSPD	6	Admission/Assessment Treatment	65
Learning Disabilities	4	Admission Therapeutic Community Treatment (2)	50
Mental Health	8	Admission (2) Continuing Care and treatment (2) Treatment Intensive Care Unit Pre-discharge ward Pre-discharge ward for patients with physical disability	110
Personality Disorder	4	Admission Treatment (3)	65
Women's Service	5	Learning Disabilities Enhanced Needs Unit Mental Illness Personality Disorder – Assessment Personality Disorder – Vulnerable Adults	50

CHAPTER 6: METHODS

STAGES OF DATA COLLECTION

This project uses a sequential mixed methods approach, giving equal weighting to both quantitative and qualitative methods. This sequential design encompassed three stages of data collection:

- Stage One – Quantitative examination of hospital databases:
The rates, frequencies and durations of seclusion and rapid tranquillisation within the hospital
- Stage Two – Standardised questionnaires:
Staff attitudes towards aggression, staff and patient perceptions of coercive measures and staff and patient experiences of ward atmosphere
- Stage Three – Semi-structured qualitative interviews:
Staff experiences of using coercive measures

Whilst these stages of data collection will be conducted sequentially, analyses of these data will adopt an iterative approach, all working towards bringing the findings and explanations for such findings together, with each stage informing the other. Given that previous studies have pointed towards the importance of cultural context, stage one will provide the basis for setting the scene of what occurs within the hospital, the types of coercive measures used, upon whom and how frequently. Stage two, will build upon this study of the environment through explorations of attitudes and experiences, most notably creating a sense of the atmosphere and culture. In turn, stage three will develop from these ideas, exploring more specifically how staff experience their work and actions through their personal and professional values, emotions and beliefs. These stages are therefore seen as synergistic, each building upon the former in building richer, more detailed and in-depth explorations and analyses of phenomena occurring within this single hospital.

THE MIXED METHODS DESIGN

Given the nature and complexities of the research questions being asked, this study set out to employ a mixed methods design. Such a design allows the use of coercive measures to be studied as a process, while giving due

considerations to the influences of wider context at multiple levels. That is, moving beyond the questions of what exists, towards investigating the experiences of existing (Pope & Mays, 2006).

TERMINOLOGY

The term 'mixed methods' has previously been used interchangeably with 'multiple methods' in multi-trait, combined, integrative, triangulation or hybrid research (Campbell & Fiske, 1959; Creswell & Plano Clark, 2007; Johnson, Onwuegbuzie & Turner, 2007; Steckler et al., 1992; Tashakkori & Teddlie, 2003). Such interchangeable terminology has lent itself to criticism for being unhelpful in the curation of bibliographies on the subject as well as for causing intellectual confusion (Creswell & Plano Clark, 2007). For the purposes of this study, the term mixed methods will be used with reference to the use of both qualitative and quantitative methods within a single study (Creswell & Plano Clark, 2007; O'Cathain & Thomas, 2006).

BENEFITS

A mixed methods approach is often referred to as 'the third research paradigm', besides the established paradigms of qualitative and quantitative research (Johnson & Onwuegbuzie, 2004; Johnson, Onwuegbuzie & Turner, 2007; Tashakkori & Teddlie, 2003). Whilst the combined use of qualitative and quantitative methods has sometimes been criticised for causing problems of compatibility (Creswell & Plano Clark, 2007; Johnson & Onwuegbuzie, 2004; Kuhn, 1962; Lincoln & Guba, 2000; O'Cathain & Thomas, 2006; Sale, Lohfeld & Brazil, 2002), this study takes a pragmatic approach, viewing mixed methods as both complementary and advantageous. Transcending the qualitative versus quantitative debate, this study recognises both qualitative and quantitative methods as complementary, important and useful, whilst profiting from the strengths of both paradigms (Creswell & Plano Clark, 2007; Johnson & Onwuegbuzie, 2004; Onwuegbuzie & Leech, 2005; Reichardt & Rallis, 1994; Tashakkori & Teddlie, 2003).

Data-collection and analysis in mixed methods research may use qualitative and quantitative methods in combination or in succession with an emphasis on each method working reciprocally to inform the other (Creswell & Plano

Clark, 2007; Ivankova, Creswell & Stick, 2006; O’Cathain & Thomas, 2006; Tashakkori & Teddlie, 2003). However, the guiding principle is that a single method may be insufficient in providing answers to the complexities of questions posed by the professional researcher (Creswell & Plano Clark, 2007; Johnson & Onwuegbuzie, 2004; O’Cathain & Thomas, 2006; Tashakkori & Teddlie, 2003). Mixed methods research may help to uncover data, explanations and answers in a more rounded way, enabling a broad range and depth of exploration whilst offering a more comprehensive approach to answering the research questions being asked (Creswell & Plano Clark, 2007; Johnson & Onwuegbuzie, 2004; Tashakkori & Teddlie, 2003). The strengths of one research method counters the weaknesses of the other, thus providing a more comprehensive strategy for data collection and analysis (Creswell & Plano Clark, 2007; O’Cathain & Thomas, 2006; Tashakkori & Teddlie, 2003).

STAGE ONE: EXAMINATION OF HOSPITAL DATABASES

This initial stage of the study, ‘setting the scene’, sought to address specific questions about the prevalence of coercive measures within the hospital. In particular, it considered the correlation between (a) age, gender, ethnicity and directorate and (b) rates, frequencies and durations of seclusion and rapid tranquillisation. It investigated how often coercive measures are used, what types of patients it happens to, and the reasons recorded as to why such practices are deemed necessary. This data is useful not only in providing a background to coercive measures used at Rampton Hospital, but also in providing comparisons with previous studies and potential indicators requiring further exploration.

The key issues pursued at this stage included:

- i) Whether younger, more recently admitted male patients are more likely to experience coercive measures than older, longer stay female patients
- ii) Whether wards of greater acuity are likely to use coercive measures more frequently

The approach at this stage was therefore quantitative, attempting to measure what happens at Rampton Hospital. Quantitative approaches have traditionally been associated with positivist paradigms based on the

assumption that an objective reality exists that can be explored through the testing of hypotheses (Maykut & Morehouse, 1994; Robson, 2002). As such, quantitative approaches are traditionally aligned with questions of *what exists* rather than necessarily with experiences of *existing* (Pope & Mays, 2006).

DATA COLLECTION AND ANALYSIS

Data was collected over a one-year period, from 1st August 2010 to 31st July 2011. These data only included patients who were residents at the hospital for the whole study period, so that individual rates (i.e. the number of times that an individual had experienced coercive measures in the year) could be obtained. Data from the hospital databases were collected anonymously. Each patient was assigned a unique code, making them unidentifiable to the researcher. Demographic information was collected, including the patients' age, gender and ethnicity, the ward and directorate on which they resided, and the date on which they had been admitted to the hospital and to the current ward.

Through recording all seclusion and rapid tranquillisation incidents within this one year period, the data could then be manipulated in order to explore the frequencies of seclusion and rapid tranquillisation for each individual patient, as well as considering those patients who had experienced both seclusion and rapid tranquillisation during the study period.

The hospital databases recorded seclusion as being used for one of three reasons, namely; 'threatening behaviour', 'attacking staff' or 'attacking fellow patient'. The start and stop times for seclusion were also recorded, such that the duration of each seclusion episode could be calculated in hours. The reasons for using rapid tranquillisation were re-coded into four categories, namely; 'disruptive or threatening behaviour', 'violence to staff', 'violence to fellow patient' or 'self-harm' such that these would be more comparable with reasons for seclusion.

All data was inputted into a specially-designed spreadsheet using the statistical software computer programme SPSS (Version 21). Using this data, the rates and frequencies of coercive measures were examined within the

hospital and individual wards and directorates compared. Variables such as age, gender, length of stay and type of ward were analysed for correlations between the rates and frequencies of coercive measures used.

PURPOSIVE SAMPLING AND CASE STUDIES

Using these data, purposive sampling was used to identify four wards as case studies to be investigated in greater detail. Purposive sampling has the benefits of strategically sampling participants most relevant to answering those research questions being posed (Bryman, 2003). As such, purposive sampling is based on areas of interests central to the study, in this instance exploring factors that influence the use of coercive measures (Cutcliffe, 2000). Using a purposive sampling approach, four wards were chosen based on apparent variations in the prevalence of coercive measures being used. Secondary to this were considerations for gender, diagnoses and variations in ward functions.

These four wards included an intensive care ward (ICU), an admission ward, a treatment ward providing continuing care, and a pre-discharge ward for those patients considered ready to be rehabilitated to a medium secure hospital environment, all within the Mental Health Directorate. The Mental Health Directorate was chosen for several reasons. Firstly, all wards within this Directorate are for male patients only, thereby automatically eliminating gender as a contributing variable in the use of coercive measures (Ahmed & Lepnurm, 2001; Beck et al., 2008; Heilbrun et al., 1995; Mason, 1998; Paavola & Tiihonen, 2010; Pannu & Milne, 2008). Secondly, the primary diagnoses of all patients within the Mental Health Directorate are one of mental illness, as opposed to learning disabilities or personality disorder, allowing consistency in comparisons. Thirdly, and finally, the Mental Health Directorate has clearly defined ward functions through which patients progress from admission to discharge. The patients on each of these four wards will therefore be at different stages of their treatment, thereby allowing variations in ward function, and more specifically, ward atmosphere to be studied.

Since ward atmosphere is considered as being constituted of variances 'in situ', a case study approach lends itself to studying participants within their 'natural' environment with such interactions between the individual and their

context taking a primary focus (Keen, 2006). The statistical stage of analysis therefore seeks to inform 'what happens' on each ward whilst further explorations consider how such variances occur and possible reasons why. The next step was to obtain data through the use of questionnaires.

STAGE TWO: STANDARDISED QUESTIONNAIRES

The second stage of the study focused on exploring whether:

- i) Variations amongst staff attitudes towards aggression and use of coercive measures are influenced by the gender, professional role and years of experience
- ii) Staff and patients working and residing on those wards where coercive measures are used more frequently are likely to be more accepting of their use
- iii) Staff are likely to be more accepting of the use of coercive measures than patients
- iv) Staff are likely to view ward atmosphere more favourably than patients in terms of ward cohesion, therapy and safety

These questions explore ways in which ward atmosphere might influence the use of coercive measures as suggested by previous studies (Brunt and Rask, 2005; 2007; Howells et al., 2009; Schalast et al., 2008) whilst exploring in greater depth the comparisons between the four wards through the use of standardised questionnaires. Three questionnaires were used in exploring staff and patient perspectives; the Attitudes towards Aggression Scale (ATAS), Attitudes towards Containment Measures Questionnaire (ACMQ), and the Essential Climate Evaluation Schema (EssenCES). Reasons for choosing these questionnaires are given below.

In addition to these questionnaires, staff were also asked to complete a short demographics questionnaire relating to their age, years of experience and professional affiliation. The ACMQ and EssenCES questionnaires were distributed to staff and patients, whilst the ATAS questionnaire was distributed to staff only since this questionnaire was designed specifically to measure staff attitudes.

ATAS

The Attitudes Towards Aggression Scale, used specifically amongst staff, aimed to measure how staff perceive patient acts of aggression (see Appendix 1: Attitudes Toward Aggression Scale (ATAS)). This questionnaire had the most relevant sets of subcategories related to this study's research questions, including aggression as offensive, destructive, intrusive, communicative and protective. The questionnaire was designed to be used amongst psychiatric healthcare professional exposed to patient aggression and has previously been used in Europe, including Germany, Netherlands, Norway, Switzerland and the UK (Jansen, Dassen & Moorer., 1997; Jansen et al., 2005; Jansen et al., 2006; Jansen, Middel & Dassen, 2006; Jonker et al., 2008). Through exploring staff perceptions of patient behaviours, indications may be given as to how patient behaviours are interpreted.

This questionnaire offered opportunities for the attempts to explore whether attitudes towards aggression are associated with staff role, experience, staff gender, age or the environment or type of ward in which they work. Through drawing comparisons between staff attitudes and prevalence of coercive measures used on each of the four wards, comparative analyses might also be used in addressing whether, and if so how, staff attitudes might influence the rates and frequencies of coercive measures used, by seeking associations between staff attitudes, rates and frequencies.

ACMQ

The Attitudes towards Containment Measures Questionnaire is the only questionnaire designed to measure staff and patient attitudes towards specific types of containment methods. The ACMQ was originally designed to measure mental health students' and professionals' attitudes across different countries. The ACMQ has previously been used in Australia, England, Finland and the Netherlands to compare student and staff attitudes in psychiatric and secure services (Bowers et al., 2004; Bowers et al., 2007; Muir-Cochrane et al., 2009). As such, not all of the containment measures depicted within the questionnaire are used in the UK.

By using this questionnaire for both staff and patients, however, this study was able to compare staff and patient attitudes; exploring whether or not

there are any differences between staff and patient perceptions, and indeed attempting to compare how attitudes at Rampton might differ between professional groups and from those at different hospitals and across different countries. Through such comparisons, this questionnaire essentially aimed to answer whether there are any differences between those who conduct, those who authorise and those who are restrained by coercive measures.

In addition, this questionnaire had aims of exploring staff and patient perceptions of containment measures that are not necessarily used within the UK, such as the use of a net bed (see Appendix 2: Attitudes Towards Containment Measures Questionnaire (ACMQ)). Through such comparisons and explorations, indications may then be sought as to what types of containment measures might be deemed more appropriate, acceptable and dignified, particularly amidst the recent reintroductions of mechanical restraints in England and Wales. Through identifying what type of containment measures are deemed most acceptable, indicators might also be given with regards perceptions of the 'least restrictive measures'; a policy orientated term, which is essentially meaningless without careful considerations of those directly responsible for and experiencing such methods.

ESSENCES

The EssenCES questionnaire was designed specifically for use in forensic psychiatric hospitals in measuring ward climate related to wellbeing and treatment outcomes (see Appendix 3: Essen Climate Evaluation Scale (EssenCES)). The EssenCES questionnaire has previously been used and validated in England and Germany (Schalast, 2008; Schalast et al., 2008; Howells et al., 2009) and was chosen as shorter alternative to ward Atmosphere Scale (WAS) (Moos, 1974; 1989). The EssenCES questionnaire is a 15+2 item instrument (two of the items are not scored) in comparison with the older WAS alternative having 100 items (Moos, 1974; Brunt & Rask, 2005; 2007). The EssenCES was therefore seen as a more efficient scale for both staff and patients to complete.

The EssenCES questionnaire is divided into three parts, each pertaining to measuring ward cohesion, therapy and perceptions of safety. Through measuring both staff and patient perceptions, these can be compared to give

indicators of similarities and differences. Findings from this questionnaire might also bring to attention areas of improvement and implications of future practice. Where any obvious discrepancies between staff and patient perceptions might arise, or where any particular areas are scored more negatively, attention may be given to these areas in looking at ways in which this might be improved, reasons why this might be and how this area may be strengthened such that both staff and patients achieve greater common understandings and expectations of ward role and functions.

DATA COLLECTION

STAFF

The sets of questionnaires were distributed to staff in two ways; via email and as hard paper copies. Firstly, an email was sent to all staff working on each of the four wards, by way of introduction, providing information on the study and inviting them to take part. The sets of questionnaires and participant information sheets were attached to this email.

Staff were informed that they could return their questionnaires in one of several ways. They could attach their completed questionnaires in a separate email to the researcher, whereby the researcher would print off the completed questionnaire, delete the email and collate further questionnaires before looking at the results in order to maintain anonymity. The participant could post their completed questionnaire anonymously to the researcher. The participant could place their completed questionnaire in a box provided on each of the four wards in a location agreed by each of the four ward managers. Or, the participant could return the questionnaire directly to the researcher in person during allocated ward visits.

A total of three emails were sent to the participants. Once at the beginning of the study period, a second time between two-three weeks after the commencement of the data collection period, and a final time two weeks prior to the study end. The researcher made regular visits to each of the four wards during this time, visiting each ward at least twice a week whilst aiming to spend as much time on each of the wards as feasible, in accordance with ward and staff demands.

Each staff member was given a paper copy of the set of questionnaires at the commencement of the data collection period. This was done with the permission of the ward manager in several ways. The paper copy of the questionnaire, along with the participant information sheet was placed in individual staff pigeon holes or drawers, they were individually addressed and given out to individual staff by their ward managers, or they were given to staff individually by the researcher during ward visits. The researcher also brought along additional paper copies on each of the ward visits in the event the original copies had been misplaced. The majority of staff questionnaires were completed and returned to the researcher during ward visits ($n = 27$), some were returned to the researcher via the box placed on the ward ($n = 25$), and minimal numbers were returned via post ($n = 5$) and email ($n = 1$).

PATIENTS

Patients were asked a maximum of three times in total, spread over separate visits, whether or not they would like to participate in the study so as not to cause distress to their wellbeing. Patient questionnaires were distributed and completed in different ways according to the type of ward. These differences appeared to be several fold, often depending on the staff who were on duty, their differences in approaches to working and opinions/interests in research and perceived levels of risk and vulnerability between the researcher and patient.

ACCESS TO PATIENTS

ADMISSIONS WARD

On the admission ward, staff would generally allow the researcher to accompany them around the main ward, but would approach individual patients on behalf of the researcher to ask the patient if they would be interested in taking part. Here, staff would ask if the patient would like to complete the questionnaire with the researcher, or whether they would like to complete the questionnaires in their own time and return their completed questionnaire to the researcher at a later date. Around half the patients chose to complete the questionnaire alone with two patients choosing to spend time with the researcher afterwards to discuss their answers.

A quarter of patients on this ward completed the questionnaire with the researcher in the visitors room with a member of staff being present, whilst a further quarter completed their questionnaire with the researcher in the dining room with staff watching from the office but not in the dining room itself. Those patients completing the questionnaires with the researcher took place on separate days with different members of staff on shift, perhaps reflecting the differences in where the questionnaires were completed and whether or not the researcher was allowed to be alone with the patient. All patient questionnaires from the admission ward were returned to the researcher in person.

INTENSIVE CARE WARD

On the intensive care ward, the researcher would be asked to wait in the ward visitor's room. The staff would initially approach the patient on behalf of the researcher to ask if the patient would be interested in participating. If patients were interested, the patient would then be escorted by a member of staff to the visitors' room and would complete the questionnaire with the researcher whilst a member of staff would wait outside, with the door always being kept open. As such, all questionnaires were returned to the researcher in person.

TREATMENT WARD

With regards to treatment ward, the ward manager invited the researcher to attend a weekly 'patient forum' to inform patients about the study and to discuss any questions the patients and staff may have had. The patient forums were conducted on a weekly basis on the treatment ward and were designed as a way for patients to vent any issues, to air any grievances and to discuss any changes to the ward.

As the treatment ward was regarded as a ward for patients who were 'treatment resistant', the majority of patients chose to complete their questionnaires with the support of the researcher or ward staff. As several patients had 'off-ward' activities on the days of the patient forum, the manager would approach these patients on an individual basis on behalf of the researcher and these questionnaires would be returned via the allocated ward box. A total of six patient questionnaires were returned directly to the

researcher in person, and three returned to the researcher via the allocated box.

PRE-DISCHARGE WARD

Finally, the pre-discharge ward used a similar approach to the treatment ward, in terms of the researcher being invited to the weekly patient forum to firstly introduce the study and to answer any questions, followed by successive visits for patients who may have either not attended the previous meeting or who may have wanted to complete their questionnaires alone in their own time. Many of the patients on this ward voiced that they did not want to take part, largely because they felt they were coming to the end of their time at the hospital and that taking part was an 'additional' demand on what had already been expected of them during their time at the hospital. Of those patients who did complete the questionnaires on this ward, all patients completed their questionnaires alone. Three patients returned the questionnaires directly to the researcher in person and five returned their questionnaires via the allocated ward box.

Findings from these questionnaires may therefore be analysed in relation to the frequencies of coercive measures used at Rampton in investigating any associations between ward staff and patients perceptions of ward atmosphere and frequency of using coercive measures. Comparisons may also be drawn with previous studies, between wards, staff roles, staff and patients, whilst all cumulating into providing a broader and in-depth picture of variables associated with environment, context and use of coercive measures.

STAGE THREE: SEMI-STRUCTURED INTERVIEWS

The final stage of data collection involved semi-structured interviews with staff, exploring their experiences of using coercive measures in context. This stage involved qualitative investigations into how institutional and emotional work contribute towards staff members' approaches to the use of coercive measures. Previous studies have acknowledged that the use of coercive measures involves complex interactions and influences. However, few studies have explored staff experiences of conducting such practices through staff narratives. This final stage therefore explored questions of:

- i) What it is like to perform such coercive practices under presumably intense/stressful situations
- ii) How staff manage such expectations placed upon them
- iii) How staff deal with the emotions accompanied by such institutionally accepted practices which would be largely deemed unacceptable elsewhere

The interviews were conducted and analysed using a largely constructivist grounded theory approach.

GROUNDED THEORY

Grounded theory is considered a useful qualitative method to adopt in mixed methods research, allowing researchers to explore understudied social phenomenon within their natural environments (Charmaz, 2011; Glaser & Strauss, 1967). There are, broadly, three types of grounded theory, namely, objectivist, post-positivist and constructivist (Charmaz, 2011). These are distinguished largely through their philosophical standpoints. While all three versions of grounded theory have commonalities in the development of theory, the philosophical underpinnings and processes by which to do this are what distinguish them.

OBJECTIVIST GROUNDED THEORY

Objectivist grounded theory, also termed Glaserian grounded theory, places emphases on positivist empiricism (Charmaz, 2011; Glaser, 1978, 1998; 2001). Researchers are assumed to take a neutral approach to data collection and analyses such that theories emerge from the data and may be generalised independent of time, place and participants (Charmaz, 2011; Glaser, 1978, 1998; 2001).

POST-POSITIVIST GROUNDED THEORY

Post-positivist grounded theory, developed by Strauss and Corbin (1990; 1998) in contrast, is rooted in symbolic interactionism and interpretivism (Charmaz, 2011; Corbin & Strauss, 2008; Strauss & Corbin, 1990; 1998). Post-positivist grounded theory places less emphasis on theories emerging from the data and greater emphasis on preconceived coding and analytical frameworks from which to apply data (Charmaz, 2011; Corbin & Strauss, 2008; Strauss & Corbin, 1990; 1998). As such, data is seen as testing,

developing and building upon existing theories rather than necessarily providing innovative new theories (Charmaz, 2007).

CONSTRUCTIVIST GROUNDED THEORY

Constructivist grounded theory integrates both objectivist and post-positivist approaches. As Charmaz (2011) states, 'constructivist grounded theory views knowledge as located in time, space and situation and takes into account the researcher's construction of emergent concepts' (Charmaz, 2011: 365). Constructivist grounded theory therefore draws upon the methodological strategy of emergence developed by Glaser, whilst building upon the social constructivist approaches inherent in Strauss's perspective (Charmaz, 2011). Constructivist grounded theory views the interactions between the researcher, participants, data and prior knowledge as influencing the processes of data collection, analyses and presentation of findings. Thus, findings and analyses are considered to be mutually constructed through the researcher's knowledge, viewpoint and understandings, as well as from those of the participants and what is learnt from their narratives.

Emphasis is placed on the roles of relativity and reflexivity, entailing that researchers be aware of their own philosophical and disciplinary positioning and communicate this transparently to their audience (Charmaz, 2011). As such, it recognises that researchers may attempt to be objective, but can never be completely value-free. Whilst the researcher is encouraged to take an open-approach to data collection and to be guided by what the participants say, they are simultaneously guided and influenced by the theoretical framework and background literature in which their study is embedded. A constructivist grounded theory approach is therefore considered best suited to this study's line of inquiry since it enables data to be considered in relation to sociological theories of deviance, social control, institutional and emotional work, whilst remaining open to new ideas in developing and enhancing current understandings, both of social theory and mental health practice.

SENSITISING CONCEPTS AND SAMPLING METHODS

The context and positioning of the researcher have been described as 'sensitising concepts' (Bowen, 2006; Charmaz, 2011). Sensitising concepts may include the discipline in which the study is located, as well as the

theoretical and conceptual frameworks in which the study is positioned (Bowen, 2006; Charmaz, 2003; 2011). They lay the foundations for research through providing a perspective, 'draw[ing] attention to important features of social interaction and provid[ing] guidelines for research in specific settings' (Bowen, 2006: 3). The sensitising concepts grounding the context of this study included the systematic literature review, quantitative analyses of hospital databases and analyses of staff and patient questionnaires, and the location of the study within an interdisciplinary framework bringing together concepts from Sociology, Psychiatry and Forensic Psychiatry.

A combination of purposive and theoretical sampling methods were used to recruit participants for interview. In adopting a grounded theory in context approach to conducting the interviews, a largely theoretical sampling approach was used to recruiting participants with some elements of purposive sampling in gaining the views of all multidisciplinary team members. A purposive sampling approach aims to seek participants strategically, gaining a variety of participants' views in order to answer those research questions being posed (Bryman, 2008). A theoretical sampling approach occurs only after collection has begun with aims to explore properties of emergent conceptual categories (Charmaz, 2006; Glaser, 1978, 1998; Morse, 2007). Whilst theoretical sampling is a key tenet of grounded theory, it is recognised however, that purposive sampling can and does often occur, at least in the early stages of data collection, in propelling the discovery and emergence of early ideas and providing direction for further sampling (Coyne, 1997; Cutcliffe, 2000; Lincoln & Guba, 1985).

Potential participants were invited to take part both during ward visits and upon return of their questionnaires when these were returned to the researcher in person. The researcher was interested in gaining the views of all multidisciplinary staff who had experience of using coercive measures (thereby being guided by purposive sampling), and also in following up ideas and themes using theoretical approaches. Overall, the numbers of staff interviewed in each professional role were representative of the proportions of staff from different professional groups working on each of the four wards. These findings, however, are perhaps generalizable only to this context given the specificity of being located within high secure hospital.

INTERVIEW SCHEDULE

Against this background, interviews were conducted using a semi-structured schedule and a narrative approach. To encourage staff to speak openly about their experiences, interviews began with the open question 'Please can you tell me about your experiences of using restraint and seclusion?'. Further questions and prompts were then guided by participants' responses, such as asking participants to speak either about their very first experience of using restraint and seclusion, or, if they could not remember this, to speak about an incident that stood out most for them.

Thus, whilst the interview schedule provided a guide to cover the topics brought about by the sensitising concepts, the interviews were conducted in a way that allowed participants freedom to respond. Through asking broad, open questions related to the research topic, opportunities were given to individuals to respond in ways that allowed them liberty to talk about their personal experiences, to reflect upon their working role and to talk openly about their personal responses to the hospital's governance arrangements.

In following an emergent approach guided by the principles of grounded theory, this open approach was conducive to the researcher being both guided and informed by what participants said, rather than imposing their ideas upon the data being collected (Blumer, 1954; Charmaz, 2011; Glaser & Strauss, 1967). During the iterative process of data collection and analysis, the research became more closely immersed in the data. The open but sensitised approach to data collection allowed actions and processes to be explored in greater detail and for further ideas to emerge, whilst such open-ended questions allowed scope for revealing individual and institutional idiosyncrasies during analyses.

Where principles of grounded theory call for 'constant comparisons' between data collection and analyses, the interviews were transcribed, compared, analysed and coded according to emerging actions and processes relevant to the participants. These actions and processes were in turn categorised according to theme, and in turn compared with existing conceptual frameworks and ideas to develop a substantive theory specific to the study context.

CHAPTER 7: ETHICAL CONSIDERATIONS & REFLECTIONS

PART 1: ETHICAL CONSIDERATIONS

Full ethical approval was sought for this study prior to collecting data and contacting potential participants. This was granted by the National Research Ethics Service Committee (NRES) (REC Ref: 11/EM/0322) and the Nottinghamshire Healthcare NHS Trust Research and Development Department (Local Ref: CSP/27/10/11) (see Appendix 5: National Research Ethics Services Committee Approval and Appendix 6: NHS R&D Ethical Approval). This included approvals of all forms used within the study process; participant information sheets, consent forms and questionnaires (see Appendix 7: NRES and NHS R&D Approved Forms). Ethical considerations have been taken into account throughout the processes of data collection, writing and dissemination of research findings. These will be outlined in three parts, namely; informed consent, anonymity and confidentiality and honesty and non-malevolence.

INFORMED CONSENT

Following NHS research ethics procedures, the patients' first contact with regards the study was always by a member of their clinical care team, rather than the researcher. The researcher did not have any contact with patients until agreement had been sought by a member of clinical staff that the patient was happy to be approached by the researcher about the study. Once agreement was gained from the patient that they were happy to be contacted by the researcher, patients would be visited on each of their respective wards, and the information sheet and questionnaires would then be given. Patients were given opportunities to speak with the researcher and to ask any questions during the researcher's visits to each ward. The information sheet also included contact details for the researcher in case of any additional questions or queries. Patients were given time to think about whether or not they wished to take part in the study, although some patients wished to complete the questionnaires straight away and this was allowed under research ethics guidance since the study was not viewed as being invasive or threatening. The researcher would revisit each patient approximately one week after initial contact, depending on ward schedules, to ask whether or not they wished to take part. For those patients who declined during the

second visit, they were no longer contacted by the researcher. For those who wanted more time to think about it, they would only be revisited once more so as not to cause any undue distress to themselves or other patients, or disruption to scheduled ward activities and routines. Patients were made aware of this. On agreement to take part, the REC advised that signed consent would not be required of patients and that the returning of questionnaires was sufficient acknowledgement of consent having been given. This was outlined to participants within the information sheet as well as during face-to-face contact. Details with regards to returning of questionnaires will be outlined in the section 'Anonymity and Confidentiality'.

With regards to staff, similar ethical procedures applied. The modern matron for the Mental Health Directorate along with ward managers of each of the four wards were initially contacted with regards their support for the study. The four ward managers each agreed to provide names of the staff members working on each of their wards. Considerations for issues of anonymity and confidentiality surrounding this will be discussed in the following subsection. Staff were invited to take part in the study via email as well as during the researcher's visits to each of the wards. Electronic copies of the participant information sheet, questionnaires and consent forms for interview were sent to staff via email. Staff were also given paper copies of these during ward visits. Staff were given time to think about whether or not they wished to take part and opportunities were given for staff to ask any questions or to raise any concerns with regard to participating. Reminders of the study were sent to staff via email two weeks after the initial email contact. Staff were also reminded of the study during the researcher's scheduled ward visits. Again, the return of questionnaires was taken as agreed consent to take part. This was outlined in the participant information sheet and reiterated during face-to-face contact. For the purposes of interview however, signed consent was required and sought, especially given that staff were digitally voice recorded. Additional information was provided for staff with regards taking part in the interviews and whom to contact should they become distressed either during or after the interviews, particularly due to the potentially sensitive nature of the topic being discussed. Details of this information can be found within the staff participant information sheet (Appendix 7: NRES and NHS R&D Approved Forms). All initialled, signed and dated consent forms were kept securely, in locked University premises in line with the research protocol, whilst taking

into account issues of anonymity and confidentiality as will be discussed in the following.

ANONYMITY AND CONFIDENTIALITY

Considerations for anonymity and confidentiality are important both in research and healthcare, yet these two terms are often used interchangeably. Anonymity has been defined as ‘the means of protecting the identity of research participants’ (Goodwin, 2006: 53), while confidentiality, ‘the safeguard against invasion of privacy’ (Goodwin, 2006: 55). Where the emphasis of anonymity is placed upon preventing the identification of participants, confidentiality in contrast places emphasis on discretion in giving information. These issues of course need to be carefully balanced and considered in relation to the honesty and openness of the researcher and of the research process, allowing fair and analytical critiques of the study and study findings. This section aims to outline the issues of anonymity and confidentiality encountered both during fieldwork and writing up, including discussions of how each of these issues have been addressed.

Health Information Services (HIS) were contacted with regards accessing the hospital level data. This service was part of the hospital, and all of this data was received and kept in anonymised, confidential and password protected formats such that the researcher was assured by the ethics committees that this satisfied ethical standards and would not require ethical approval.

A primary concern in the management of anonymity and confidentiality was the collection and storage of information regarding participants. This included the recording and safe storage of staff names, collection of questionnaires, storage of staff consent forms and safe recording and storage of staff interviews. These will be discussed in turn. Patient names were never recorded. However, each patient questionnaire included a unique identification number for the purposes of recording and analysing study findings. The recording and safe storage of identifiable data was a particular issue for staff, where names were required so that individual staff members could be contacted. In order to maintain the anonymity of staff participants, all staff names were kept in a secure password protected file, using a University password protected computer. Unique identification numbers were assigned to individual members of staff for the purposes of data

collection and analysis, such that staff wards and roles could be identified by the researcher but the full identity of the individual remained protected. This process was put in place not only to preserve the anonymity of staff but also to regulate any potential researcher bias during analysis of results.

Issues of anonymity and confidentiality were also raised with regards the returning of questionnaires. All patient and staff participants were given the option of either returning their completed questionnaires directly to the researcher during ward visits, or to return them via a secure box placed on each of the four wards. Staff were also given the option of posting their completed questionnaires, although this was not an option for patients due to security regulations of the hospital. All questionnaires were collated prior to the inputting of data on the study spreadsheet such that this would reduce the likelihood of the researcher being able to identify participants individually through questionnaires that might have been returned directly in person on a visiting day.

Consent forms from staff were stored in a locked cupboard within University key accessed premises for secure storage. These were kept separately from the interview recordings. Hospital security procedures were followed with regards the use of a digital voice recorder, being encrypted and approved by the Hospital's security department. The voice recorder was kept in secure University premises when not in use, and any names or other identifiable information mentioned during interviews were not transcribed. Transcriptions of interviews included details of staff gender, ward and role for purposes of analysis. Word processed copies of these were password protected and paper copies were stored in locked cupboards when not in use. Much time was spent between the researcher and supervisors debating whether or not the name of the hospital as well as staff genders and roles should be disclosed within this thesis. The decision was made to disclose this information since the research setting is central to both the understanding of high secure hospitals as well as the theoretical underpinnings of this thesis. Moreover, the disclosure of staff roles and experiences, along with the types of wards from which data were collected, are seen as vital in providing openness and transparency to the reader; adding towards richness of data found within a single hospital; as well as in allowing comparisons to be made between studies. The issues of anonymity and confidentiality have therefore undergone much thought throughout this study and it has not been without

due regard that locations, staff roles and ward types have been revealed, with the full intentions of maintaining anonymity and confidentiality to all involved.

HONESTY AND NON-MALEVOLENCE

To not deceive or not to do harm to participants are central tenets of conducting ethical research. The researcher was honest about their role at all times; making both patients and staff aware that they were conducting this study as part of an ESRC PhD Case-funded Studentship and that they are a mental health nurse by background with a personal interest in this subject. It was of great importance to the researcher that they disclose this information, not only due to the professional role as a registered healthcare professional, but also in being open, honest and trustworthy to the patients, staff and potential participants they were working with during this time. Prior to conducting their fieldwork, the researcher undertook security training, which was mandatory to working within a high secure hospital. They also organised a four-week placement as a qualified mental health nurse working on one of the wards, where they were able to gain better insights and understandings of the environment and of staff roles and expectations. This helped inform the questions they might ask during interviews.

Whilst the process of interviewing always involves the risks of participants disclosing personal or unexpected information, the interviews were never intended to raise uncomfortable feelings for staff. The researcher was actually surprised by how honest the participants were with regards the emotions revealed by staff, which were often suggestive of the “machoistic” cultures and intensities of working in a high secure environment, where such feelings and emotions are so often hidden. Each member of staff was given an information sheet detailing support services to contact should they become distressed by the interview process. This was also reinforced verbally at the end of each interview, and members of staff were given the opportunities to talk informally with the researcher should they have wished. As far as the researcher is aware, additional support was not required or sought by any members of staff as a result of having taken part in the study.

The researcher was open about her role as a researcher and PhD student throughout this time, and so at no times during the study process was the researcher acting covertly. The disclosure of the researcher’s role and the

influences this might have had on her experiences working at the hospital and of the collection of study data will be presented in greater detail through the researcher's own personal reflective account. While this section is intended to be a personal, rather than necessarily 'academic' discussion, the researcher has chosen to write her reflections in first person, so that her thoughts, ideas and recollections will be both personal to herself and to the readers.

PART 2: PERSONAL REFLECTIONS OF THE STUDY PROCESS

'BEING INDUCTED'

In order to work within Rampton High Secure Hospital, I was first required to undertake mandatory training; one week of intense induction, education and preparation with regards the values and expectations of the hospital; the security measures required of staff; hospital policies and procedures; as well as physical training in personal protection and the management of violence and aggression. As part of this induction, I was required to sign a disclaimer that I would not repeat what was covered in this week's training for security purposes, and so I will say that this week was something of an 'eye-opener' – the simple, core message being, to; 'forget everything you have previously learnt, because different rules apply here – you come as a blank slate – a 'tabula rasa' – or you leave'. I was in my first week and I was already being broken, or at least being broken into, the dominant institutionalised ways of thinking – my years of training and experiences practicing as a mental health nurse counted for nothing, and the reasons why I went into nursing felt as though they were being eroded. As if attempting a PhD was not enough of a huge undertaking in itself – I had now signed myself up to a Secrecy Act, was working in one of the most secure environments in the country and living in the 'staff quarters' of the hospital, in a house by myself, in remote countryside, all of which felt desperately isolating.

This was followed by a four week placement, between November and December 2010, where I experienced for the first time, the real intensity of the day-to-day workings of a high secure environment. After a week's training, I was subject to almost daily rub down searches into and out of work - I would be responsible for my own set of keys - the locking of heavily reinforced doors and high fences. I was armed with a long list of do's and

don'ts - alloweds and not alloweds - the breach of any of these resulting in instant dismissal. But, of course, these were all things I was constantly told I would 'get used to' – the stubborn and rebellious streak refusing to let myself get used to any of this, because this was just not normal – and I certainly did not want it to become normal for me.

My placement was based on a 'continuing care ward for people with severe and complex, treatment resistant mental health problems' – a supposed 'therapeutic community' within a high secure environment and supposedly one of the 'friendlier wards' of the hospital. This would, unbeknown to me at the time, become one of the wards for my study. My presence on the ward appeared to arouse immediate suspicion and was met with mixed reactions from staff. I had been completely open and honest about my background and role as a registered mental health nurse, who was now embarking on a PhD – being a covert researcher did not sit comfortably with me or my role as a healthcare professional, and I was concerned that I might 'slip up' were I attempt to work 'undercover'. This however, seemingly raised many questions from staff working on the ward. Why would a registered nurse voluntarily choose to do a placement – after all, had I not 'done my time' as a student? What could a nurse possibly want to research? (- nurses don't do research) Why 'our' ward? From these questions, many judgments, assumptions and 'jumped to conclusions' were made: that I must be working for the management to uncover 'something' (vague and unspecific but nevertheless sinister); that I myself was under investigation and so was required to be on 'placement' and unable to perform my full quotient of 'nursing duties' (- a likely frustration to many), or that I was indeed a researcher and therefore to be viewed with suspicion (as research can only be negative – conducted by 'do-gooders' who demand change). Indeed I was told many stories during this period, of how the hospital has historically been rife with undercover reporters purporting to be 'researchers' (the suggestion here of me too being an 'undercover reporter'). This apparently occurred just after the 1979 television broadcast of 'The Secret Hospital', which uncovered cases of gross staff misconduct, subsequent investigations and successful prosecutions. So it became clear the challenges that would lie ahead of me, the enthusiastic naivety from which I had chosen to study this topic and the wonder of what I might uncover.

'INITIATION': ENGAGING STAFF & GAINING TRUST

Engaging staff in the study and gaining their trust were huge obstacles throughout the research process. A major obstacle to gaining staff trust was that an internal investigation was being conducted during the time of my fieldwork, whereby several members of staff were suspended from practice due to questions surrounding their conduct of restraint. Being reasonably thick skinned, persistent and having a good sense of humour were all vital to making this study work – although there were many times, when even armed with these supposed qualities, the study looked as though it was just not going to work and that the fieldwork was just not going to happen. I began my fieldwork in August 2011 – approximately nine months after completing my placement, having collated and analysed the data from the whole hospital and completed stage one of the study. I spent my first few weeks, again, wondering what I had let myself in for and again questioning why I had made the PhD so very difficult and challenging for myself. My first two weeks 'out in the field' involved staff refusing to speak to me point blank, simply because I was a researcher – but it 'was not personal and I should not take it as such'. Staff would invent 'different' names for themselves so that when I arrived on the wards having arranged to meet with someone they would 'not be there'. There were times when I would have arranged to attend the ward to find it empty, as all the staff and patients were out on 'ward activities'. The staff would suddenly become extremely busy with my presence on the ward; the office would become deserted but the main ward would 'not be an appropriate place to talk about my research'. These were all hugely frustrating times, but seemingly part of the hospital culture in 'initiating' new members; seeing how far 'newbies' could be pushed before crumbling; testing their resilience, perseverance and determination. Luckily, after an extremely gruelling and challenging first few weeks, I appeared to have withstood this test. Not all staff were completely accepting of me being there, but the few who were not, became 'civil' by the time of my leaving.

As the more dominant characters of each ward, namely those who were the 'alpha males' or 'leaders of the pack' (although not necessarily always the ward managers), began to demonstrate some acceptance of me being there, others became more accepting of my presence. Perhaps being a relatively young female influenced this and I frequently question whether I would have been met with the same reception, results or findings if I had have been an

older female, had a more dominant character or presence, or even been a male researcher. Ironically, patients were often more readily accepting of me than staff, although, as these were all male wards, this was also had to be met with caution. Where I had been warned about the perils of being a lone female worker and the potential vulnerabilities of this role with regards risks of grooming from patients, I had not been warned, or foreseen, these risks from staff. I frequently found myself behaving in ways I would not normally do for the sake of being able to 'do my job' and having to 'fit in'; adopting a somewhat 'laddish sense of humour', for example; laughing at crude jokes and staving off inappropriate comments by staff, when inwardly cringing for putting up with this. I began questioning my honesty as a researcher, my integrity as a person and what made me behave this way. Although there are no easy answers, perhaps there are some ironic parallels between my role as a researcher not wanting to be an 'outsider' and the members of staff I interviewed not wanting to be left alone 'on the outside' within such a vulnerable place (see pages 235-239).

PERCEPTIONS OF A 'RESEARCHER'

My dual role as a nurse and researcher meant that I was often perceived as being both an insider and outsider. It was certainly interesting how my role, and perceptions of my role as a researcher had evolved, from being on placement to collecting data. Staff perceptions and reactions towards me certainly seemed to change during this time; perhaps because I was on the wards for the purposes of fieldwork, I was doing the work that 'researchers do' and so my role was less confusing and therefore less threatening; also because I was no longer spending 7-14 hours per day at a time on a single ward. Staff predominantly assumed that I was a psychologist and not a nurse, at least to begin with, and until I made a point of correcting them; perhaps because psychologists were perceived as outsiders whilst nurses were hands on and not afraid of 'dirty work', and so there was a commonality from which to work from, and I was considered a bit more a 'part of the team'. There remained some underlying suspicion and mistrust of my role as a researcher however, not least because of the ongoing internal investigation, from which I would later find out one member of staff resigned prior to a decision being made, and the other members of staff were severely demoted. This sparked quite mixed reactions from staff with regards the topic of my study and who I might be working for. Again, staff anxieties seemed to stem from concerns

that I may either be an 'undercover internal investigator working for the management, or a reporter. Some staff reacted positively to the study during this time; saying that they wanted to speak out over a major part of their role and to talk about the challenges they face working in a high secure environment; others were willing to give their views via questionnaires but withdrew from the interviews being cautious that they might be reprimanded. Taking part in the study therefore required a lot of trust between the participants and researcher, and the very presence of a researcher proved anxiety provoking for some. As a researcher, it was therefore paramount to address how these feelings of discomfort might be addressed and resolved.

OPENING UP UNCOMFORTABLE FEELINGS: ROLE CONFLICT AS NURSE & RESEARCHER

Some staff were often reluctant to participate in the study since there was an expectation from them either for immediate results and change or seeming not to want change at all. Of course, this is speaking of two extreme views and there were many staff who's views were somewhere in between. Staff appeared initially reluctant to take part in the interviews due to being recorded and many appeared anxious at this; largely because they felt they would be made 'identifiable', or at least more easily so than via the completion of questionnaires. These anxieties were allayed through taking the time to talk to staff about how the interviews would be transcribed and used.

During the interviews, I was primarily struck by how open and honest staff talked about their personal feelings and emotions in relation to their work; how they openly expressed the fears, anxieties and anguish they face in being at work and the potential risks and harm they fear they subject themselves to on a daily basis. This was in great contrast to my initial experiences of working in this environment with these individuals; the 'testing' of my perseverance and how I was used to each of the individual staff members behaving amongst the general ward milieu. I was used to observing these individuals bantering with one another, responding apparently fearlessly to incidents, 'blick' alarms, sitting outside seclusion room doors calmly and collectedly while patients were swearing, shouting threats, pounding their fists and kicking at the doors and walls. Many of these staff, perhaps purposely, appear

quite intimidating; they stride with confidence down the corridors; they adopt a glare that is emotionless, and even with years of training and experience is difficult to read. They have the ability to give nothing away when speaking to another member of staff; in their body language, tone of voice or reactions to receiving information; all of which I understand now is part of their years of experience working in this environment, and what has become their protection from those they work with. Many of the staff adopt a strict gym regime – using the hospital gym during their breaks. There is an obvious body building culture throughout the hospital, and particularly on wards with a reputation as being ‘problematic’. Many of the female members of staff take an interest in either body building or martial arts, and although uniform is no longer required, an informal uniform code is adopted by many. For men, this would usually be a white or pale blue shirt with black trousers, for females this will usually be replaced by a dark coloured t-shirt and black trousers. Through these subtle hints of institutional norms and culture the disclosure of feelings and emotions were therefore greatly unexpected and in huge contrast to the daily containment of emotions I had grown accustomed to observing.

Staff frequently spoke of the rare opportunities they had with which to speak with such frankness and unreservedness, especially within their work environment. On the one hand they spoke to the colleagues because their family and friends outside of work simply just would not understand. On the other hand however, they remained cautious of how much to disclose to colleagues, since to disclose these fears would be to lose face, confidence and cohesion amongst the team. What resonated with me was the poignancy in similarities between each of these staff members’ feelings, yet the inability to disclose these; both in my role as a researcher in breaching confidentiality as well as the inhibitions of staff to disclose these feelings between themselves. I felt bittersweet for quite some time at having conducted these interviews. I felt as though I had opened up something of a Pandora’s box for those who had taken part in the interviews, yet felt, and still feel, somewhat helpless in terms of what I can actually do to alleviate those feelings of burden, pain, guilt and fear. I had gone from being a researcher whom no one wanted to speak to, to being the researcher whom on an individual basis, staff spoke to with great frankness, openness and honesty, and I was massively confused and at a loss as to what to do with this. I was sitting with staff, listening to the narratives of their experiences, sometimes for over an hour. Then they would

simply go back to their daily jobs having just disclosed to me how challenging and difficult their work was, and each time I passed them on the wards or corridors of the hospital, I knew that I too, had to learn not to allow too much emotion to pass in my body language, such as not to betray to others what they had so honestly told me.

This felt at great odds between my roles as a researcher and a nurse. As a nurse I would be asking those individuals to be kind to themselves, at least for the rest of the day. To take things steady and to recuperate from those emotions before taking on anything too strenuous again. Yet, here, as a researcher, I was allowing participants to disclose this mass of feeling and emotion, only to return to the place they told me they don't feel safe working in. I realised that my role here was not as a counsellor or a nurse, but longed for some answers as to how to manage both these roles that are so much a part of me. I was surprised at the lack of literature on the tensions between being a researcher and a nurse, and even when asking academic nurse colleagues with regards to this, was no closer to finding any more literature on these role conflicts and dilemmas. I had advised the individuals whom I had interviewed of the staff counselling service and given them phone numbers to contact should they have needed to, although all staff declined. Many of the staff whom I had interviewed expressed their gratitude at the end of their interview, of having been given the opportunity to speak to somebody about these burdensome thoughts and feelings which they would not normally be able to do, and the catharsis they felt at having done so. It was somewhat with regret on my part therefore, with regards to those who had not taken the opportunity to be interviewed; not necessarily for the purposes of research, but more so, for the unburdening of the feelings, emotions and tensions that they too might be experiencing.

Returning to the main ward environment after an interview was always something of a 'wake up call'; the ironic return to the 'normality' of working in this environment meant that staff who had gone through the interview process were often encouraging of their colleagues to take part. This in itself for me, raised issues regarding confidentiality and anonymity for those involved, however, it was not myself who disclosed who had taken part in the interviews, but rather the interviewees themselves. This encouragement of other staff was often apparently based on 'competitive spirit' between staff; who could be interviewed for the longest period of time, or who could speak

the quickest and get the most words in to an interview. This competitiveness appeared to be part of the culture amongst staff; the bravado and camaraderie that is both needed in spending fourteen hours at a time with each other working shifts on the wards, as well as reinforcing the need to be a 'close knit' team where working in this physically and emotionally challenging environment. Being back to the realities and daily grinds of working in the high secure environment after the interviews was therefore something of a shock to the system; reinforcing the notion of 'hidden emotions' within this highly regimented, masked environment.

CHAPTER 8: HOSPITAL LEVEL DATA

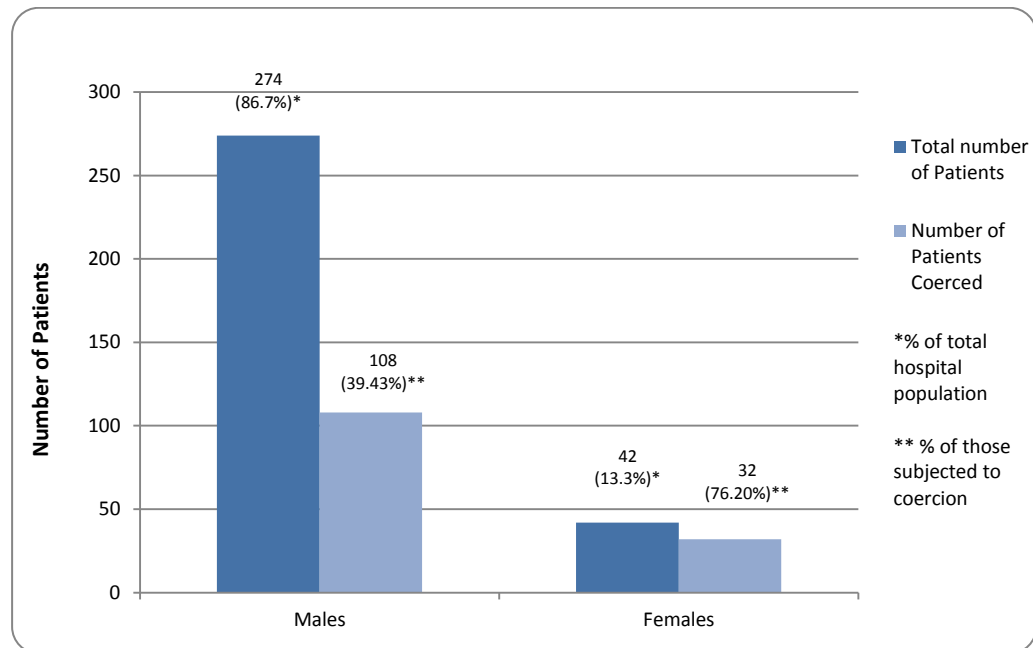
OVERVIEW

This chapter provides detailed analyses of hospital database recordings on the uses of seclusion and rapid tranquillisation between 1st August 2010 and 31st July 2011. These analyses aim to provide an overview of the rates and frequencies by which coercive measures are used within Rampton Hospital and the characteristics of those coerced. The chapter will be divided into four sections exploring the rates, frequencies and characteristics of those who have experienced i) coercion, namely seclusion or rapid tranquillisation; ii) patients who have experienced seclusion only; iii) patients who have experienced rapid tranquillised only; and iv) patients who have experienced both seclusion and rapid tranquillisation during the one year study period, although not necessarily resulting from the same incident. Statistical tests were conducted for those patients who experienced either seclusion or rapid tranquillisation singularly as well as for those who experienced both since these methods have different practice implications and therefore might reflect differences in ward, and patient characteristics and needs. Non-parametric tests were used for analyses as the data violated assumptions of normality, identified through Kolmogorov-Smirnov tests.

During August 2010-July 2011, 316 patients were continuous residents at Rampton Hospital, and it is those patients who will be included in this report. 274 were male (aged 20-73, *mean* = 39.7, \pm 10.75) and 42 were female (aged 20-55, *mean* = 36.8, \pm 8.66), with a mean age of all patients being 39.52 years (\pm 10.54). The average length of stay for patients at the end of the study period, was just under six years (total population, *mean* = 2151.6, \pm 1789.0; male, *mean* = 2189.0, \pm 1849.5 days; female, *mean* = 1907.3, \pm 1320.0 days). There were no statistically significant differences in age or length of stay between males and females. Of the whole hospital population, data was missing regarding ethnicity for one patient. Of the 315 remaining patients for whom ethnicity was available, 259 of these patients were categorised as being of 'white' ethnic background and 56 of 'non-white' ethnic background. Numbers were too small however, to analyse ethnicity more specifically amongst the 'non-white' population who were coerced (total coerced, *n* = 139; white, *n* = 113; Asian, *n* = 6, Black, *n* = 12, Mixed, *n* = 8).

PART 1: COERCION

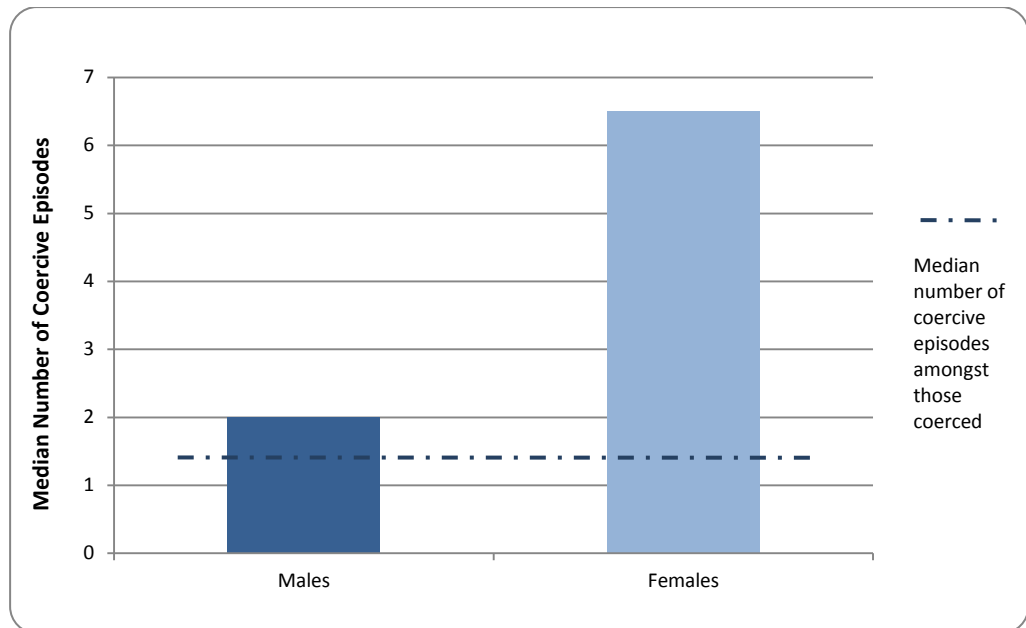
During the one year study period there were a total of 911 incidents involving either seclusion or rapid tranquillisation; (*seclusion* = 794; *rapid tranquillisation* = 117). 140 patients ($m = 108$; $f = 32$), were involved in these incidents, accounting for 44% of the total hospital patient population (see Bar Chart 1).



BAR CHART 1: PROPORTIONS OF PATIENTS EXPERIENCING COERCION BETWEEN AUGUST 2010 – JULY 2011

GENDER

Where taking into account the whole hospital population, significant differences were found between the proportions of male and female patients who experienced coercive measures. Female patients were proportionately more likely to experience either form of coercive measures than males, $\chi^2 (1, n = 140; f = 32; m = 108) = 11.12, p \leq .001$. Of those patients experiencing coercion, female patients ($Md = 6.5, n = 32$) were also coerced significantly more times than males ($Md = 2.0, n = 108$), $U = 842.00, z = -4.493, p < .000, r = -.38$.



BAR CHART 2: MEDIAN NUMBER OF TIMES MALES AND FEMALES EXPERIENCED COERCION

AGE

The ages of those patients who experienced coercive measures ($Md = 36, n = 140$) were compared with the ages of those who did not ($Md = 40, n = 176$). Patients who experienced coercive measures were found to be significantly younger than those who did not, $U = 9447.50, z = -3.562, p < .000, r = -.200$. Amongst those patients who experienced coercive measures, no significant differences in age were found between males and females. Neither were significant correlations found between age and number of times patients experienced coercion.

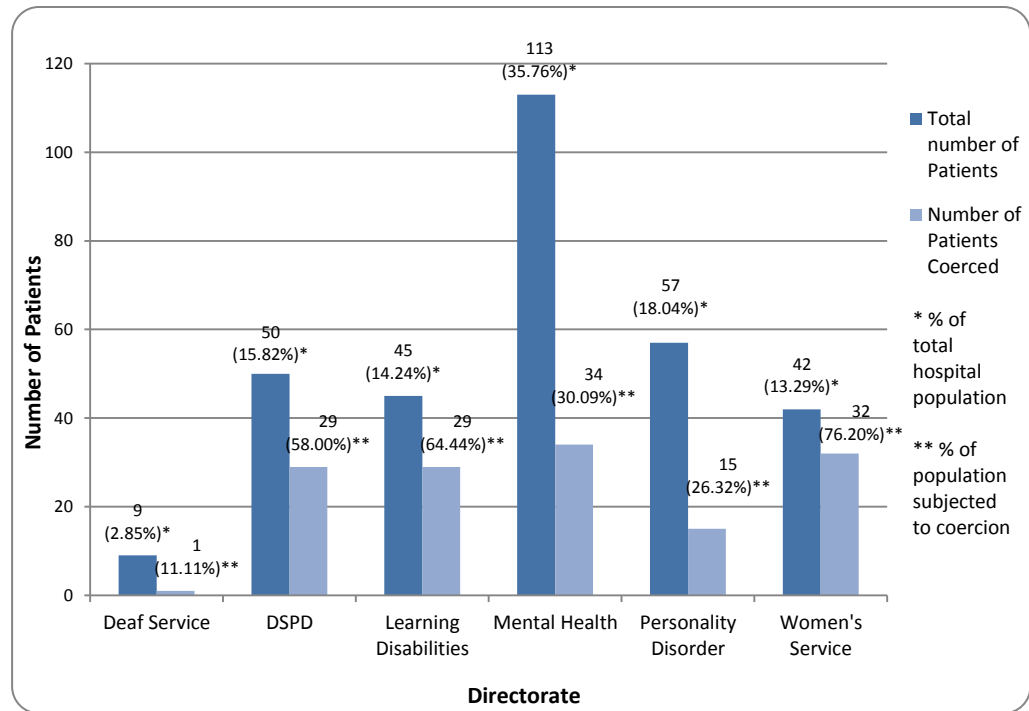
LENGTH OF ADMISSION

A Spearman's rho correlation coefficient revealed no statistically significant association between patients' length of admission and coercive episodes.

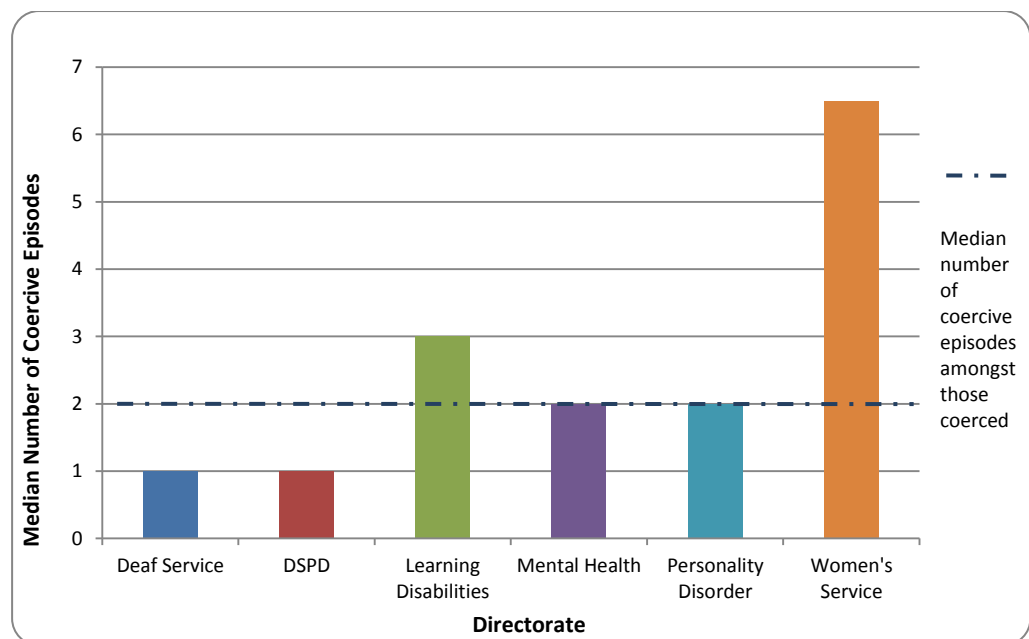
DIRECTORATE

Where taking into account the overall numbers of patients within each directorate, significant differences were found in the proportions of patients experiencing coercive measures between each directorate. Patients within

the Women’s Service Directorate were proportionally most likely to experience coercion, $\chi^2 (5, n = 140) = 27.431, p < .001$. Of those patients experiencing coercion, patients within the Women’s Service Directorate also experienced coercion more times, $\chi^2 (5, n = 911) = 11.54.357, p < .001$. These findings reflect the hospital-wide gender differences amongst patients who were coerced.



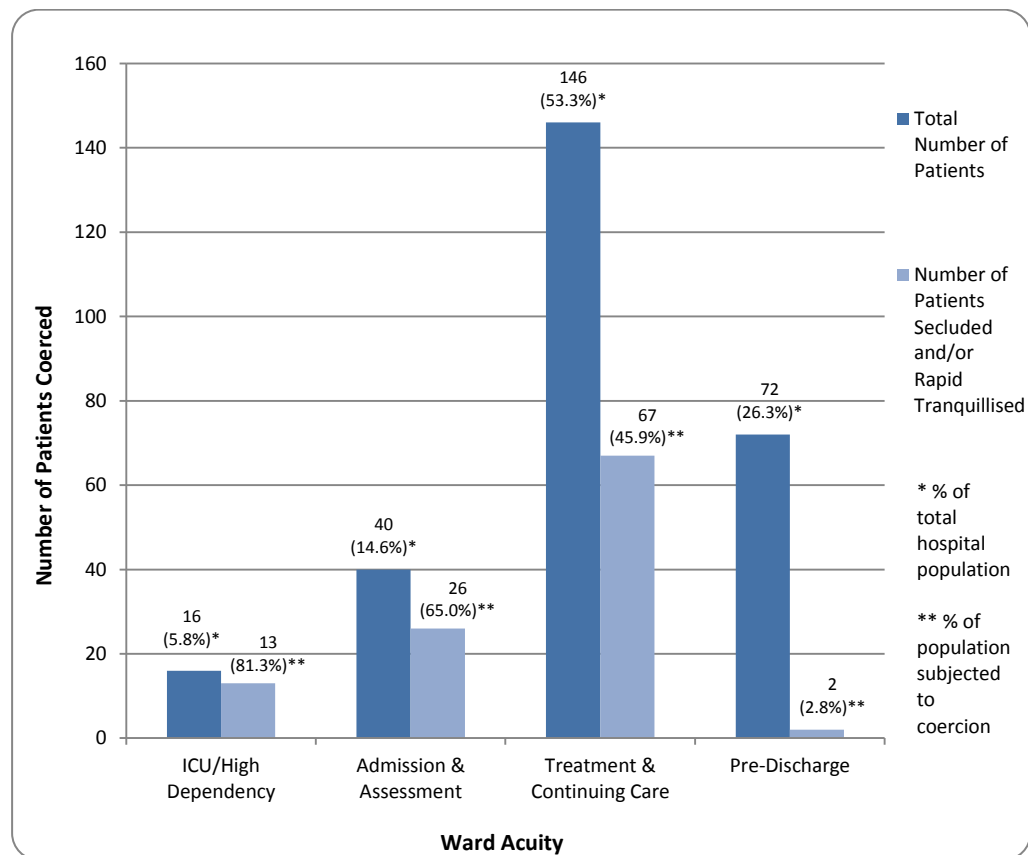
BAR CHART 3: PATIENTS EXPERIENCING COERCION WITHIN EACH DIRECTORATE



BAR CHART 4: MEDIAN NUMBER OF TIMES PATIENTS WERE COERCED WITHIN EACH DIRECTORATE

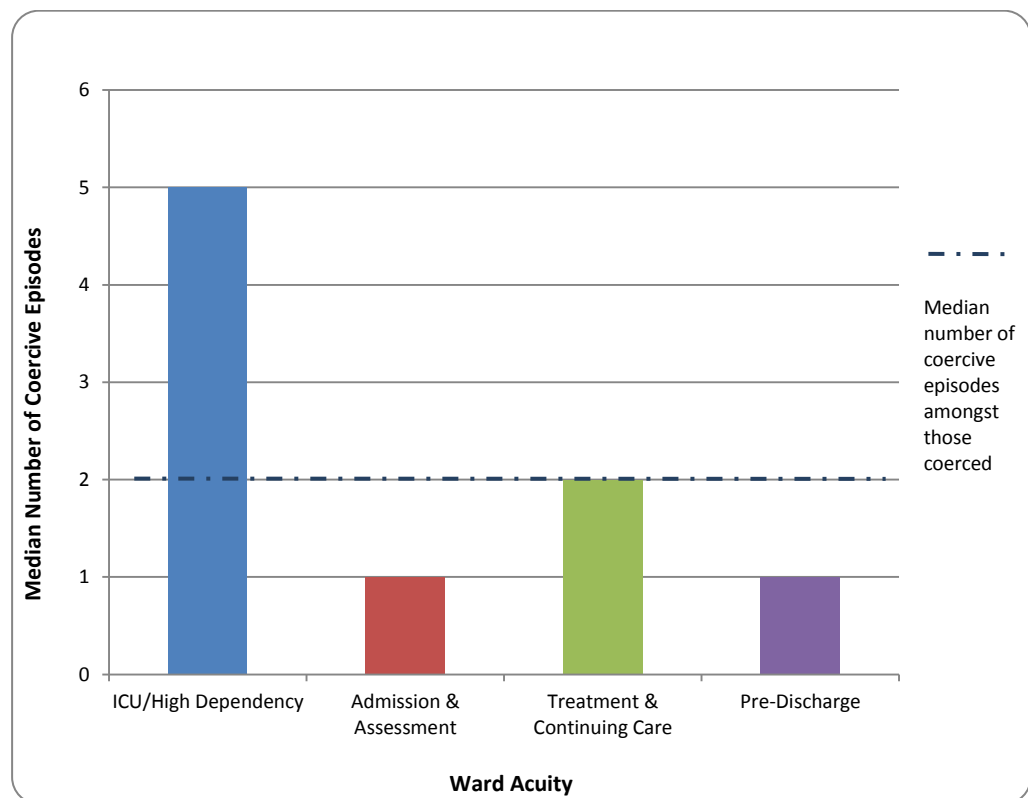
WARD ACUITY

It was hypothesised that patients who are newly admitted or requiring the most intensive levels of care would be those most often coerced. Such levels of care were identified through ward functions. Each of the Directorates within Rampton Hospital, with the exception of the Women’s Service Directorate, can be divided into four levels of ward acuity pertaining to; i) Intensive Care and High Dependency ii) admission and Assessment; iii) treatment and Continuing Care; and iv) pre-discharge. Where cases from the Women’s Service Directorate were excluded from analyses, 451 incidents of coercive measures over the one year study period remained, attributable to 108 individuals. A Chi-squared test revealed that significantly greater proportions of patients residing on the Intensive Care Units experienced coercive measures, $\chi^2 (3, n = 108) = 39.820, p < .001$.



BAR CHART 5: PROPORTIONS OF PATIENTS COERCED BY WARD ACUITY

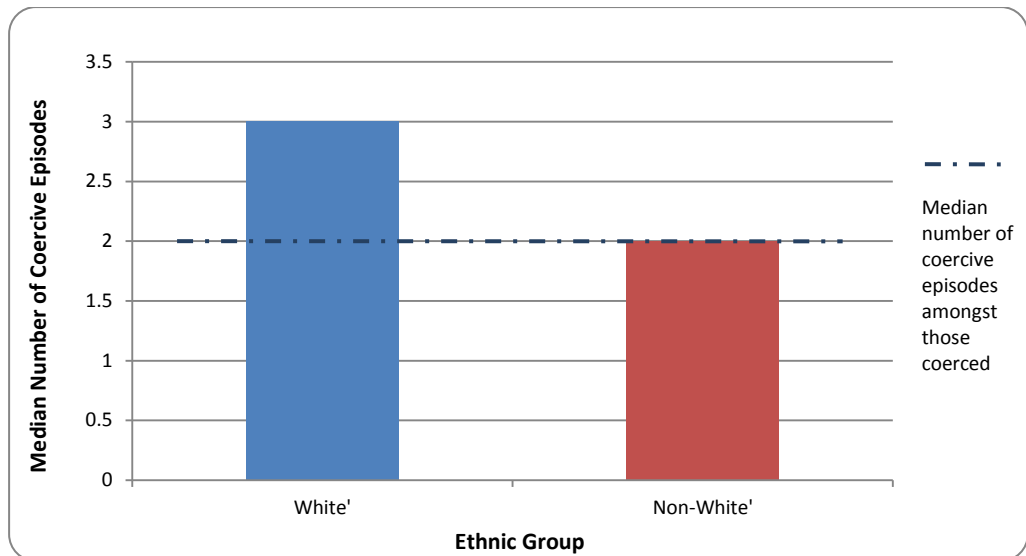
Patients on the Intensive Care wards also experienced coercive measures most times where the proportions of patients residing on each of the wards are taken into account, $\chi^2(3, n = 451) = 400.834, p < .001$. Patients residing on the pre-discharge wards were least likely to experience coercive measures and for the least amount of times. Whilst these divisions of ward acuity are helpful in providing indicators of the type of ward most likely to use coercive measures, it is also important to note that some patients may have changed wards during the study period and so these data are not entirely reliable.



BAR CHART 6: MEDIAN NUMBER OF TIMES COERCED BY WARD ACUITY

ETHNICITY

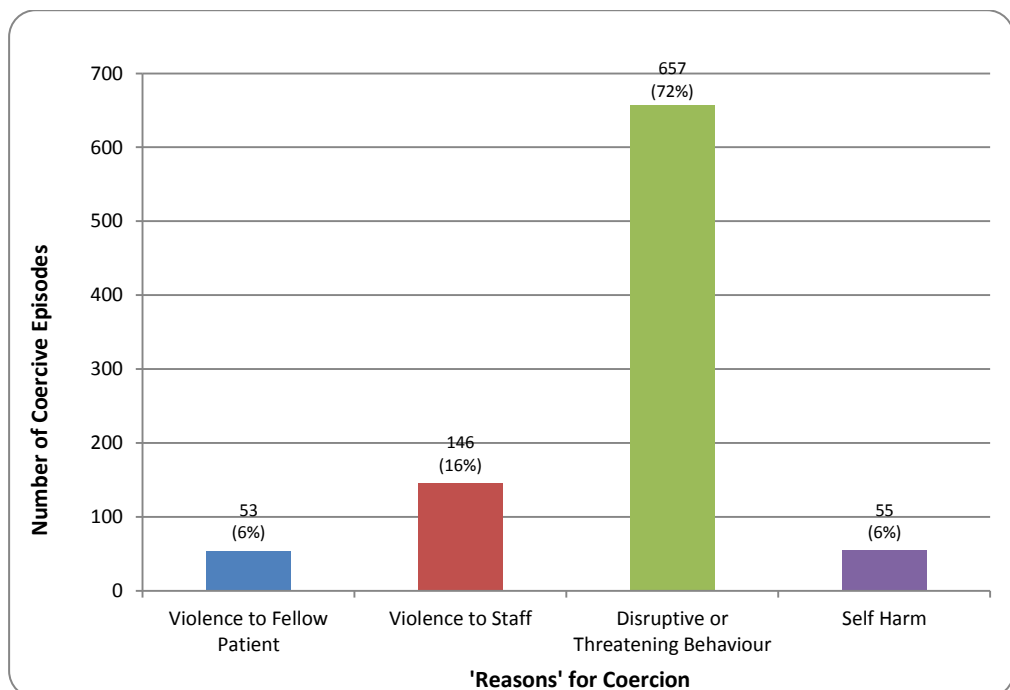
Limited studies have reported patient ethnicity in relation to coercive practices. Where patients' ethnic groups were divided into either 'white' or 'non-white' categories, no significant differences were found between numbers of patients being coerced proportionate to the whole hospital population, $\chi^2(1, n = 139) = .082, p > .05$. Patients of 'non-white' ethnic origin however, were coerced more times than patients of 'white' ethnic origin where proportions of patients were taken account, $\chi^2(1, n = 910) = 4.783, p < .03$.



BAR CHART 7: MEDIAN NUMBER OF TIMES COERCED WITHIN EACH ETHNIC GROUP

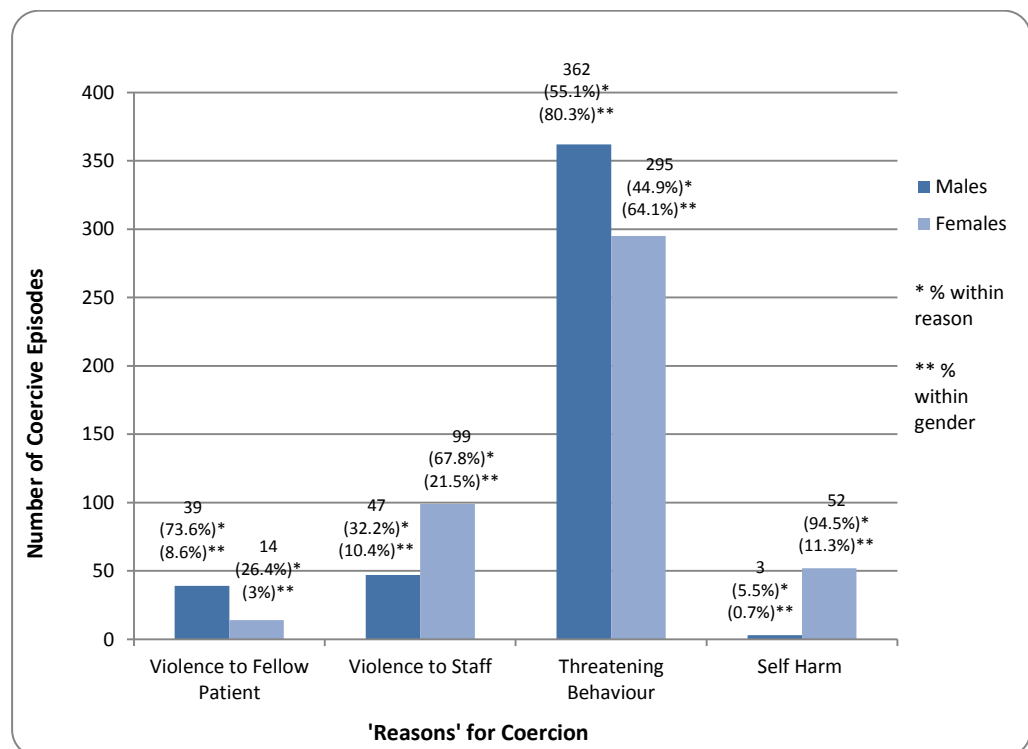
REASONS

Reasons for using coercive measures were categorised into four groups in accordance with the hospital's databases, namely; 'violence to fellow patient'; 'violence to staff'; 'disruptive or threatening behaviour' or 'self-harm'. Significant differences were found between these four categories, with disruptive or threatening behaviour accounting for the most common reason for using coercive measures, $\chi^2(3, n = 911) = 1103.485, p < .001$.



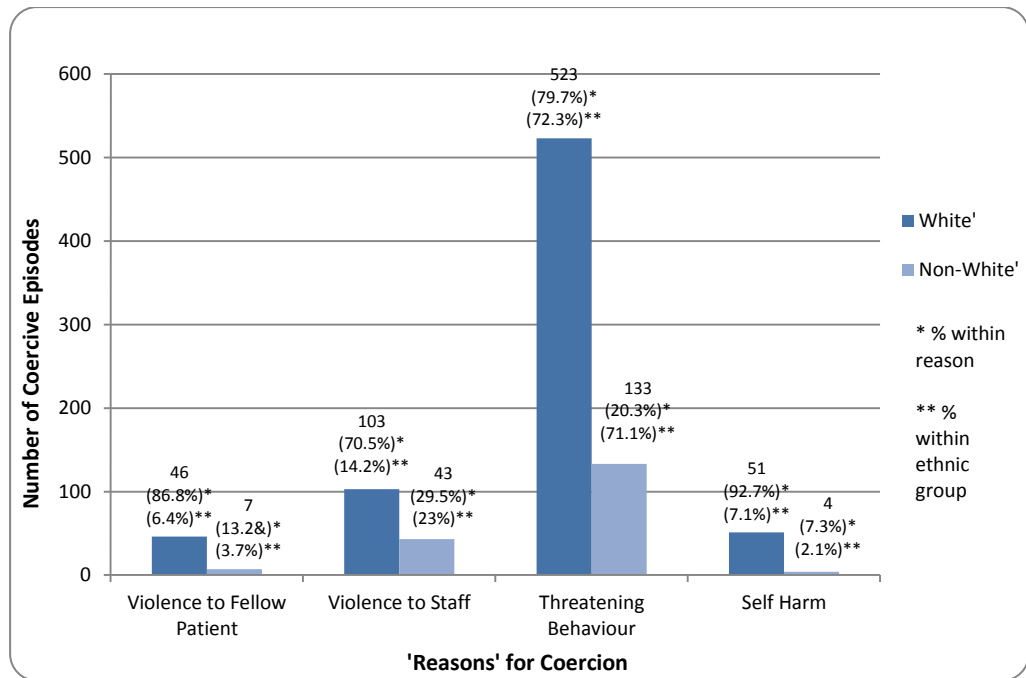
BAR CHART 8: REASONS FOR COERCION

Where examining reasons for using coercive measures in relation to gender, significant associations were found, $\chi^2 (3, n = 911) = 80.719, p < .001, phi = .298$. Post hoc Chi-square pair wise analyses revealed that female patients were proportionately more likely to experience coercion than males for all four reasons (violence to fellow patient, $\chi^2 (1, n = 53) = 7.921, p < .005$; violence to staff, $\chi^2 (1, n = 146) = 376.524, p < .001$; disruptive or threatening behaviour, $\chi^2 (1, n = 657) = 569.622, p < .001$; and self-harm, $\chi^2 (1, n = 55) = 315.087, p < .001$).



BAR CHART 9: REASONS FOR COERCION BY GENDER

A Chi-square test for independence indicated significant associations between reasons for coercion and ethnicity where patients' ethnic groups were divided into 'white' and 'non-white', $\chi^2 (3, n = 910) = 14.806, p < .002, phi = .128$. Post hoc Chi-square pair wise analyses indicated that patients of 'non-white' ethnic origin were proportionately more likely to experience coercion for reasons of violence to staff, $\chi^2 (1, n = 146) = 13.613, p < .001$. Patients of 'white' ethnic origin were proportionately more likely to experience coercion for reasons of self harm, $\chi^2 (1, n = 55) = 4.152, p < .045$. No significant differences however were found between patients of 'white' and 'non-white' ethnic groups for reasons of coercion relating to violence to fellow patients or disruptive or threatening behaviour.



BAR CHART 10: REASONS FOR COERCION ASSOCIATED WITH ETHNICITY

A multivariate logistic regression analysis was conducted to examine the influences of age, directorate, and ward acuity on whether or not patients were coerced. The full model explaining all predictors was statistically significant, $\chi^2 (8, n = 274) = 93.289, p < .001$, indicating that the model was able to distinguish between those coerced and those not coerced. The model as a whole explained between 28.9% (Cox and Snell R square) and 39.1% (Nagalkerke R squared) of variance in coercion, and correctly classified 63.7% of cases. Of these variables, ward acuity made the largest contribution ($beta = 4.810, p < .001$) to whether or not patients were coerced, whilst directorate ($beta = - 2.460, p < .03$) also made a significant contribution, perhaps reflecting differences in gender. Surprisingly, no significant contributions were found for age.

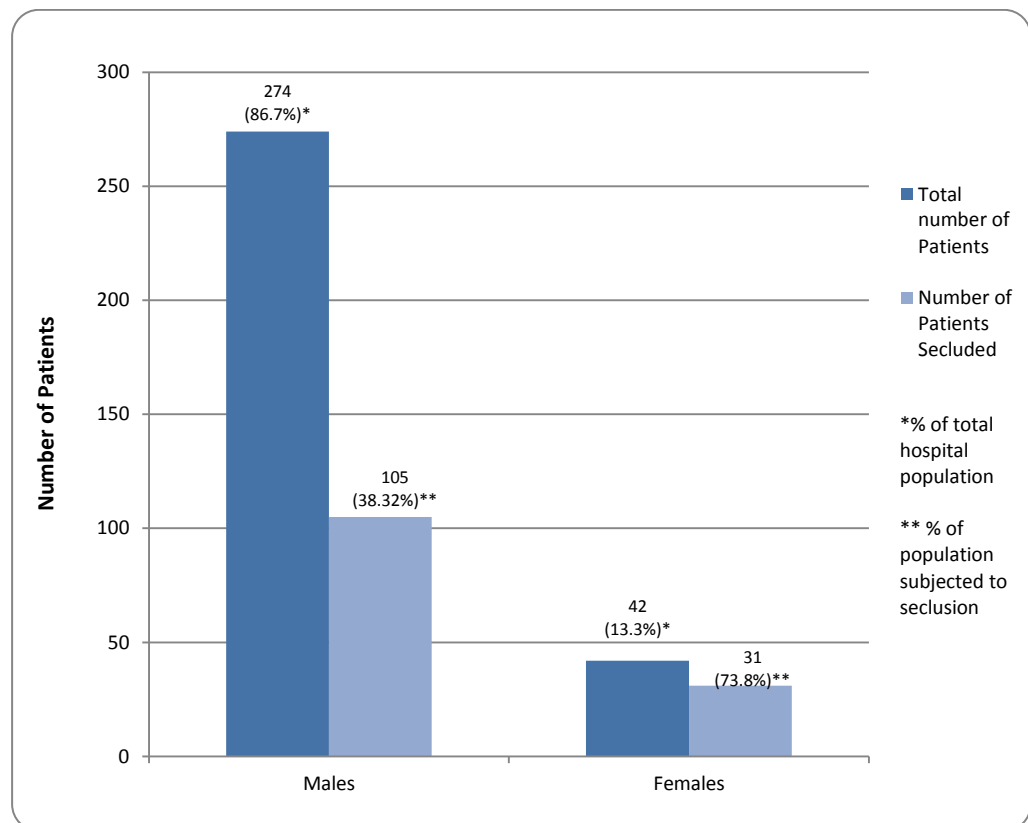
Overall then, these findings indicate that female patients or patients residing on Intensive Care Units would be those most likely to be coerced, and most frequently. Although these findings suggest that female patients requiring intensive care would be those most likely to be coerced, such assumptions cannot be made from this data since ward acuity is not categorised as such within the Women's Service Directorate at Rampton Hospital. Instead, this is a hypothesis that requires further investigation. In addition, these findings do not distinguish between the characteristics of those patients experiencing either seclusion or rapid tranquillisation individually, and so these statistical

tests will be replicated for those patients who experienced one of either seclusion or rapid tranquillisation only, and then for those patients who experienced both.

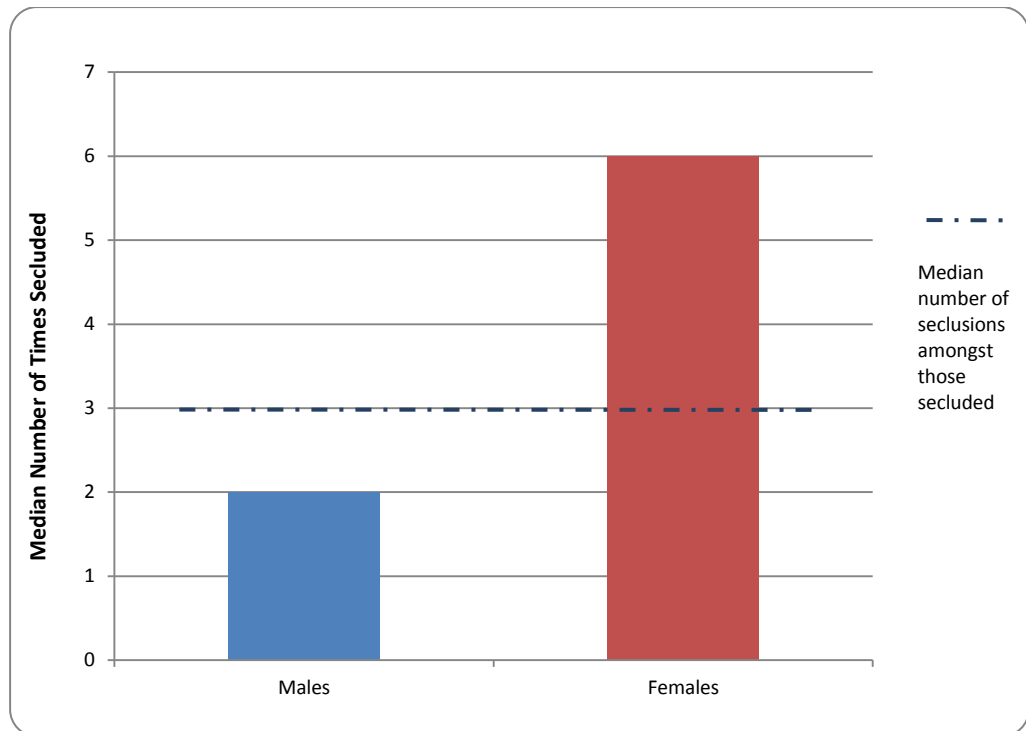
PART 2: SECLUSION

GENDER

Between August 2010 and July 2011, there were a total of 794 episodes of seclusion. These were attributable to 136 patients; 105 of whom were male and 31 of whom were female. Male patients were involved in 440 of these incidents while female patients were involved in 354 of them. Overall, when taking into account the proportion of males and females within the hospital, a significantly greater proportion of the females were secluded in comparison with males $\chi^2 (1, n = 794) = 10.657, p < .001$. Of those secluded, females also experienced seclusion significantly more times (females, $Md = 6.0, n = 31$; males, $Md = 2.0, n = 105$), $Mann\ Whitney\ U = 884.00, z = -3.946, p < .001, r = -.338$, although there were no significant differences in the lengths of time spent in seclusion.



BAR CHART 11: PROPORTIONS OF PATIENTS EXPERIENCING SECLUSION BETWEEN AUGUST 2010 – JULY 2011



BAR CHART 12: MEDIAN NUMBER OF TIMES MALES AND FEMALES EXPERIENCED SECLUSION

AGE

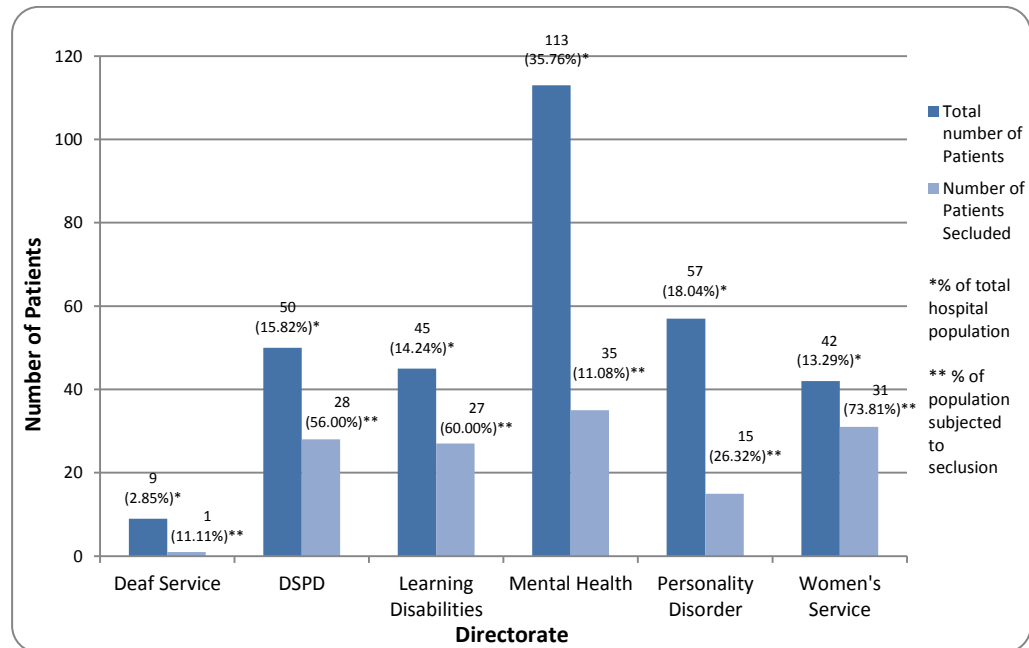
Patients who were secluded (20-61 years, $Md = 36$, $n = 136$) were significantly younger than those patients not secluded (21-73 years, $Md = 40$, $n = 180$), $Mann\ Whitney\ U = 9290.00$, $z = -3.67$, $p < .001$, $r = -.206$. Younger patients were also secluded for longer periods, $Spearman's\ rho = -.218$, $n = 794$, $p < .001$. No significant associations however, were found between age and number of times patients were secluded for, $Spearman's\ rho = -.158$, $n = 316$, $p > .05$.

LENGTH OF ADMISSION

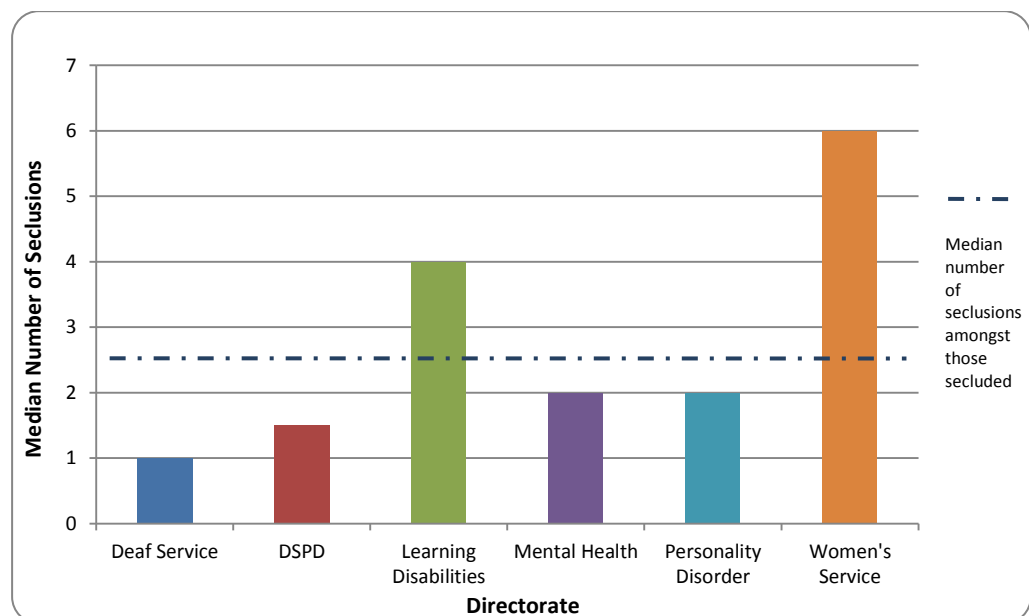
A negative correlation was found between a patient's length of admission and the number of times they were secluded ($Spearman's\ rho = -.179$, $n = 136$, $p < .04$), suggesting that patients are more likely to be secluded during the initial stages of their admission. A significant positive correlation was found between patients' length of admission and their time spent in seclusion, where each episode of seclusion was considered individually ($Spearman's\ rho = .155$, $n = 794$, $p < .001$), indicating that each successive episode of seclusion is likely to increase in duration.

DIRECTORATE

Significant differences were found in the proportions of patients who experienced seclusion between each directorate, $\chi^2 (5, n = 136) = 24.439, p < .001$. This proportion was highest in the Women's Service Directorate and lowest in the Mental Health Service Directorate, again perhaps reflecting gender differences amongst those experiencing seclusion.

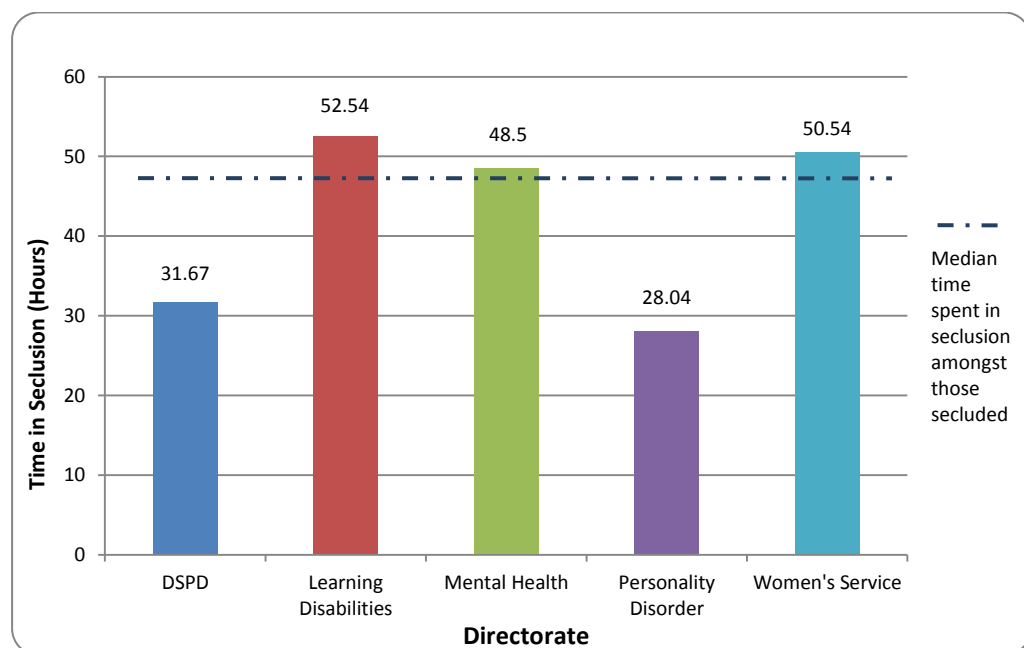


BAR CHART 13: PATIENTS EXPERIENCING SECLUSION WITHIN EACH DIRECTORATE



BAR CHART 14: MEDIAN NUMBER OF TIMES PATIENTS WERE SECLUDED WITHIN EACH DIRECTORATE

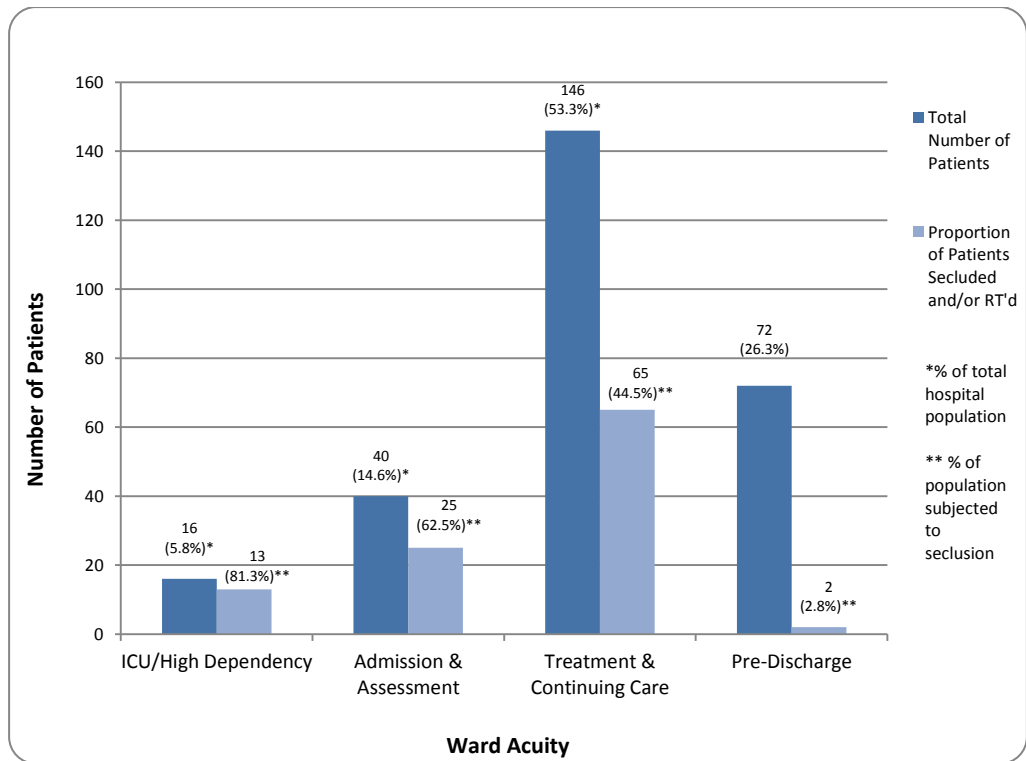
There was a modest association between the number of times a patient was secluded and their mean duration of seclusion, *Spearman's rho* = 0.245, *n* = 136, *p* < .005. Given that only one patient was secluded from the Deaf Service Directorate, and only once during the study period, this single case was excluded from the following analyses so as not to bias the results. The median duration of all seclusions between August 2010 and July 2011, was 48.00 hours. Length of time patients spent in seclusion differed significantly between directorates, with longest durations of seclusion being within the Learning Disability Directorate and shortest durations within the Personality Disorder Directorate, *Kruskal Wallis H* (4, *n* = 793) = 13.688, *p* < .01.



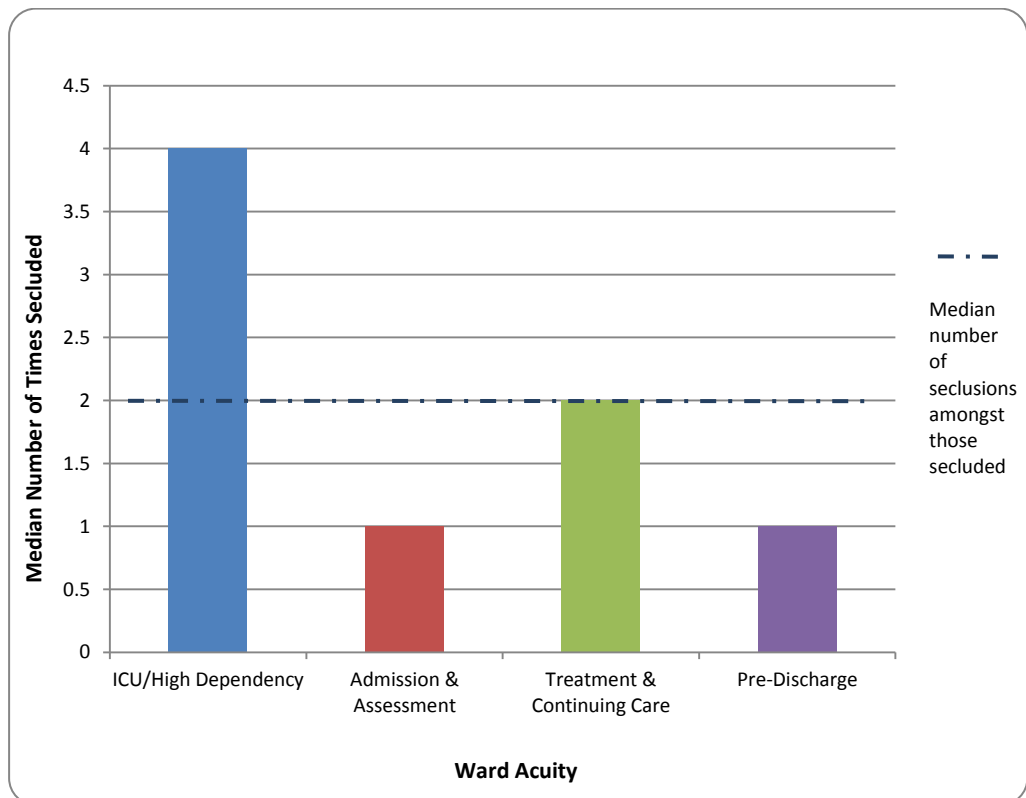
BAR CHART 15: MEDIAN DURATION OF SECLUSION WITHIN EACH DIRECTORATE

WARD ACUITY

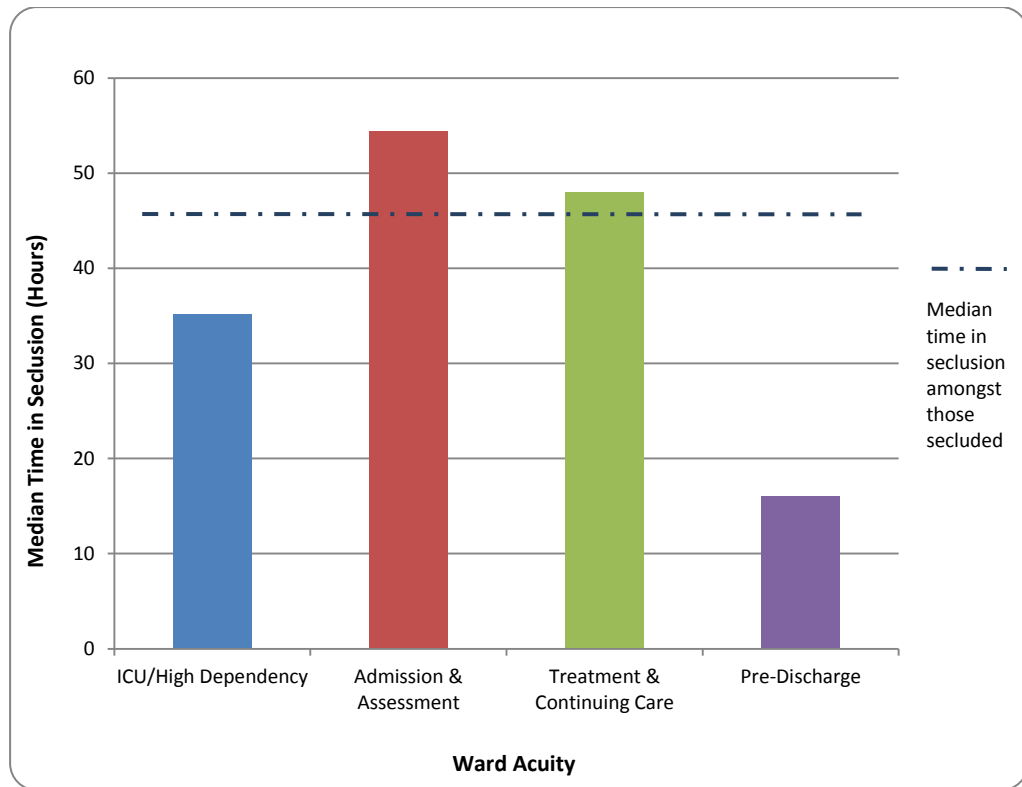
A Chi squared analysis revealed that patients residing on the ICU wards were proportionately more likely to be secluded than patients on the admission, treatment and pre-discharge wards, χ^2 (3, *n* = 105) = 38.997, *p* < .001. Patients residing on the ICU wards were also secluded significantly more times where proportions of patients were controlled for, χ^2 (3, *n* = 439) = 67.394, *p* < .001. A Kruskal-Wallis H test however, indicated that patients residing on the admission wards were secluded for significantly longer periods, χ^2 (3, *n* = 439) = 10.948, *p* < .015.



BAR CHART 16: PROPORTIONS OF PATIENTS EXPERIENCING SECLUSION BY WARD ACUITY



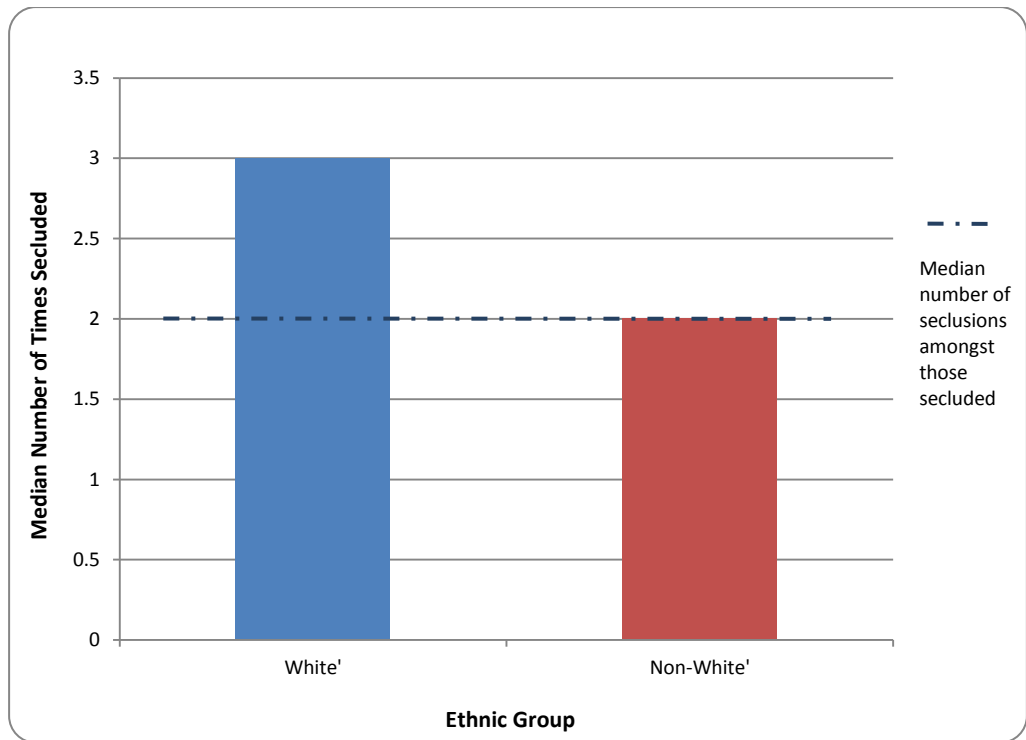
BAR CHART 17: MEDIAN NUMBER OF TIMES SECLUDED ASSOCIATED WITH WARD ACUITY



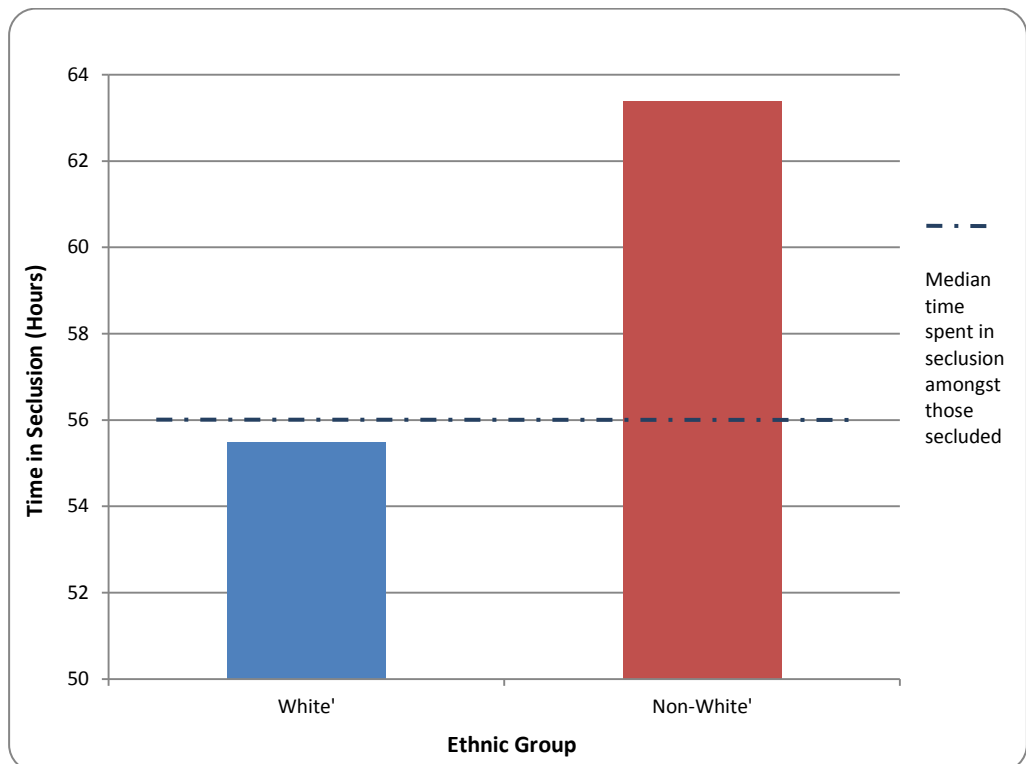
BAR CHART 18: ASSOCIATIONS BETWEEN TIME IN SECLUSION AND WARD ACUITY

ETHNICITY

Amongst the 794 incidents of seclusion over the one year study period, data was missing on ethnicity for one patient who was involved in a single incident of seclusion. The findings reported with regards to ethnicity throughout this section, therefore represent the 793 incidents of seclusion, where data on ethnicity was available. A Chi squared analysis revealed no significant differences between the proportions of 'white' and 'non-white' patients experiencing seclusion, $\chi^2 (1, n = 135) = .051, p > .05$. Patients of 'non-white' ethnic background however, were likely to experience seclusion more times than patients of 'white' ethnic, $\chi^2 (1, n = 793) = 8.846, p < .003$. Lengths of time spent in seclusion also differed significantly, with patients of 'white' ethnic background ($Md = 52.00$ hours, $n = 620$) being secluded for significantly longer periods than patients of 'non-white' ethnic backgrounds ($Md = 37.63$ hours, $n = 173$), $Mann\ Whitney\ U = 41182.50, z = -4.672, p < .001, r = -.166$.



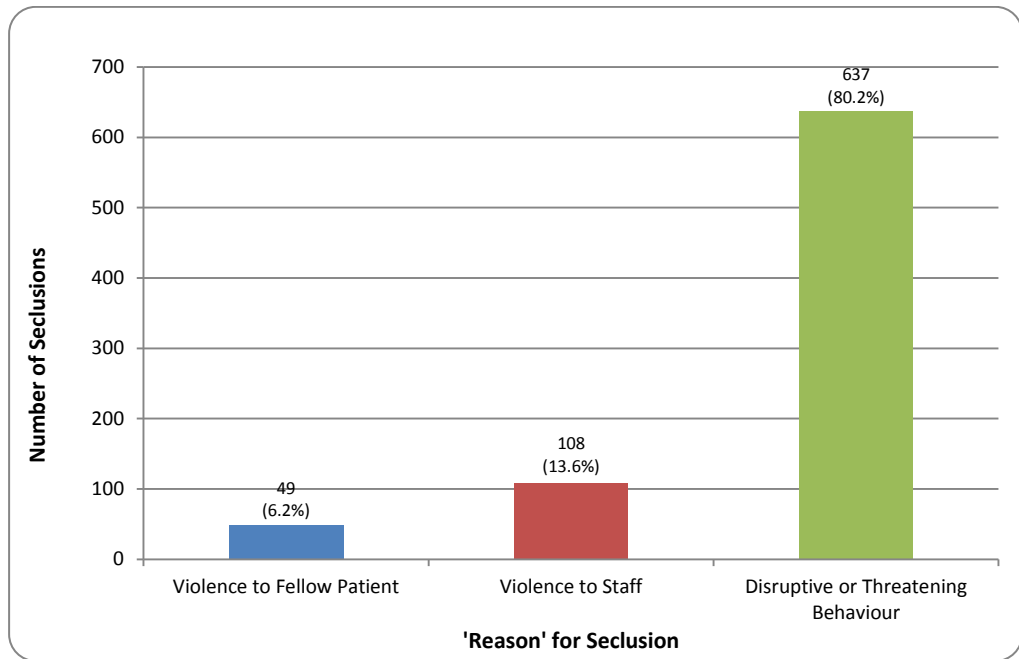
BAR CHART 19: MEDIAN NUMBER OF TIMES SECLUDED WITHIN EACH ETHNIC GROUP



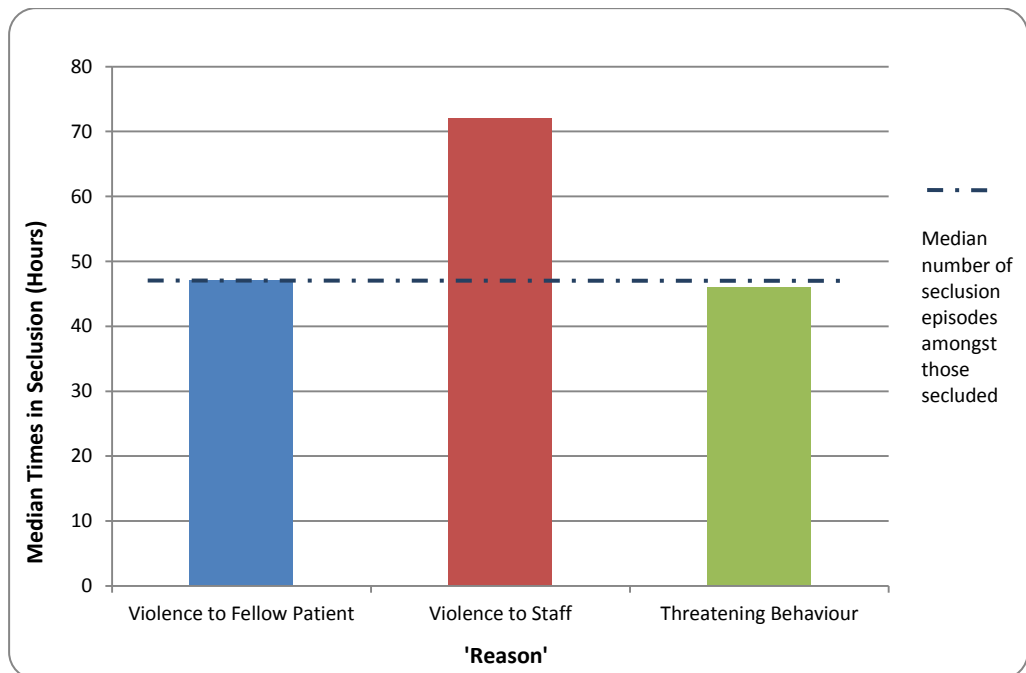
BAR CHART 20: MEDIAN DURATION OF SECLUSION WITHIN EACH ETHNIC GROUP

REASON

A Chi square analysis revealed significant differences in reasons for seclusion, with 'Threatening Behaviour' being most often associated with patients being secluded, $\chi^2 (2, n = 794) = 792.275, p < .001$. A Kruskal-Wallis H test revealed that patients 'Attacking Staff' accounted for the longest times spent in seclusion, $\chi^2 (2, n = 794) = 17.266, p \leq .001$.



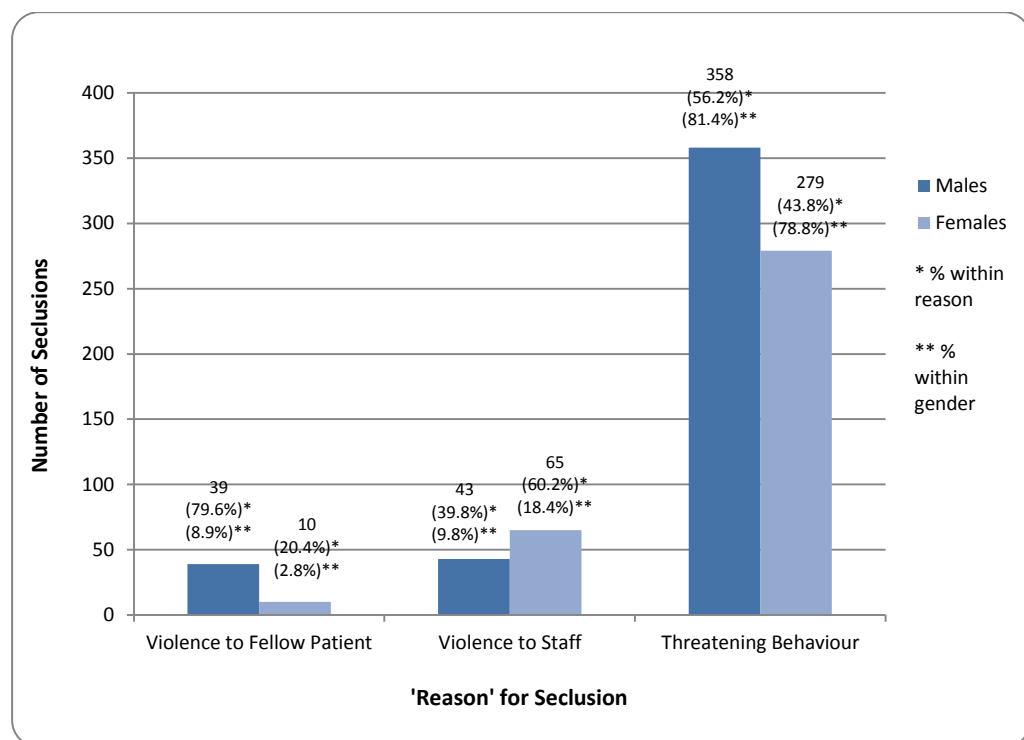
BAR CHART 21: REASONS FOR SECLUSION



BAR CHART 22: MEDIAN TIME SPENT IN SECLUSION ASSOCIATED WITH REASON

REASONS FOR SECLUSION BY GENDER

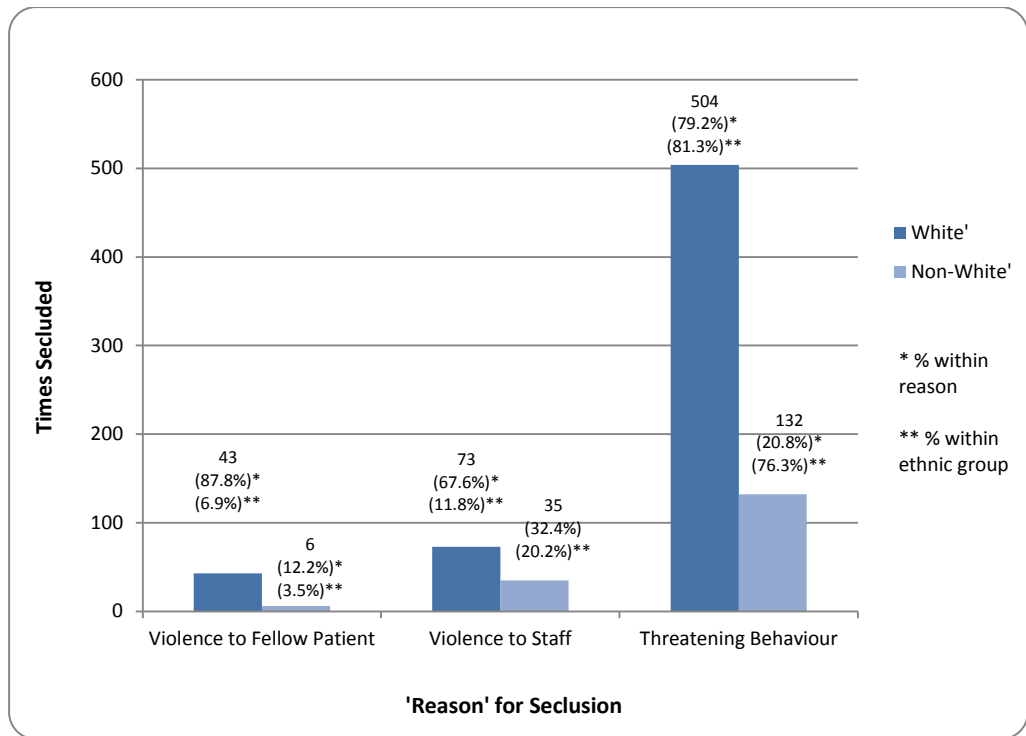
A Chi square test for independence indicated significant differences in reasons for using seclusion between male and female patients, $\chi^2 (2, n = 794) = 22.390, p < .001, phi = .168$. Post hoc pair wise analyses revealed that female patients were significantly more likely to be secluded than males for 'Violence to Staff', $\chi^2 (1, n = 108) = 206.079, p < .001$; and 'Threatening Behaviour', $\chi^2 (1, n = 637) = 514.445, p < .001$, where proportions of the whole hospital population were controlled for. There were no significant differences however, associated with 'Violence to Fellow Patient' between males and females.



BAR CHART 23: REASONS FOR SECLUSION BY GENDER

REASONS FOR SECLUSION BY ETHNICITY

A Chi square test for independence revealed significant differences between reasons for seclusion and ethnic group where ethnic group was divided into 'white' and 'non-white' categories, $\chi^2 (2, n = 793) = 10.155, p < .006, phi = .113$. Post hoc analyses indicated that patients of 'non-white' ethnic background were proportionately more likely to experience seclusion as a result of 'Violence to Staff' than patients of 'white' ethnic background, $\chi^2 (1, n = 108) = 15.813, p < .001$. No significant differences were found between other reasons for seclusion related to patients' ethnic backgrounds.



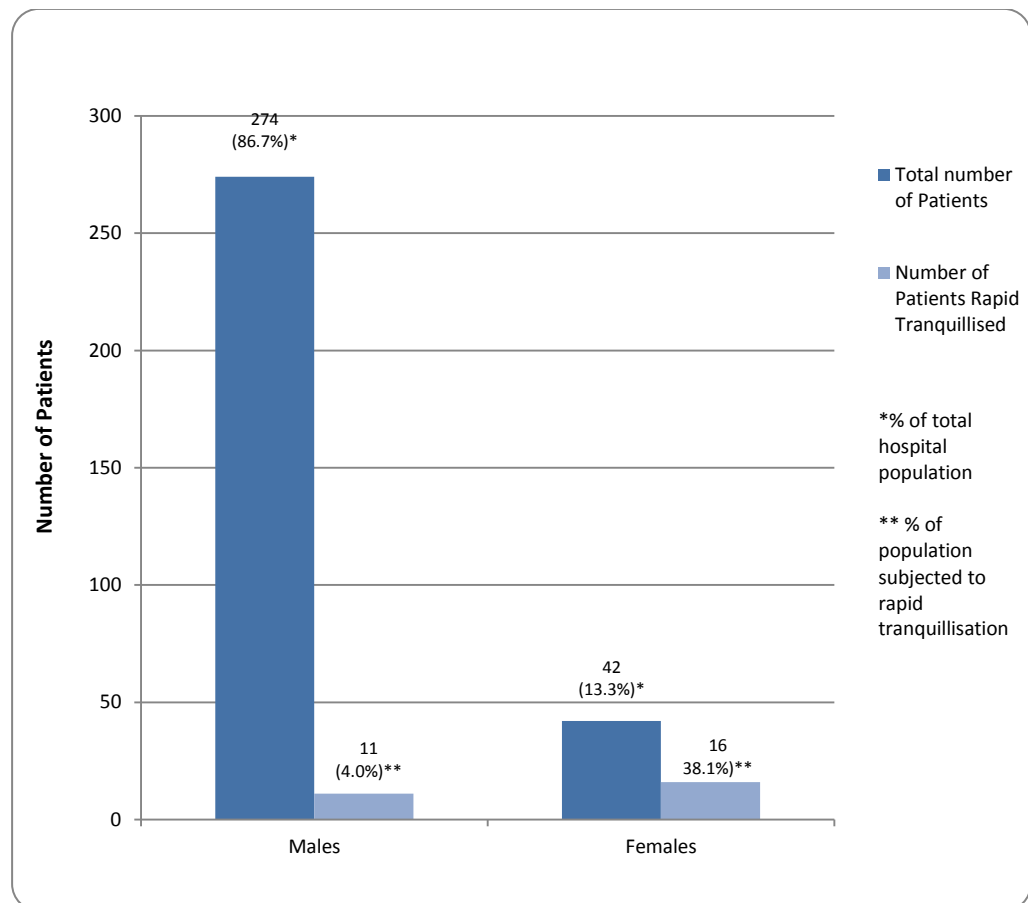
BAR CHART 24: REASON FOR SECLUSION ASSOCIATED WITH ETHNICITY

PART 3: RAPID TRANQUILLISATION

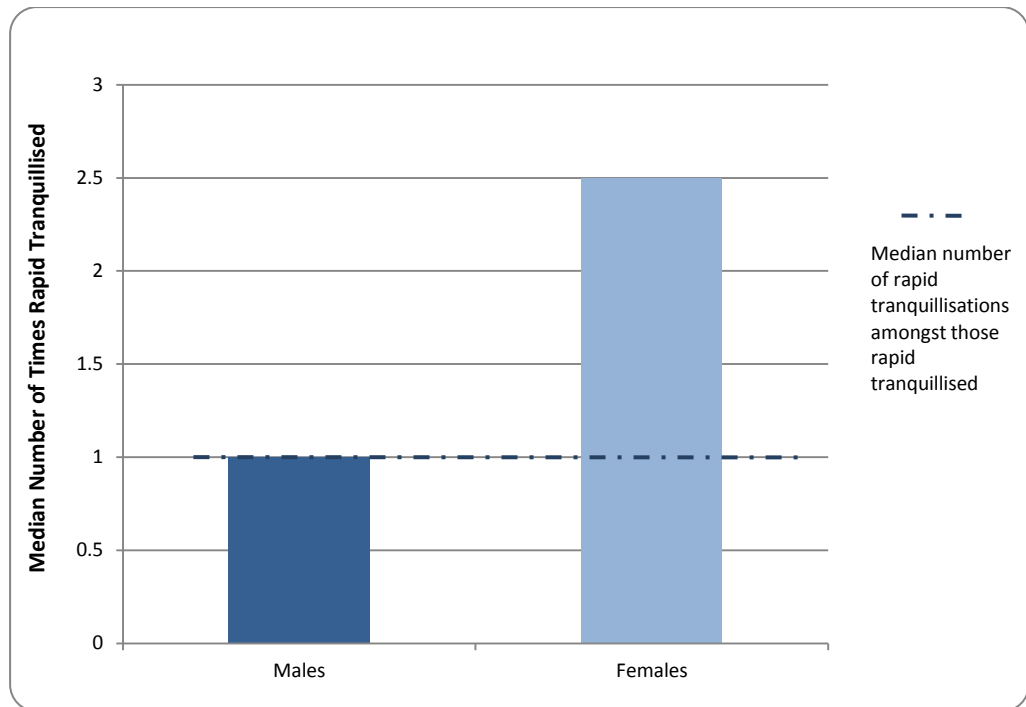
During August 2010 and July 2011, there were a total of 117 incidents where rapid tranquillisation was used. These were attributable to 27 patients; 11 of whom were male and 16 of whom were female.

GENDER

A Chi squared test revealed that significantly greater proportions of females were rapid tranquillised than males, $\chi^2 (1, n = 117) = 606.736, p < .001$. Females ($Md = 2.50, n = 16$) were also rapid tranquillised significantly more times than males ($Md = 1, n = 11$), $Mann\ Whitney\ U = 22.000, z = -3.591, p < .001, r = -.691$.



BAR CHART 25: PROPORTIONS OF PATIENTS EXPERIENCING RAPID TRANQUILLISATION BETWEEN AUGUST 2010 - JULY 2011



BAR CHART 26: MEDIAN NUMBER OF TIMES MALES AND FEMALES EXPERIENCED RAPID TRANQUILLISATION

AGE

Patients experiencing rapid tranquillisation were significantly younger ($Md = 31$ years, $n = 27$) than those who did not ($Md = 41$ years, $n = 289$), *Mann Whitney U* = 2559.000, $z = -2.959$, $p < .003$, $r = -.166$. No significant associations were found however, between the age of patients and the number of times they were rapid tranquillised.

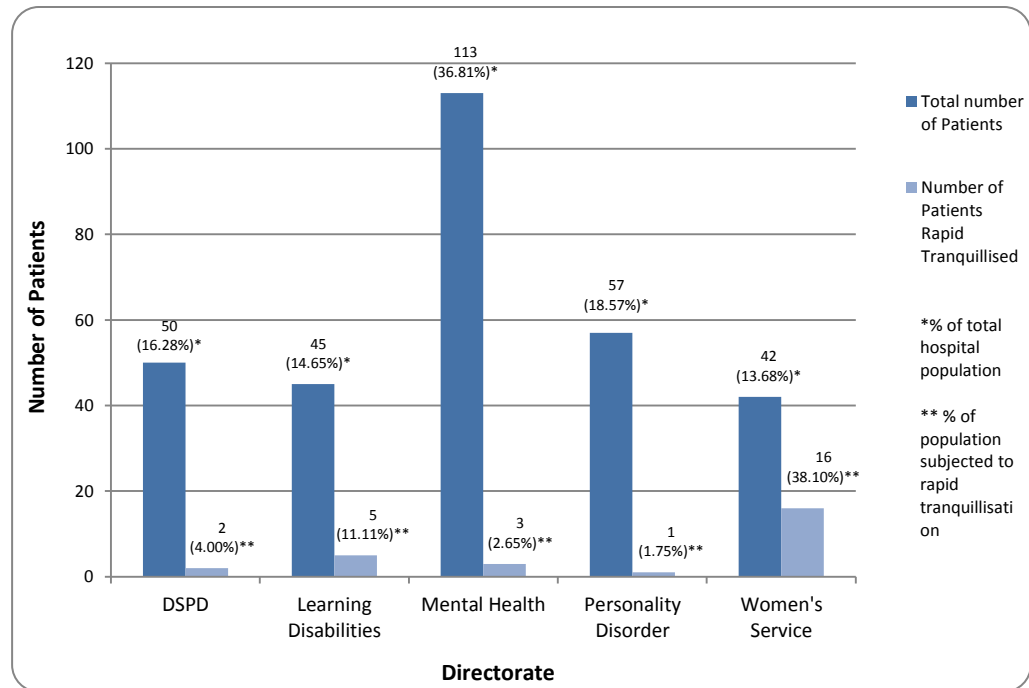
LENGTH OF ADMISSION

A Spearman's Rho correlation was conducted to examine in significant associations between length of admission and number of times patients were rapid tranquillised. No significant relationships were found.

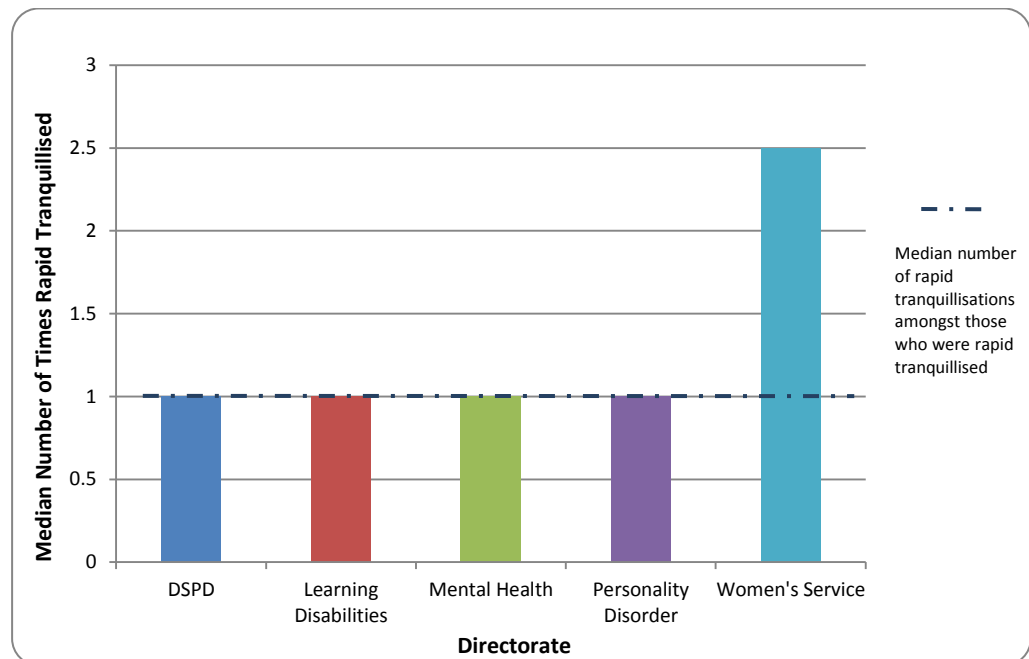
DIRECTORATE

A Chi square analysis revealed that patients accommodated within the Women's Service Directorate were proportionately more likely to experience rapid tranquillisation than patients accommodated within the other

directorates, $\chi^2 (4, n = 117) = 586.887, p < .001$. A Kruskal-Wallis H test revealed that patients with the Women's Service Directorate were also significantly more likely to experience rapid tranquillisation more times, $\chi^2 (4, n = 27) = 12.894, p < .015$. These findings support and reflect the overall hospital gender bias that females experience rapid tranquillisation more often and more times than males.



BAR CHART 27: PATIENTS EXPERIENCING RAPID TRANQUILLISATION WITHIN EACH DIRECTORATE



BAR CHART 28: MEDIAN NUMBER OF TIMES PATIENTS EXPERIENCED RAPID TRANQUILLISATION WITHIN EACH DIRECTORATE

WARD ACUITY

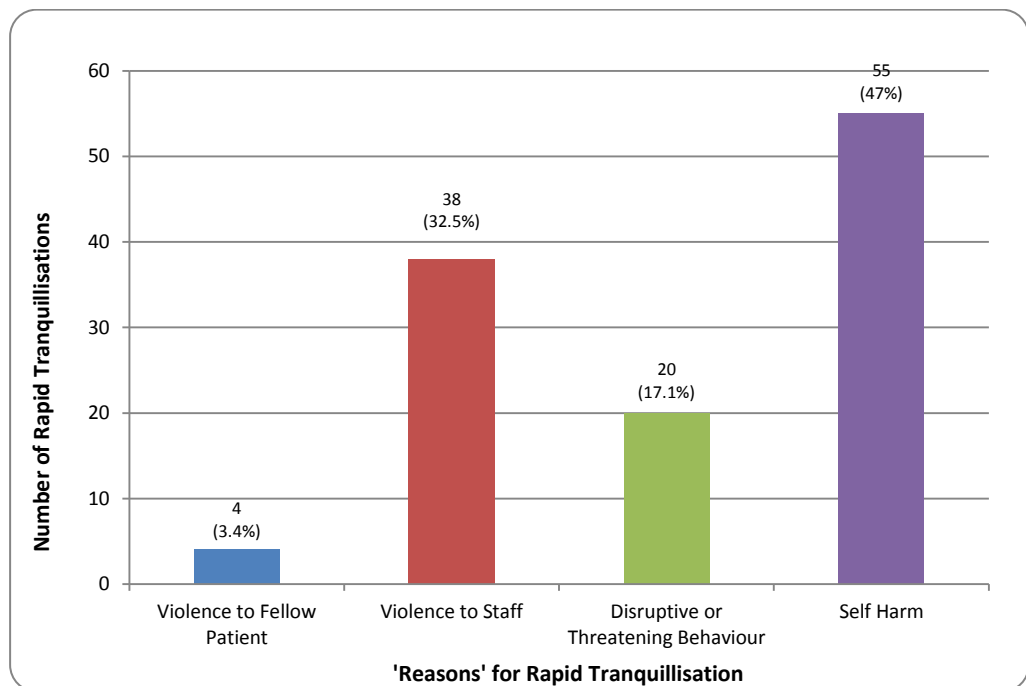
Attempts were made to examine the rates and frequencies of patients experiencing rapid tranquillisation in relation to ward acuity, however, sample sizes were too small in each of these categories for any meaningful comparisons to be made.

ETHNICITY

Where patients' ethnic backgrounds were divided into 'white' and 'non-white' categories, no significant differences were found in the proportions of patients of each group being rapid tranquillised. A Mann Whitney U test revealed no significant differences between the number of times patients of 'white' and 'non-white' ethnic groups were rapid tranquillised.

REASON

Reasons for rapid tranquillisation are largely comparable to those recorded for seclusion, with the addition of self harm. Significant differences were found between these four categories, with 'Self Harm' being the most prevalent reason recorded for using rapid tranquillisation, $\chi^2 (3, n = 117) = 50.009, p < .001$.



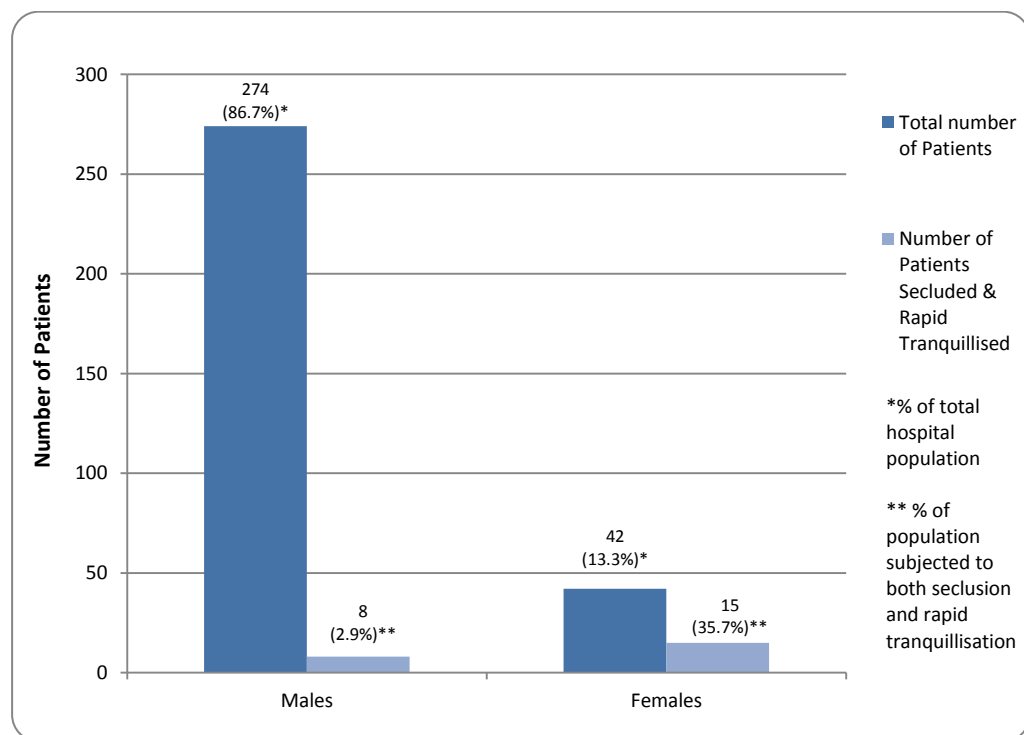
BAR CHART 29: REASONS FOR RAPID TRANQUILLISATION

Numbers were too small and therefore violated assumptions of the Chi squared tests for independence for reasons of rapid tranquilisation associated with gender, directorate and ethnicity.

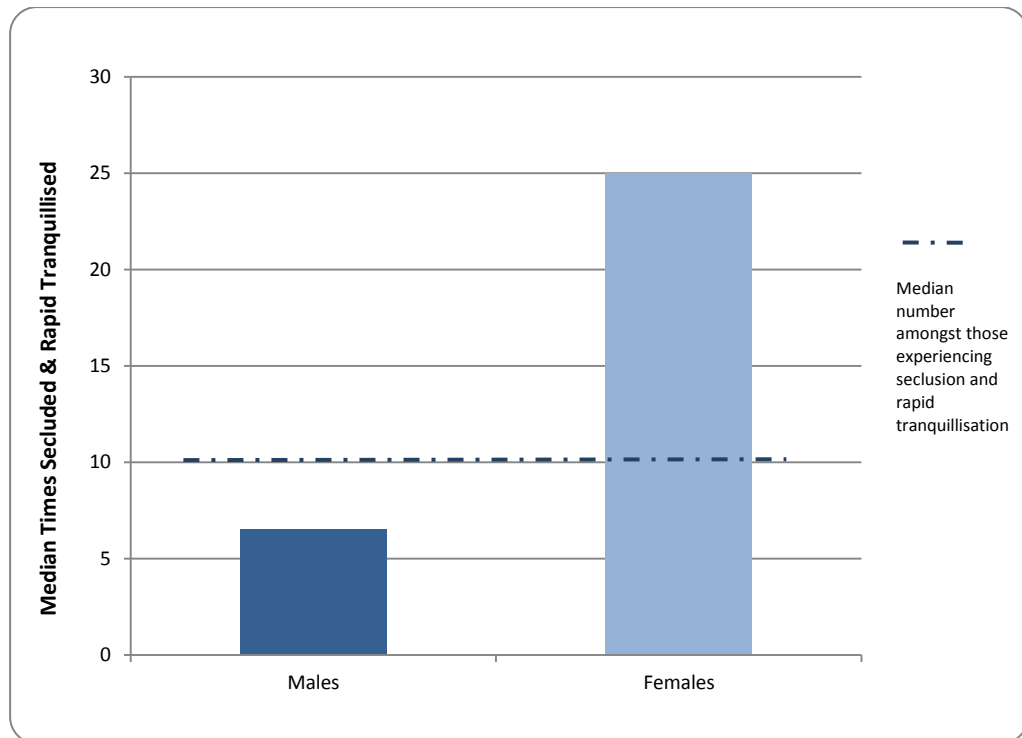
PART 4: SECLUSION AND RAPID TRANQUILLISATION

Of the 316 patients who were continuous residents for the whole duration of the study, 7.28% ($n = 23$) of these were secluded and rapid tranquillised on at least one occasion during the one year study period, although not necessarily experiencing these measures at the same time. Patients who experienced both seclusion and rapid tranquillisation ($Md = 31$ years, $n = 23$) were significantly younger than those who had not ($Md = 40$ years, $n = 293$), *Mann Whitney U* = 1949.500, $z = -3.367$, $p < .001$, $r = -.189$.

Female patients were proportionately more likely to be both secluded and rapid tranquillised than males, $\chi^2 (1, n = 23) = 53.812$, $p < .001$. Female patients ($Md = 26.00$, $n = 15$) were also more likely to be secluded and rapid tranquillised significantly more times than males ($Md = 6.5$, $n = 8$), *Mann Whitney U* = 29.500, $z = -1.974$, $p < .05$, $r = -.412$.



BAR CHART 30: PROPORTIONS OF PATIENTS EXPERIENCING SECLUSION AND RAPID TRANQUILLISATION BETWEEN AUGUST 2010 - JULY 2011



BAR CHART 31: MEDIAN NUMBER OF TIMES MALES AND FEMALES EXPERIENCED SECLUSION AND RAPID TRANQUILLISATION

The numbers of cases within each category were too small to make any meaningful comparisons between patients who were secluded and rapid tranquillised between different directorates, differing levels of ward acuity or patients of different ethnic groups.

Overall, these findings suggest age, gender, directorate and ward acuity to be significant contributing factors towards the rates and frequencies of which coercive measures are used. Younger patients are significantly more likely to experience either or both seclusion and rapid tranquillisation; females are more likely to be secluded and/or rapid tranquillised than males; whilst male patients residing on intensive care wards are most likely to experience seclusion. Whilst age and gender are indicative of patient demographics and individual differences having some influences upon the use of coercive measures, directorate and ward acuity are suggestive of external factors; most notably ward environment and atmosphere.

In order to examine ward atmosphere in greater detail whilst limiting any variables or biases associated with gender, diagnosis or directorate, the four wards, as case studies, would have to be chosen from one single directorate, accommodating either male or female patients while having one primary

diagnosis and clearly specified ward roles for comparability. The decision was therefore made to examine four wards within the Mental Health Directorate as case studies for further exploration. The Mental Health Directorate accommodates male patients only. Is less likely to have co-morbid diagnoses of personality disorder or dangerous and severe personality disorder combined with mental illness as would have been the case for the Women's Service, PD or DSPD Directorates, and overcomes any barriers in communication and subsequent scoring of questionnaires that may have been encountered in the Deaf Service Directorate. Furthermore, the Mental Health Directorate has clearly defined ward functions, approximating different stages of the treatment pathway and as such, may be conducive towards studying differences in roles and attitudes that contribute towards ward environment and atmosphere. The four wards chosen included an intensive care unit, admission ward, treatment ward and pre-discharge ward.

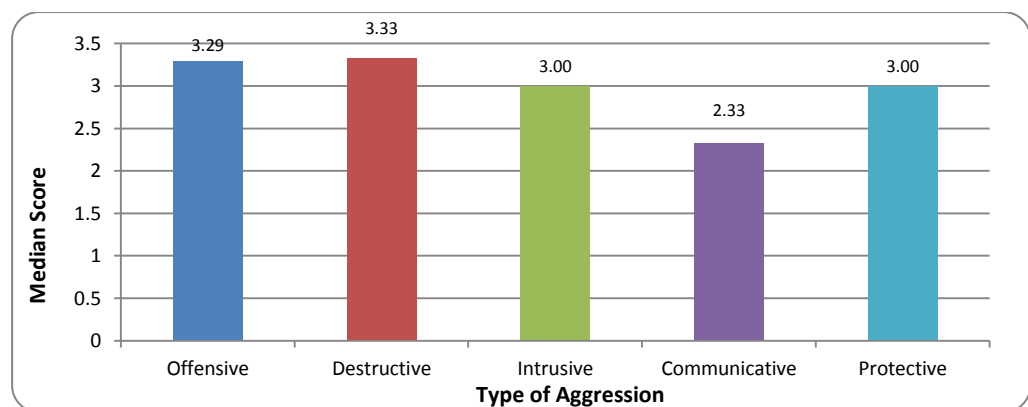
CHAPTER 9: QUESTIONNAIRE FINDINGS

PART 1 : ATTITUDES TOWARD AGGRESSION SCALE (ATAS)

The Attitudes Toward Aggression Scale (ATAS) is an 18-item questionnaire designed to compare staff attitudes towards different types of aggression. Five domains of aggression are depicted through a series of eighteen statements. These include aggression as i) offensive; ii) destructive; iii) intrusive; iv) communicative and v) protective. Staff are asked to rate their levels of agreement towards these eighteen statements along a five-point Likert scale; ranging from 1 = strongly disagree to 5 = strongly agree (see Appendix 1: Attitudes Toward Aggression Scale (ATAS)). In the context of this study, the ATAS was used to measure staff attitudes towards the five domains of aggression, to compare staff attitudes towards aggression relating to ward on which they work, gender, professional role, level of education and years of forensic experience. Findings from these statistical analyses are presented in the following.

FIVE DOMAINS OF AGGRESSION

A Friedman Test revealed significant differences in staff attitudes towards the five domains of aggression, $\chi^2 (4, n = 54) = 26.35, p < .001$. Aggression was most often perceived as being destructive. Post hoc Wilcoxon Rank Tests revealed that staff scores were significantly lower for the communicative domain of aggression in comparison with all other domains, indicating that staff perceive aggression as being significantly less likely to be communicative in comparison with other aggressive domains.

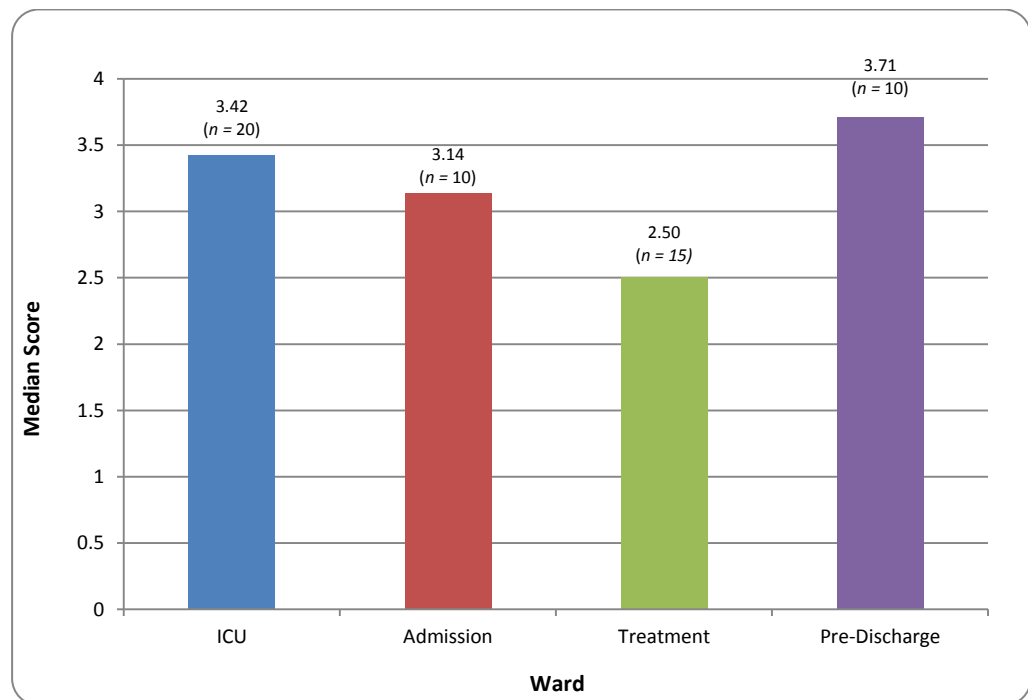


BAR CHART 32: COMPARISON OF STAFF SCORES BETWEEN FIVE DOMAINS OF AGGRESSION (ATAS)

COMPARISONS OF FOUR WARDS

OFFENSIVE

A Kruskal-Wallis Test revealed significant differences in staff scores for the offensive domain of patient aggression between the four wards (ICU, $n = 20$; treatment, $n = 10$; admission, $n = 15$; pre-discharge, $n = 10$), $\chi^2 (3, n = 55) = 11.26, p < .01$. Post hoc Mann-Whitney U Tests revealed staff scores as being significantly higher on the pre-discharge ward in comparison with the treatment (pre-discharge, $Md = 3.71, n = 10$; treatment, $Md = 2.50, n = 10, U = 10.50, z = -3.00, p < .003, r = -.67$) and admission wards (pre-discharge, $Md = 3.71, n = 10$; admission, $Md = 3.14, n = 15, U = 28.50, z = -2.59, p < .01, r = -.52$), indicating that staff working on the pre-discharge ward perceived aggression as being significantly more offensive than staff working on each of the treatment and admission wards, according to the ATAS.

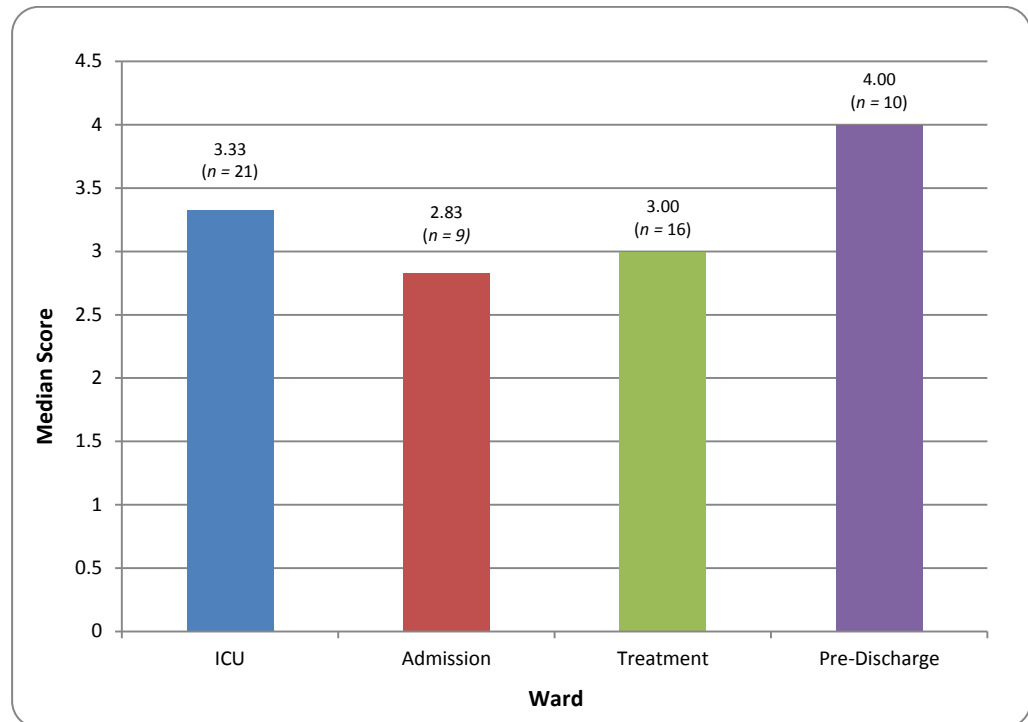


BAR CHART 33: OFFENSIVE DOMAIN OF AGGRESSION BY WARD (ATAS)

DESTRUCTIVE

A Kruskal-Wallis Test revealed significant differences in staff scores for the destructive domain of patient aggression across the four wards (ICU, $n = 21$; treatment, $n = 9$; admission, $n = 16$; pre-discharge, $n = 10$), $\chi^2 (3, n = 56) = 10.52, p = .02$. Post hoc Mann Whitney U tests revealed that staff working on

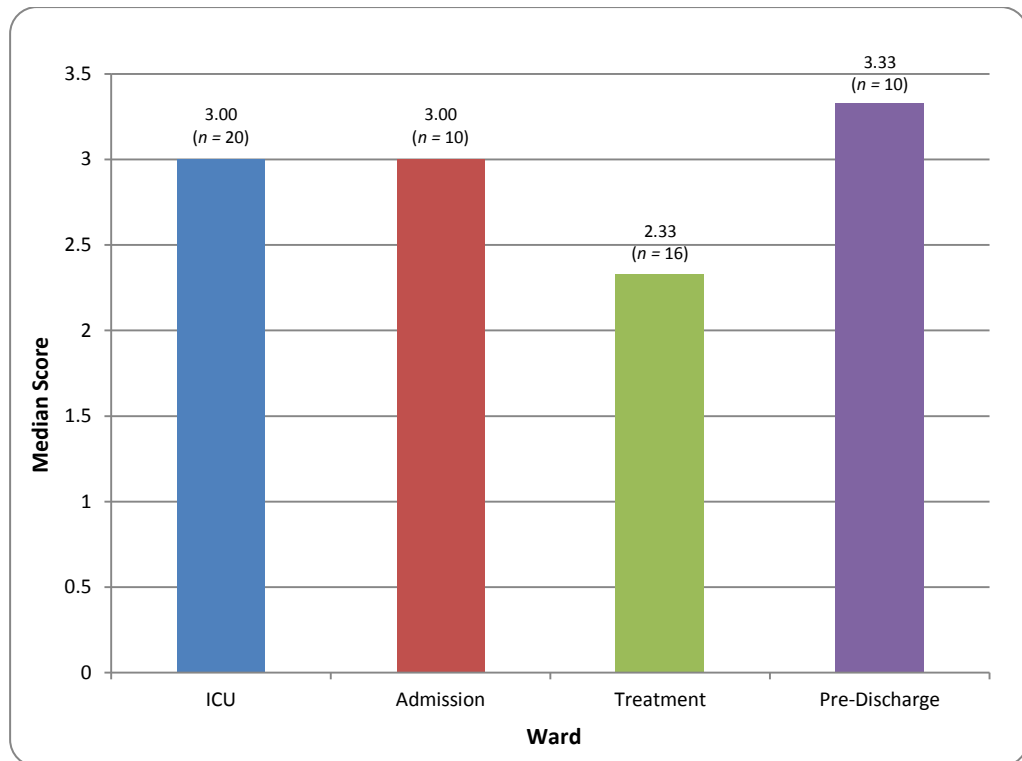
the pre-discharge ward ($Md = 4.00, n = 10$) perceived aggression as being significantly more destructive than staff working on the ICU, ($Md = 3.33, n = 21$), $U = 53.50, z = -2.22, p < .026, r = -.399$; treatment ($Md = 3.00, n = 9$), $U = 19.50, z = -2.10, p < .035, r = -.48$; and admission wards respectively ($Md = 2.83, n = 16$), $U = 24.00, z = -2.97, p < .003, r = -.58$. No significant differences were found in staff scores for the destructive domain of aggression between other wards.



BAR CHART 34: DESTRUCTIVE DOMAIN OF AGGRESSION BY WARD (ATAS)

INTRUSIVE

A Kruskal-Wallis Test revealed significant differences in staff scores for the intrusive domain of patient aggression across the four wards (ICU, $n = 20$: treatment, $n = 10$: admission, $n = 16$: pre-discharge, $n = 10$), $\chi^2 (3, n = 56) = 8.699, p = .034$. Staff working on the treatment ward scored aggression as being less intrusive amongst the four wards, with post hoc Mann-Whitney U Tests revealing significant differences between the treatment ward ($Md = 2.33, n = 10$) and ICU ($Md = 3.00, n = 20$), $U = 56.00, z = -1.96, p < .05, r = -.358$; treatment ward ($Md = 2.33, n = 10$) and admission ward ($Md = 3.00, n = 16$), $U = 42.50, z = -2.01, p < .045, r = -.449$; as well as the treatment ward ($Md = 2.33, n = 10$) and pre-discharge ward ($Md = 3.33, n = 10$), $U = 14.00, z = -2.76, p < .006, r = -.617$.



BAR CHART 35: INTRUSIVE DOMAIN OF AGGRESSION BY WARD (ATAS)

COMMUNICATIVE AND PROTECTIVE DOMAINS

No significant differences were found between the four wards when comparing staff scores for the communicative or protective domains of aggression.

GENDER

A Kruskal-Wallis Test was conducted to compare staff scores for each of the five domains of aggression by gender. No significant differences were found.

PROFESSIONAL ROLE

A Kruskal-Wallis Test was conducted to explore any significant differences in staff scores between the five domains of aggression where professional role was divided into 'ward-based' and 'non-ward based' staff. No significant differences were found.

EDUCATION

Relationships were explored between staff levels of education and scores for each of the five domains of aggression as measured by the ATAS. No significant correlations were found.

YEARS OF FORENSIC EXPERIENCE

Relationships were explored between staff years of experience working in forensic services and staff scores for each of the five domains of aggression as measured by the ATAS. No significant correlations were found. Relationships were also explored between staff years of experience working on their current ward and staff scores for each of the five domains of aggression as measured by the ATAS. Again no significant differences were found.

The statistical analyses of these findings would suggest differences in staff perceptions of aggression being related to the wards influences rather than individual staff variables. Such ward influences however, may be related to patients, ward function or staff perceptions of their role relating to each ward. Given that all of these factors are interrelated and conducive to creating ward environment, these factors will be explored through further analyses and comparisons of staff and patient attitudes towards containment measures as well as staff and patient experiences of ward atmosphere.

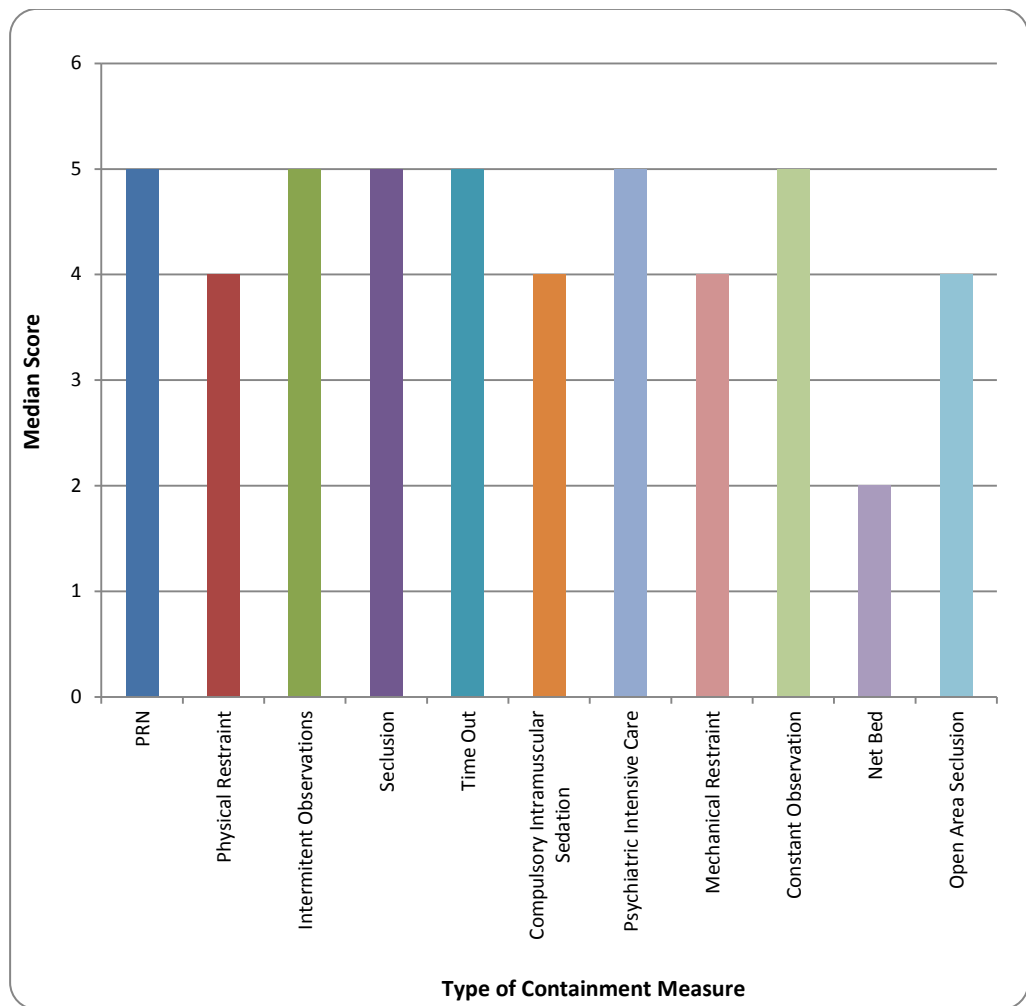
PART 2 : ATTITUDES TO CONTAINMENT QUESTIONNAIRE (ACMQ)

The ACMQ is an 11-item questionnaire, with each item relating to a different type of containment measure. Each item includes a picture as well as a brief description of each type of containment measure. The types of containment measure depicted include; PRN medication, seclusion, physical restraint, time out, intermittent observation, compulsory intramuscular sedation, psychiatric intensive care, net bed, mechanical restraint, open area seclusion and constant observation. Not all of the containment measures depicted within the questionnaire are used within the UK, for example, the net bed. However, all of the containment measures are used in at least one European country (Bowers, 2004, 2010). Each of the 11-items are divided into two parts. The first part asks participants to score their rating of acceptability along a five-point Likert scale, ranging from 1 = strongly disagree to 5 = strongly agree. The second part asks participants whether or not they have either used (if staff), or experienced (if patient), that type of containment measure (see Appendices).

The ACMQ was designed to compare attitudes between different groups or attitudes of same groups over time. For the purposes of this study, the ACMQ was used to i) identify whether there are any significant differences in staff or patient attitudes towards the different types of containment measures depicted; ii) to compare staff and patients attitudes; iii) to compare staff and patient attitudes between the four wards; iv) to examine whether staff attitudes are influenced by gender, professional role and level of education; and v) to address the research hypothesis of whether exposure and experience of containment measures contribute towards perceptions of acceptability. The following sections will present findings from staff and patient respectively, followed by comparisons between the two.

STAFF

The results of a Friedman Test indicated that there were statistically significant differences in staff scores of acceptability between the eleven types of containment measures, $\chi^2 (10, n = 49) = 242.57, p < .001$. Time out, observations and PRN medication were found to be most acceptable types of containment measures whilst the net bed was found to be the least acceptable method of containment amongst staff.

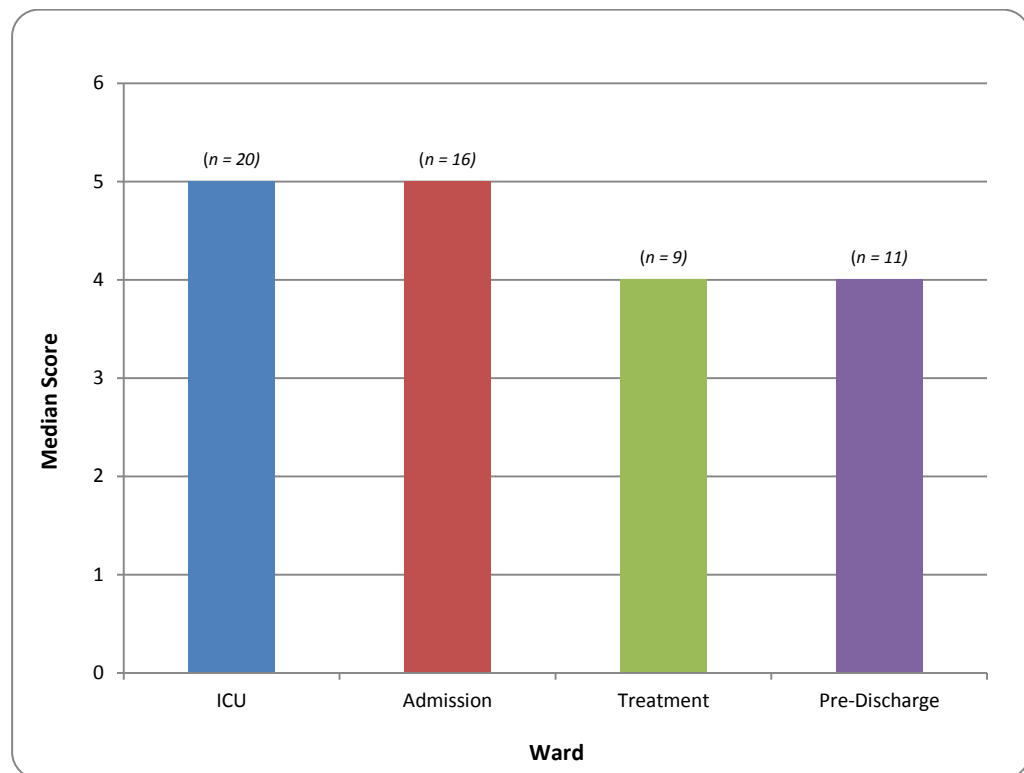


BAR CHART 36: STAFF ATTITUDES TO CONTAINMENT MEASURES (ACMQ)

COMPARISONS OF FOUR WARDS

A Kruskal Wallis Test revealed a statistically significant difference in staff scores for physical restraint across the four different wards (ICU, $n = 20$: treatment, $n = 9$: admission, $n = 16$: pre-discharge, $n = 11$), $\chi^2 (3, n = 56) = 8.691, p < .035$. Post hoc Mann Whitney U Tests revealed significant differences in staff scores for physical restraint between the ICU ($Md = 5, n = 20$) and treatment ward, ($Md = 4, n = 9$) $U = 45.50, z = -2.29, p < .025, r = -.19$, and the admission ($Md = 5, n = 16$) and treatment ward respectively ($Md = 4, n = 9$), $U = 29.00, z = -2.71, p < .01, r = -.54$. Staff working on the ICU and admission wards scored physical restraint as being significantly more acceptable than staff working on the treatment ward. No significant differences were found between the four wards where examining other types of containment measures. Neither were any significant differences found

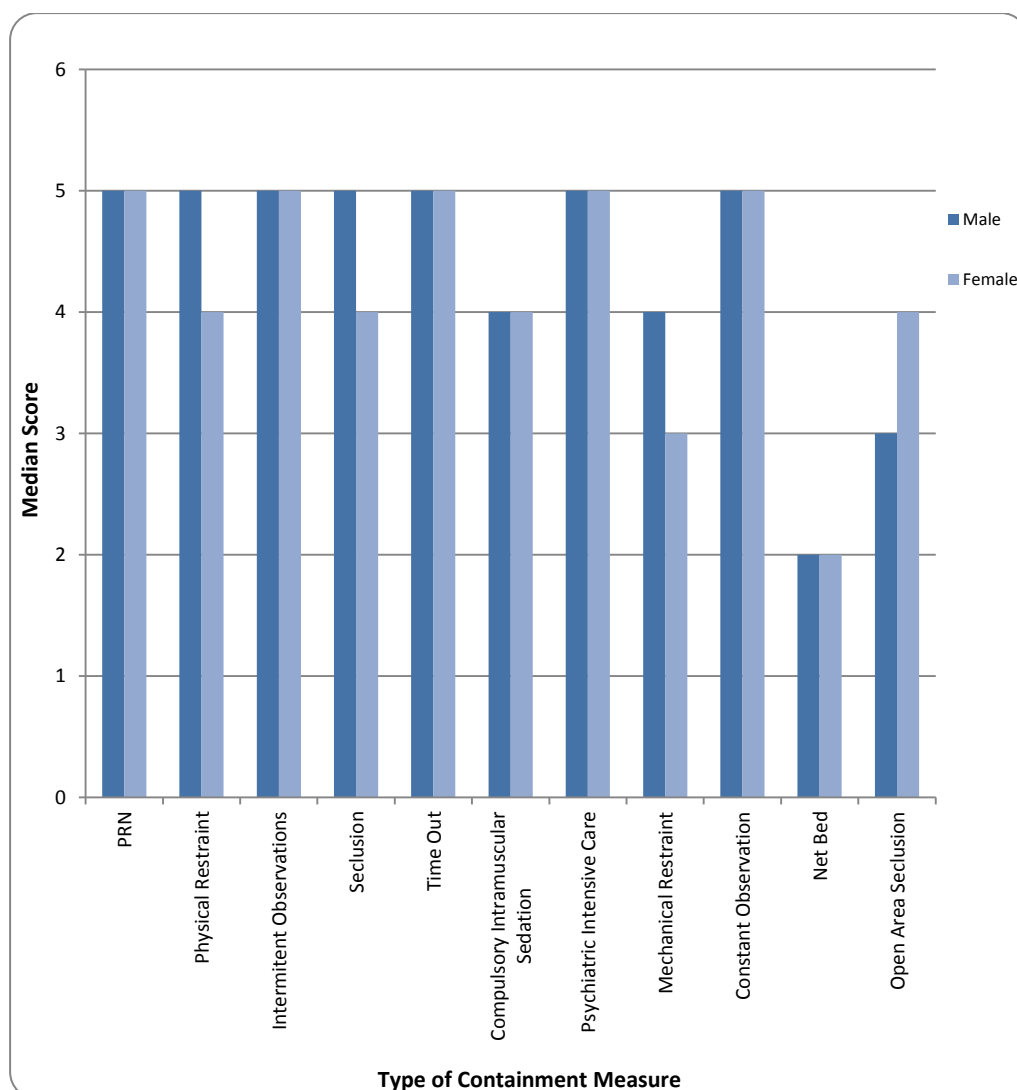
between the other types of containment measures where the four wards were collapsed into two groups denoting short stay and long stay wards.



BAR CHART 37: STAFF ATTITUDES TOWARDS PHYSICAL RESTRAINT BETWEEN WARDS (ACMQ)

GENDER

Mann Whitney U Tests were conducted to explore any significant differences in staff scores for each type of containment measure by gender. Male members of staff generally scored containment measures as being more acceptable than female members of staff. Male members of staff rated physical restraint, seclusion and mechanical restraint as being significantly more acceptable than females; (Physical restraint; male, $Md = 5.00$, $n = 36$; female, $Md = 4.00$, $n = 20$, $U = 229.50$, $z = -2.47$, $p < .01$, $r = -.33$; seclusion male, $Md = 5.00$, $n = 37$; female, $Md = 4.00$, $n = 20$, $U = 218.00$, $z = -2.87$, $p < .00$, $r = -.38$; mechanical restraint; male, $Md = 4.00$, $n = 37$; female, $Md = 3.00$, $n = 20$, $U = 229.50$, $z = -2.48$, $p < .01$, $r = -.33$). Open area seclusion was the only type of containment measure that female staff rated as being significantly more acceptable than males (male, $Md = 3.00$, $n = 37$; female $Md = 4.00$, $n = 19$), $U = 210.50$, $z = -2.55$, $p < .01$, $r = -.34$.

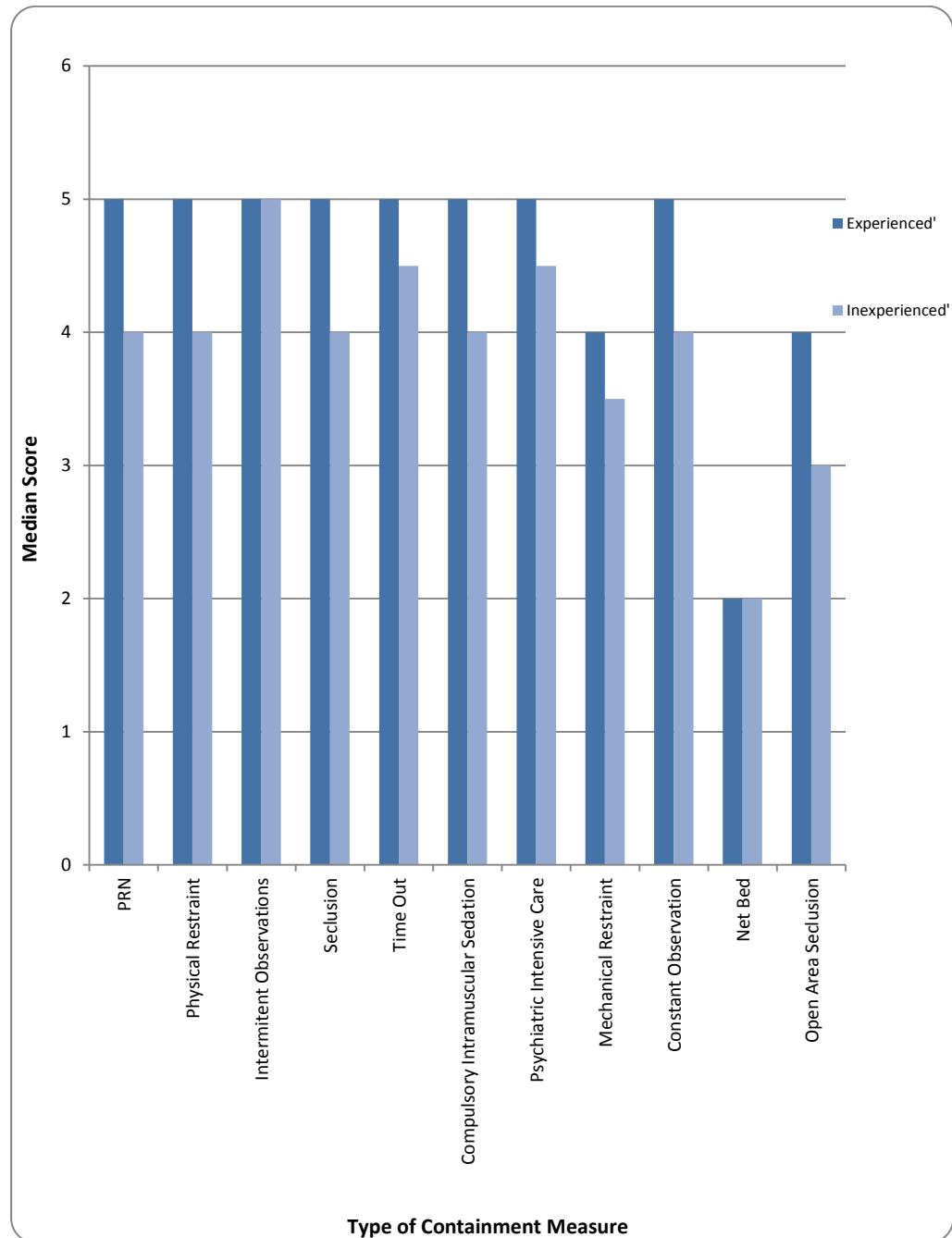


BAR CHART 38: STAFF ATTITUDES TOWARDS CONTAINMENT MEASURES BY GENDER (ACMQ)

STAFF EXPERIENCE

Mann Whitney U Tests were conducted to explore any significant differences in staff scores of acceptability for each containment measure, according to whether they had or had not experienced using them. Significant differences were found, with ‘experienced staff’ being more likely to rate containment measures as being more acceptable than those who were ‘inexperienced’. Staff who had experience of using physical restraint (‘experienced’, $Md = 5.00$, $n = 48$; ‘inexperienced’, $Md = 4.00$, $n = 7$), $U = 89.00$, $z = -2.22$, $p < .05$, $r = -.30$; seclusion, (‘experienced’, $Md = 5.00$, $n = 50$; ‘inexperienced’, $Md = 4.00$, $n = 5$), $U = 36.50$, $z = -2.92$, $p < .001$, $r = -.39$; compulsory intramuscular sedation (‘experienced’, $Md = 5.00$, $n = 38$; ‘inexperienced’, $Md = 4.00$, $n = 17$), $U = 176.00$, $z = -2.91$, $p < .001$, $r = -.39$; mechanical restraint (‘experienced’, $Md = 4.50$, $n = 22$; ‘inexperienced’, $Md = 3.50$, $n = 34$), $U =$

150.00, $z = -3.98$, $p < .001$, $r = -.53$; and open area seclusion ('experienced', $Md = 4.00$, $n = 18$; 'inexperienced', $Md = 3.00$, $n = 37$), $U = 187.50$, $z = -2.73$, $p < .01$, $r = -.37$; scored each of these containment measures as being significantly more acceptable than those staff who had not experienced using them. No significant differences were found for PRN medication, intermittent observations, time out, psychiatric intensive care, constant observations or net bed.



BAR CHART 39: STAFF ATTITUDES TOWARDS CONTAINMENT MEASURES BY EXPERIENCE (ACMQ)

PROFESSIONAL ROLE

Attempts were made to address whether or not staff attitudes towards containment measures were associated with professional role. However, the number of respondents from each professional role were too small from which to draw any meaningful comparisons.

LEVEL OF EDUCATION

No significant differences were found between staff scores relating to levels of education.

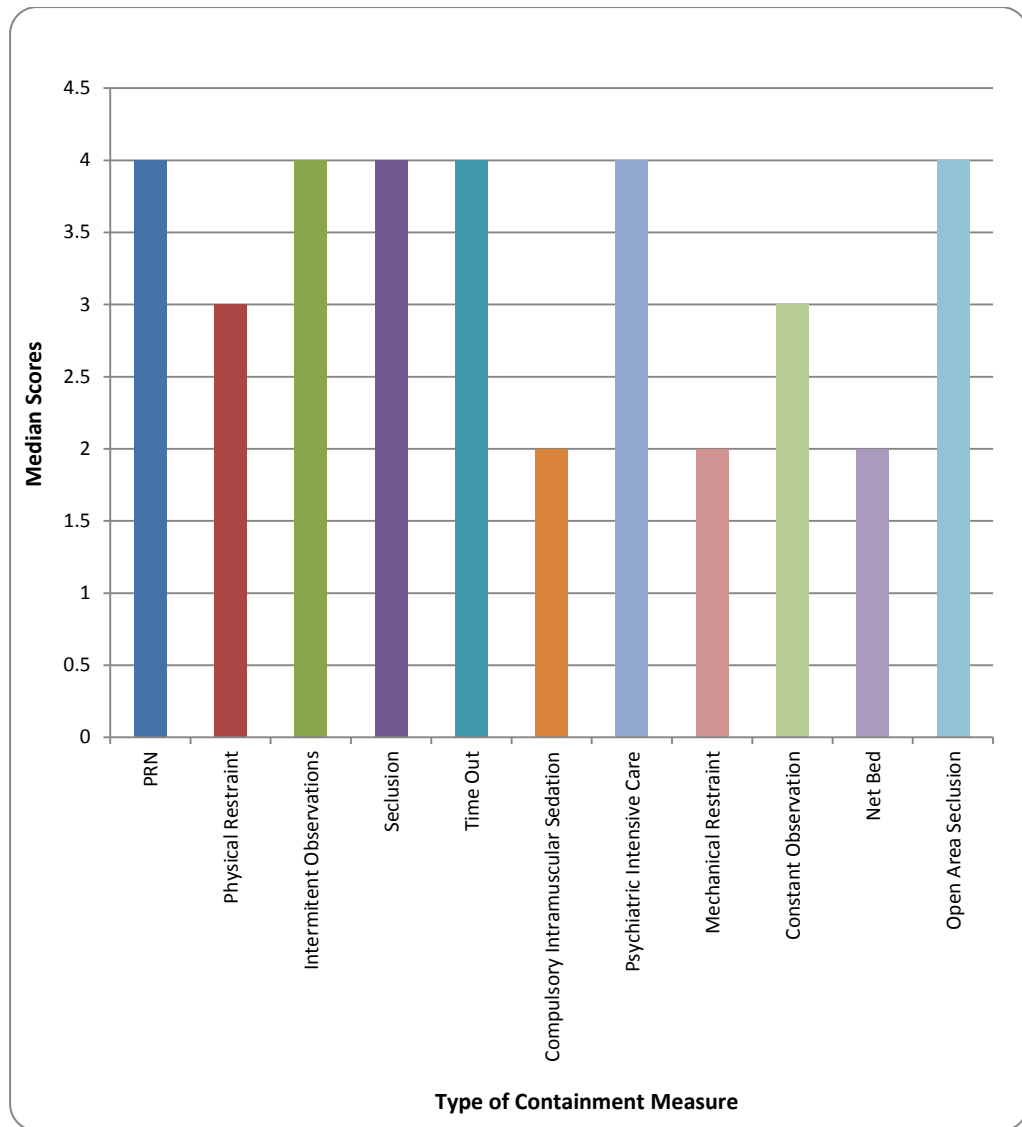
Staff findings from the ACMQ suggest that differences in attitudes towards different types of containment measure. These appear to be influenced by staff gender as well as familiarity and experience. Male members of staff tended to rate containment measures as being more acceptable than females. Staff who had experience of using the containment measure in question rated them as being more acceptable. Staff on the ICU and admission wards also rated physical restraint as being significantly more acceptable than staff on the treatment and admission wards.

PATIENTS

The results of a Friedman Test indicated that there were statistically significant differences in patient scores of acceptability between the eleven types of containment measures, $\chi^2 (10, n = 29) = 73.96, p < .001$. Patients scored PRN medication, time out and intermittent observations as being the most acceptable methods of containment, whilst uses of a net bed and mechanical restraints were perceived as least acceptable methods (see Bar Chart 40).

COMPARISONS OF FOUR WARDS

A Kruskal Wallis Test revealed no statistically significant differences in patient scores each of the eleven containment measures across the four wards. Where the four wards were collapsed into two groups, namely short stay and long stay wards, no significant differences remained.



BAR CHART 40: PATIENT ATTITUDES TOWARDS CONTAINMENT MEASURES (ACMQ)

PATIENT EXPERIENCE

Mann Whitney U Tests were conducted to explore any significant differences in patient scores of acceptability for each containment measure, according to whether or not patients had been subjected to each method. No significant differences were found. The hypothesis that patient exposure to containment measures would influence perceptions of acceptability is therefore unconfirmed.

At first glance then, patient scores of acceptability appear comparable with those of staff in terms of the net bed being the least acceptable method of containment. Patient ratings of acceptability however, do not appear to be

influenced either by ward or exposure to containment measures. Staff and patient findings will therefore be more examined more closely.

ACMQ: STAFF AND PATIENTS COMPARED

Pairwise analyses were conducted comparing staff and patient scores of acceptability for each of the eleven containment measures. Significant differences were found between staff and patient scores for all types of containment measures with the exceptions of using a net bed or open area seclusion. For all other types of containment measures outlined within the ACMQ, staff rated these as being significantly more acceptable than patients

STAFF AND PATIENT SCORES BY WARD

A two-way between groups analysis of variance was conducted to explore the impact of ward on staff and patient perceptions for each of the eleven containment measures. No significant interactions were found where analysing the impact of ward on staff and patient perceptions of compulsory intramuscular medication and mechanical restraints. Where examining the impact of ward on staff and patient perceptions of the remaining nine types of containment measures set out in the ACMQ, assumptions of the Levene's Test were violated and so any meaningful analyses could not be obtained.

Overall findings from the ACMQ indicated that there were greater variances amongst staff attitudes towards containment measures than patients. Staff gender and experience of using containment measures appeared to influence staff scores of acceptability, with male staff generally scoring containment measures as being more acceptable than females and experienced staff scoring containment measures as being more acceptable than those who were inexperienced. Whilst patient respondents were all males, exposure to containment measures did not appear to influence their perceived levels of acceptability. It is perhaps unsurprising that staff generally scored containment measures as being more acceptable than patients subjected to such measures. However, types of ward on which staff work appear to influence both attitudes towards aggression as well as perceptions of acceptability towards the types of containment measures used. The wards on which patients reside however, do not appear to influence patient attitudes towards containment measures. Given these differences in attitudes and

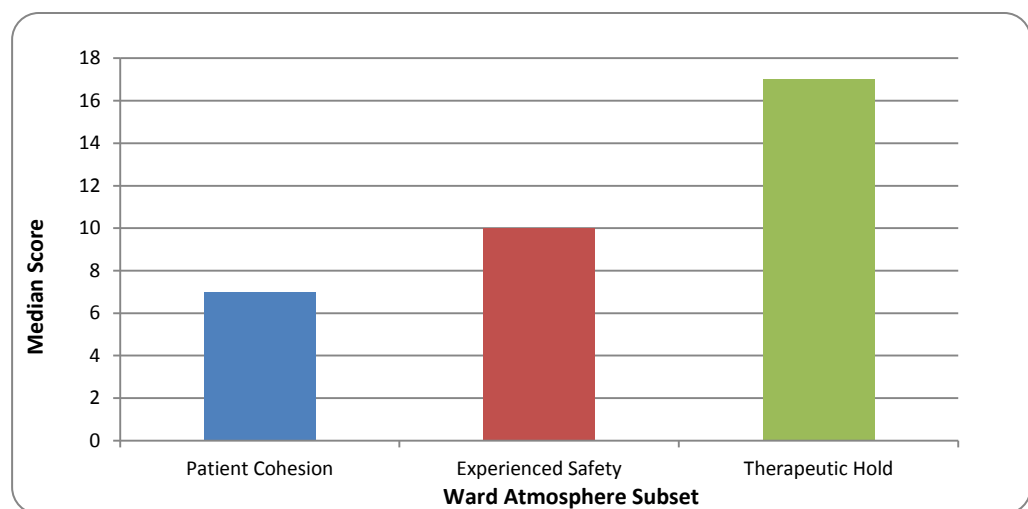
perceptions between staff and patients, and indeed between the four wards where staff are concerned, it would be interesting to explore further how ward atmosphere is perceived between staff and patients and between the four wards.

PART 3: ESSENCES

The EssenCES questionnaire is a 17-item questionnaire designed to measure ward atmosphere. Two of the items, the first and last question, are not scored, whilst the remaining fifteen questions fall into one of three categories pertaining to; patient cohesion, experienced safety and therapeutic hold (Schalast, 2010) (see Appendix 3: Essen Climate Evaluation Scale (EssenCES)). The questionnaire was designed to compare either experiences of different groups or same groups over time. For the purposes of this study, the EssenCES questionnaire was used to i) measure staff and patient perceptions of ward atmosphere; ii) to examine whether or not perceptions of ward atmosphere are influenced by staff and patient roles; and iii) to explore whether staff and patient perceptions are influenced by the ward on which they either work or reside. Findings from these analyses will be presented in the following.

STAFF FINDINGS

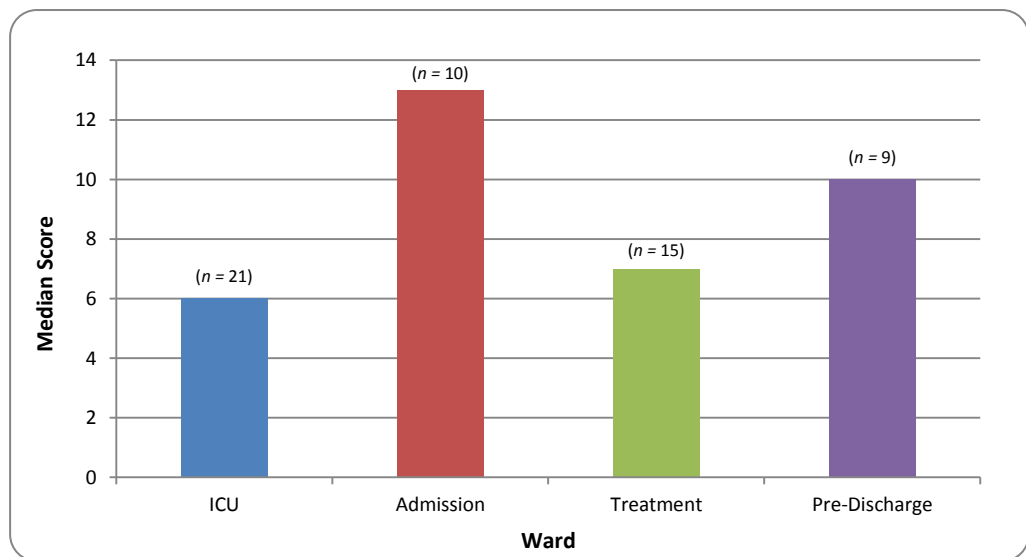
A Friedman Test revealed significant differences in staff scores for patient cohesion, experienced safety and therapeutic hold, $\chi^2 (2, n = 55) = 73.560, p < .001$. Post hoc Wilcoxon signed rank tests revealed that staff scores for therapeutic hold were significantly greater than for experienced safety, $z = -6.091, p < .001, r = .581$, and that staff scores for experienced safety were significantly greater than those for patient cohesion, $z = -2.194, p < .005, r = .209$. These findings suggest that staff perceived ward atmosphere as being most therapeutic whilst least supportive between patients.



BAR CHART 41: ESSENCES STAFF SCORES

PATIENT COHESION

A Kruskal-Wallis test was conducted to examine any significant differences in staff perceptions of patient cohesion across the four wards. Significant differences were found, $\chi^2(3, n = 55) = 18.12, p < .001$. Post hoc Mann-Whitney U tests revealed significant differences between staff scores for patient cohesion between the ICU and treatment ward ($U = 26.00, z = -3.38, p < .001, r = -.61$), ICU and pre-discharge ward ($U = 22.00, z = -3.33, p < .001, r = -.61$), and the treatment and admission wards ($U = 24.50, z = -2.81, p < .02, r = -.56$), indicating that staff on the treatment and pre-discharge wards perceived greater patient cohesion than staff working on the ICU and admission wards

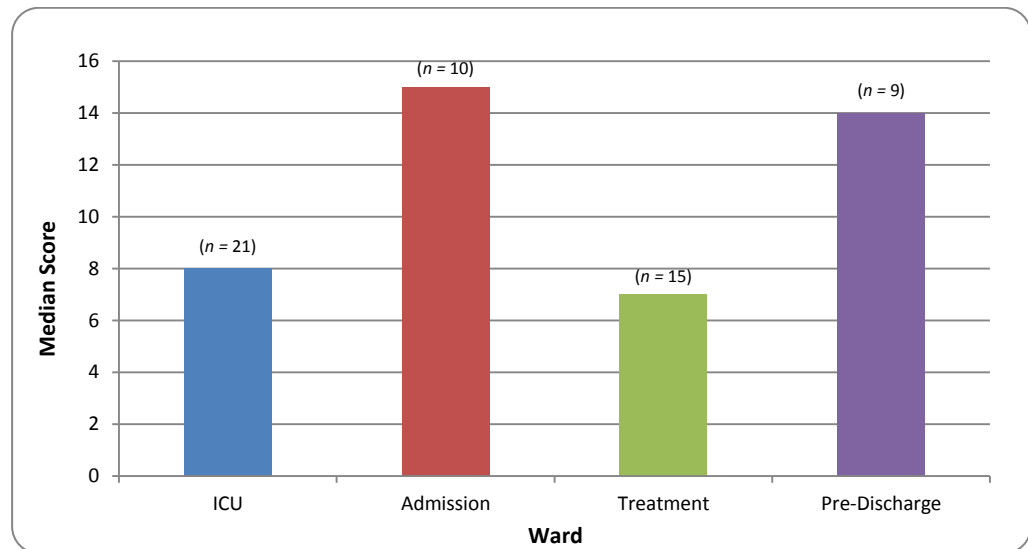


BAR CHART 42: STAFF SCORES FOR PATIENT COHESION (ESSENCES)

EXPERIENCED SAFETY

A Kruskal-Wallis test revealed significant differences between staff scores for experienced safety across the four wards, $\chi^2(3, n = 55) = 28.84, p < .001$. Post hoc Mann-Whitney U tests revealed significant differences for staff scores of experienced safety between the treatment ward and ICU, ($U = 3.00, z = -4.32, p < .001, r = -.78$) and treatment ward and admission ward, ($U = 10.5, z = -3.61, p < .001, r = -.72$). Significant differences were also found between the pre-discharge ward and ICU, ($U = 14.00, z = -3.66, p < .001, r = -.67$), and the pre-discharge ward and admission ward, ($U = 16.50, z = -3.06, p < .001, r = -.63$). Staff scored significantly greater experienced safety amongst the

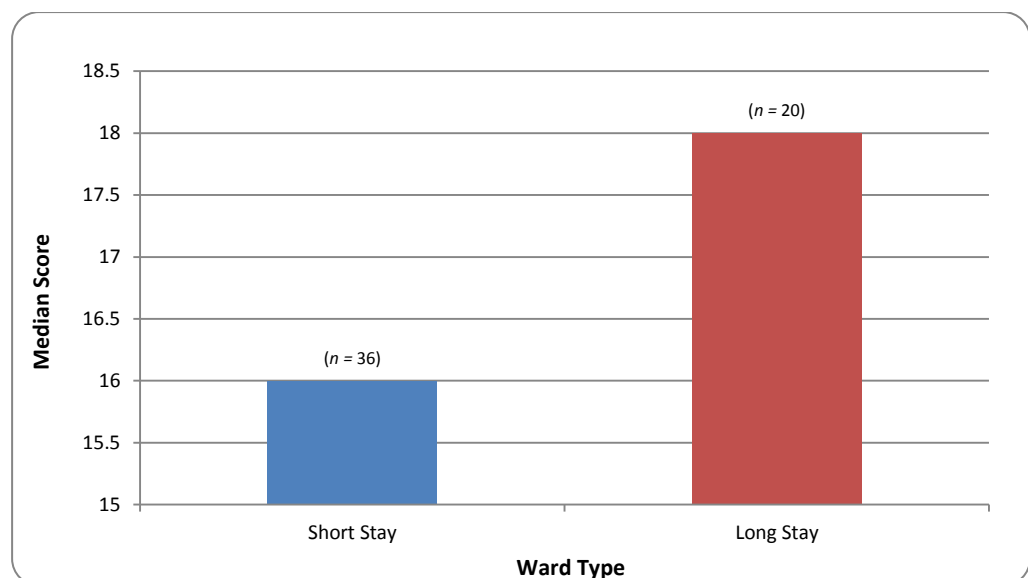
treatment and pre-discharge wards in comparison with the ICU and admission wards.



BAR CHART 43: STAFF SCORES FOR EXPERIENCED SAFETY (ESSENCES)

THERAPEUTIC HOLD

A Kruskal Wallis test revealed no significant differences in staff scores between the four wards for therapeutic hold. Where wards were collapsed into short-stay (ICU and admission wards) and long-stay wards (treatment ward and pre-discharge) however, significant differences were found, with staff scoring significantly greater therapeutic hold amongst the long stay than short stay wards, $U = 224.00$, $z = -2.35$, $p < .02$, $r = -.31$; indicating that the long stay wards were perceived as having a more therapeutic atmosphere by staff.



BAR CHART 44: STAFF SCORES FOR THERAPEUTIC HOLD (ESSENCES)

GENDER

No significant differences were found in staff scores by gender between the three subsets.

PROFESSIONAL ROLE

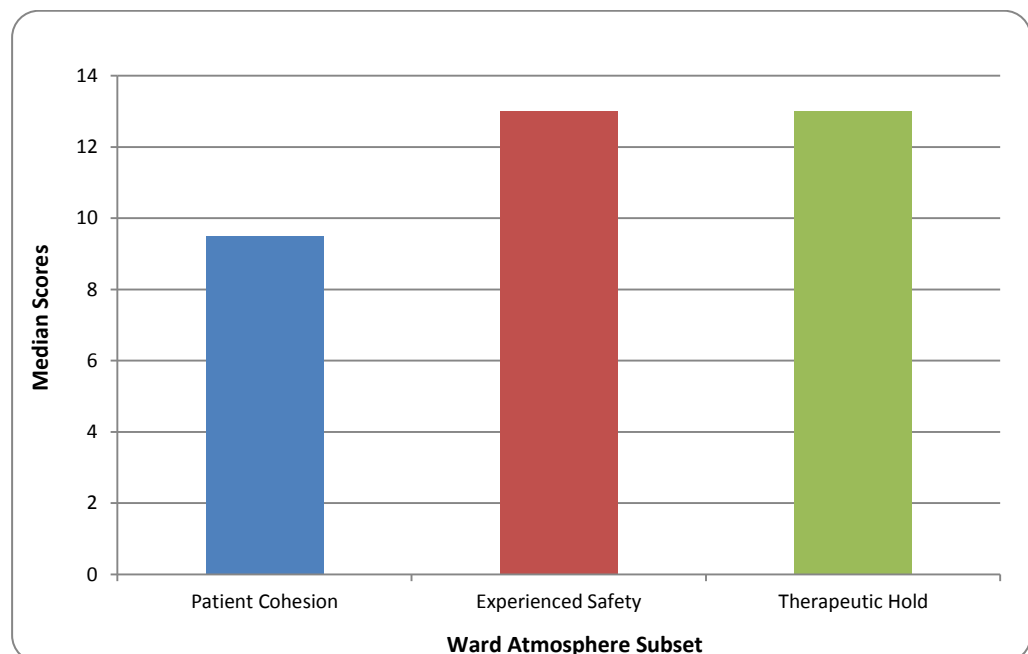
No significant relationships were found between staff scores and years of experience working on their current ward between the three subsets.

YEARS OF EXPERIENCE

Staff perceptions of ward atmosphere according to professional role could not be statistically analysed due to the small number of respondents.

PATIENT FINDINGS

A Friedman Test revealed significant differences in patient scores for patient cohesion, experienced safety and therapeutic hold, $\chi^2(2, n = 34) = 10.126, p < .006$. Post hoc Wilcoxon signed rank tests revealed that patient scores for patient cohesion were significantly less than those for therapeutic hold, $z = -2.388, p < .02, r = .290$, and experienced safety, $z = -2.246, p < .025, r = .272$. These findings suggest that patients perceived ward atmosphere as being significantly safer and more therapeutic in comparison with patient cohesion.



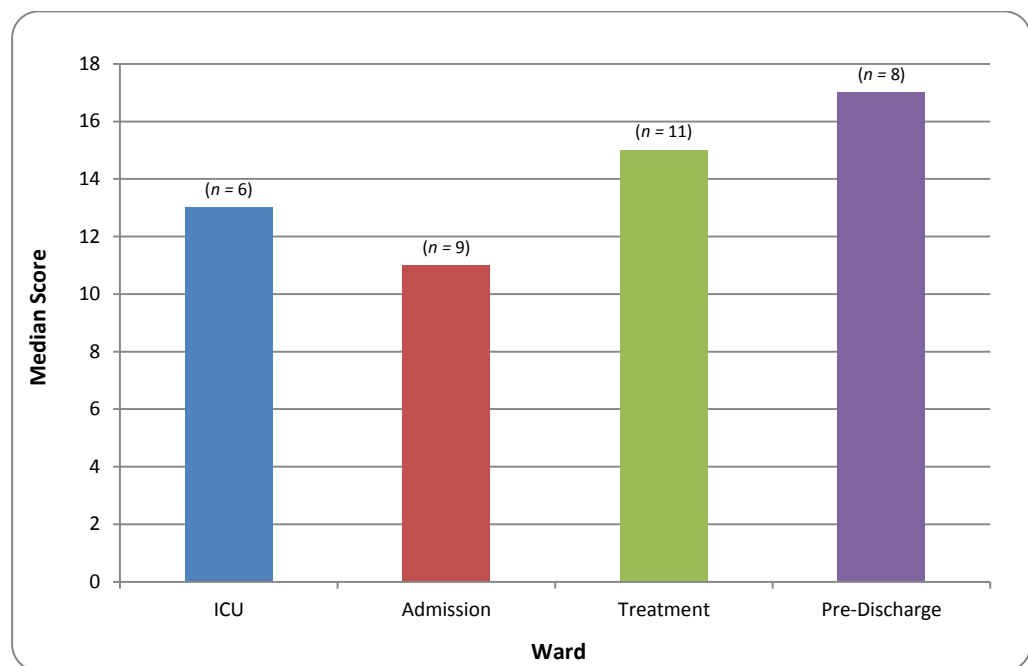
BAR CHART 45: ESSENCES PATIENT SCORES

PATIENT COHESION

A Kruskal-Wallis test revealed no significant differences between patient scores for patient cohesion across the four wards. Where wards were combined into two groups, divided into short stay and long stay wards, no significant differences remained.

EXPERIENCED SAFETY

A Kruskal-Wallis test revealed significant differences between patient scores for experienced safety across the four wards, $\chi^2(3, n = 34) = 11.32, p < .01$, with patients on the pre-discharge ward scoring greatest levels of experienced safety. Post hoc Mann-Whitney U tests revealed significant differences for patient scores of experienced safety between the ICU and pre-discharge ward ($U = 8.50, z = -2.02, p = .04, r = -.54$) and admission ward and pre-discharge ($U = 9.00, z = -2.90, p = .00, r = -.67$).



BAR CHART 46: PATIENT SCORES FOR EXPERIENCED SAFETY (ESSENCES)

THERAPEUTIC HOLD

A Kruskal-Wallis test revealed no significant differences between patient scores for therapeutic hold across the four wards. Where wards were collapsed into short stay and long stay wards, no significant differences remained.

ESSENCES: STAFF AND PATIENTS COMPARED

PATIENT COHESION

Staff and patient scores for each of three EssenCES subsets were compared using Mann-Whitney U tests. Significant differences were found between staff and patient scores for patient cohesion, (staff, $Md = 7.00$, $n = 55$; patients, $Md = 9.50$, $n = 34$) $U = 639.50$, $z = -2.51$, $p < .01$, $r = -.27$, with patients scores being significantly greater than staff. This finding indicates that patients overall perceive relationships between patients as being more supportive than staff.

A two-way between-groups analysis of variance was conducted to explore staff and patients perceptions of experienced safety according to ward. The interaction effects for staff and patient scores of experienced safety by ward was statistically significant, $F(3, 81) = 4.63$, $p < .01$, with a large effect size, partial eta squared = .15. Statistically significant effects were found for whether respondents were staff or patient, $F(1, 81) = 7.48$, $p < .01$, partial eta squared = .09; and also the ward to which respondents were affiliated, $F(3, 81) = 12.56$, $p < .001$, partial eta squared = .32. Post-hoc comparisons using the Tukey HSD test revealed that respondents' scores from the ICU ($M = 8.67$, $SD = 4.10$) were significantly lower than those from the treatment ($M = 14.26$, $SD = 3.66$) and pre-discharge wards ($M = 15.19$, $SD = 3.26$) respectively. Respondents' scores from the admission ward ($M = 14.26$, $SD = 4.12$) were also significantly lower than those from the pre-discharge ward ($M = 15.19$, $SD = 3.26$), supporting the view that staff and patients belonging to the long stay wards perceive greater patient cohesion than those on the short stay wards.

EXPERIENCED SAFETY

A Mann Whitney U test revealed significant differences between staff and patient experienced safety, (staff, $Md = 10.00$, $n = 55$; patients, $Md = 13.00$, $n = 34$), $U = 584.00$, $z = -2.97$, $p < .01$, $r = -.31$. Patient scores for experienced safety were significantly greater than those of staff, indicating that patients felt safer than staff overall.

A two-way between-groups analysis of variance test revealed statistically significant interactions between staff and patient perceptions of experienced safety between the four wards, $F(3, 81) = 4.63$, $p < .01$, with a large effect

size, partial eta squared = .15. Statistically significant main effects were found for whether respondents were staff or patient, $F(1, 81) = 7.48, p < .01$, partial eta squared = .09, as well as the ward to which they were affiliated, $F(3, 81) = 12.56, p < .001$, partial eta squared = .32. These findings indicate that both ward and staff or patient roles have significant effects upon individual perceptions of experienced safety. Post-hoc comparisons using the Tukey HSD test indicated that respondent scores from the ICU ($M = 8.67, SD = 4.10$) were significantly lower than those from the treatment ($M = 14.26, SD = 3.66$) and pre-discharge wards ($M = 15.19, SD = 3.26$). Respondent scores from the admission ward ($M = 14.26, SD = 4.12$) were also significantly lower than those from the pre-discharge ($M = 15.19, SD = 3.26$), again indicating greater overall perceived experienced safety amongst the long stay wards in comparison with short stay wards.

THERAPEUTIC HOLD

A Mann-Whitney U test revealed significant differences between staff and patient scores for therapeutic hold, (staff, $Md = 17.00, n = 56$; patients, $Md = 13.00, n = 34$), $U = 513.50, z = -3.67, p < .001, r = -.39$. Staff scores were significantly higher than those of patients, suggesting that staff perceive ward atmosphere as being more therapeutic than patients. A two-way between-groups analysis of variance however, revealed no significant interactions between staff and patients scores for therapeutic hold according to ward.

To summarise and conclude this chapter, findings from the ATAS revealed that aggression was most often perceived as being destructive by staff overall, and that significant differences were found in staff attitudes between the four wards. Of particular note is that staff working on the pre-discharge ward viewed aggression as being significantly more offensive and destructive than staff from other wards. These findings suggest that whilst there is a general attitude from staff working at Rampton Hospital that aggression is not acceptable, microcosms of institutional culture also exist within each of the individual wards. These might be linked to Lemert's (1951) notions of deviant communities in deviant spaces, whereby subtle differences in rules, norms and values exist within and amongst marginalised groups, as they do within any community or society. Comparisons between each of the four wards therefore provide glimpses of these subtle differences in culture, attitudes and expectations.

Findings from the ACMQ revealed differences in staff and patient perceptions of the least acceptable methods of containment. This was particularly in relation to the use of constant observations and compulsory intramuscular sedation (rapid tranquillisation) where the greatest significant differences were found. These findings create interesting dilemmas for healthcare professionals required to use the 'least restrictive methods'. The methods perceived as being least restrictive by staff are not necessarily perceived as being the least restrictive method by patients. Similarly, the least restrictive method should not be assumed as being the most therapeutic (Olsen, 1998). Whilst it is unsurprising that staff rated each of the containment measures as being more acceptable than patients, these findings are of particular relevance and importance in relation to the findings from EssenCES.

The EssenCES demonstrated that patients experience the environment as being more supportive and cohesive than staff. These findings suggest the high secure hospital environment as being one where patients feel more comfortable being contained than staff do containing them. Several paradoxes therefore become apparent. Firstly, that patients perceive coercive measures as being less acceptable than staff, yet patients experience the overall hospital environment more positively. Secondly, that staff perceive containment measures as being more acceptable than patients, yet their roles of conducting coercive measures result in staff experiencing the high secure environment more negatively. A contradiction is therefore apparent between staff perceptions of acceptability of containment, and their physical actions of containing. These each contribute towards the theories of institutional and emotional work; the influences and relationships between institutional expectations and individual actions; personal feelings and professional roles. These will be further explored in greater depth and detail through the examination of staff interviews.

CHAPTER 10: FINDINGS FROM STAFF INTERVIEWS

Having examined and highlighted possible differences between staff and patient perspectives with regards to ward atmosphere and the use of coercive measures, this chapter will present findings from twenty eight interviews, specifically exploring staff experiences of using coercive measures and the processes by which such practices occur. The interviews were conducted with staff across the four high secure hospital wards with particular attention to the actions and emotions by which staff process and perform such practices. The staff included two ward managers, two team leaders, nine staff nurses, eleven healthcare assistants, two responsible clinicians, one social worker and one psychologist. The majority of staff who were interviewed were from the ICU (Total = 19; Team leader, n = 1; ward Manager, n = 1; Team Leader, n = 1; Staff Nurses, n = 6; Healthcare Assistants, n = 9), 4 from the pre-discharge ward (1 responsible clinician, 1 ward manager, 1 team leader, 1 staff nurse and 1 healthcare assistant), 3 were from the admission ward, (2 staff nurses and 1 healthcare assistant) and 2 from the treatment ward (1 responsible clinician and 1 team leader) (see Table 2: Interview Participants). The psychologist and social workers who were interviewed have roles working on both the ICU and admission ward. Such differences in numbers of staff interviewed between the four wards perhaps reflect some of the challenges that the researcher experienced in recruiting participants as well as the anxieties that staff voiced in being recorded for the purposes of research.

Whilst at face value, it would appear that such a sample might be biased towards the views of those staff working on the ICU, it is important to consider that those staff working on the ICU are charged with the most challenging of patients and are therefore most proficient and experienced in using seclusion and restraint. Staff working on the ICU are certainly the most experienced in using segregation, since it is the only ward within the Mental Health Directorate to have two designated segregation suites. Where segregation is required on other wards, the patient is either transferred to the ICU or segregated in their bedrooms. The majority of staff have had previous experience working on other wards and all staff are required to respond to incidents on neighbouring wards. The non-ward based staff most often have duties and responsibilities on multiple wards. The numbers of staff from each professional group taking part in the interviews are representative of the

overall proportions of staff from these professional roles working on each of the four wards.

TABLE 2: INTERVIEW PARTICIPANTS – STAFF ROLE AND WARD AFFILIATIONS

	ICU	Admission	Treatment	Pre-discharge	Totals
Ward Manager	1			1	2
Team Leader	1		1		2
Staff Nurse	6	2		1	9
Healthcare Assistant	9	1		1	11
Responsible Clinician			1	1	2
Psychologist - female	0.5	0.5			1
Social Worker	0.5	0.5			1
Totals	18	4	2	4	28

The interviews were conducted using a narrative approach, enabling respondents to access and share their lived experiences of using coercive measures. Participants were invited and encouraged to reconstruct their experiences and to talk about their thoughts and feelings within the context of using rapid tranquillisation, restraint, seclusion and segregation. Thus, participants' thoughts and feelings were made accessible during the reconstructions of coercive measures as a process, describing their experiences of individual isolated incidents that have stood out for them, as well as their personal experiences more broadly. The analysis of these interviews was conducted using a grounded theory approach while taking into account the concepts of institutional and emotional work as previously outlined. While it is recognised that micro-level analyses traditionally focus upon the individual before taking into account wider influences, given the centrality of context within the theoretical framework of this study, these analyses will instead firstly explore the wider institutional influences surrounding the individual prior to examining the individual within their organisational context.

The combined theoretical framework of institutional and emotion work is particularly important in the study of coercive measures since it enables the study of interactions between emotions and actions, as well as interactions between the individual and their environment. In viewing the use of coercive measures as a process, this study aims to analyse the emotions and actions that precede the use of coercive measures, those that occur during the act of

using coercive measures as well as those that occur afterwards. As such, not only can emotions and actions be studied as processes rather than simple outcomes, but the interrelations between individuals, organisations and institutions also be explored in analysing how all of these factors work together in creating, maintaining and disrupting institutions (Lawrence & Suddaby, 2006).

From listening to, transcribing, reading and re-reading the interviews and transcripts, it became apparent that staff experiences can be divided into four stages. These relate to; i) background influences, relating to working in a very public institution often with high media attention coupled with the realities of day to day working within a high secure environment; ii) factors immediately preceding the use of coercive measures, including the challenges of working in a dynamic, unpredictable and risky environment, alongside the judgment values of staff expected maintain a safe environment; iii) the act of and emotions associated with the actual practice and conduct of coercive measures and iv) the aftermath of managing, consolidating and coping with the institutional and emotional demands of the personal and professional self. Not only do these influences and interactions occur as a sequence of processes but also at the levels of i) the institution; ii) the organisation; iii) the ward and iv) the individual. These subdivisions of time point towards the use of coercive measures as processes for analyses, encouraging closer examinations of the influences, effects and interrelations between the institution, organisation and the individual. Each of these influences appear to hold greater prominence at different stages of the process where coercive measures are used. This chapter will focus on the presentation of such interview findings, whilst later discussions will connect findings from these staff interviews to the wider literature and theories surrounding such emotions and actions of individuals working in institutions. Each of the four stages will be considered in turn, taking into account the different levels which influence collective and individual attitudes, actions and emotions.

PART 1: BACKGROUND

During the interviews, staff described a series of societal, institutional and organisational influences that acted as wider background precursors to the use of coercive measures. These have been divided into two groups for ease of exploration and understanding. These relate to:

- i) Working in a Very Public Institution;
 - Media
 - Exposure Beyond the Fence
 - Commitment to Institutional Life

- ii) Everyday Realities of Working in a High Secure Hospital;
 - Priorities of Security
 - Hierarchies in relation to staff role, esteem and ward
 - Obligations to conform to Organisational Rules
 - Maintenance of Boundaries

Each of these themes and subthemes will be presented in turn, however, a caveat must be made regarding the fluidity, interactions and interrelations between each of these themes, which have been somewhat superficially categorised in the interests of exploration and understanding.

WORKING IN A VERY PUBLIC INSTITUTION

MEDIA

During the interviews, staff frequently distinguished between the 'outside' institution and the 'inside' organisation of the hospital. At an institutional level, staff referred to Rampton as being an enigmatic yet paradoxical place to 'outsiders'. On the one hand, it is a place that is very much shrouded in mystery to those on the outside, yet on the other, it is one that continues to be subject to much criticism, scrutiny and fascination by both the public and media. The mysterious and enigmatic nature of Rampton to 'outsiders' has been described by staff through the following extracts:

'No one's got a clue of what happens inside so I think everybody on the outside just think we all wear white coats, all the walls are painted white, and people are walking around like zombies' (NA - male)

'We're still quite a bit of an entity aren't we, Rampton, Broadmoor and Ashworth... people have assumptions of what we do here and assumptions of what the patients are like, and you know, the media doesn't particularly portray us in a very good light, so I think on the whole probably got a negative view' (NA - male)

'I think there's a difference between how patients are perceived by people already working here versus patients being perceived by the media and lay people because I think there's something about high secure services and the idea that that's where the bad and dangerous people go' (Psychologist - female)

'It's the people who don't work here and don't understand the place and know the place, it's a complete mystery, it's an enigma you know, it's a strange place and the only way you can learn the place is by spending time here isn't it' (NA - male)

Such limited knowledge of outsiders was contrasted with the negativity and apparent connotations of dangerousness by the media and public, often by the same interviewees:

'Whenever there's any news in the newspaper it's always negative isn't it about the hospital' (NA - male)

'It's always bad publicity isn't it, it's always, oh that monster's in there or that monster's escaped, pretty much, it's not, oh the staff are doing a really good job, oh look at him, he's progressed really well. It's not like that with your Ramptons, Broadmoors, Ashworths and Carstairs, because they're offenders basically, they're not just mentally ill' (NA - male)

'The media has got this thing about high secure hospitals and they always paint a bleak picture, never ever look at the positives' (NA - male)

'You see some crazy things in the media, butcher to wed angel of death... it always does it, some kind of catchy title but it always blows it up into an extreme and what is surprising here is that the

patients are not as dangerous as the media would have you think'
(RC - female)

'You know what the public's like, they're probably expecting to see people with three heads and you know, it's ridiculous' (NA - female)

EXPOSURE BEYOND THE FENCE

The very public nature of working in a high secure hospital, met with much media attention and public scrutiny, resulted in staff feelings of heightened vulnerability, 'nakedness' and exposure where working outside the confines of the fenced organisation. The ways in which insiders located themselves and their roles on the outside are examined here through the explorations of escorting patients outside of the hospital.

PATIENT ESCORTS

Staff often refer to the vulnerable nature of escorting patients outside of the hospital, particularly with regards to being outside the safety zone of the fenced organisation, the use of handcuffs and being physically tied to a patient:

'It's strange, it is strange... you can feel quite vulnerable, because I'm stuck to a potentially very very violent patient who might not like me, certainly doesn't want to be at Rampton, so there's all those sorts of things to look at. You're leaving the safety and security of the hospital, for however many hours, so yeah, you can feel a little bit vulnerable' (NA - male)

'It's not an easy time I feel' (NA - female)

'Potentially, if a patient begins to fight when you've got the handcuffs on, that could cause a lot of injury to the staff and to the patient, but like I say, unfortunately you have to wear them' (SN - male)

'You are very vulnerable, because potentially they [the patient] can grab you, you're in a close proximity to that patient so you

are in a very vulnerable position of being taken hostage' (SN - male)

'When you're outside you haven't got the fence to stop people escaping, you know, someone's in a secure area and they run off, okay, it's not great but there's a massive big high fence and then a gap and then another big high fence, they're not going to get out, not going to happen... whereas you simply haven't got that physical security If you're taking someone to [another] hospital, you are walking in the open' (RC - male)

'When you're going outside the hospital, things are a lot more dangerous there' (SN - male)

'[Inside] there's more staff, there's more buildings, there's more stuff; there's everything which is inside; it's contained, it's so structured that some risks are eliminated before you even start' (SN - female)

PUBLIC SAFETY

While working on the outside, staff appear to place greater responsibility on themselves and greater ownership of their role in maintaining public safety:

'These people are in a high, they're in a high secure hospital so there is a risk, you know, we might be willing to accept that risk, but should the general public be expected to accept that risk' (SN - male)

'You have to bear in mind that we are providing a service to the public and keeping them safe as well... so you've got to be very mindful of that, very careful, it's the reason it's high secure, the big fences around it is because these people may pose a risk, so while trying to maintain a therapeutic environment for the patients, it's making sure everybody's safe as well. Which can be tricky' (NA - male)

'You have to protect the public' (SN - male)

OUTSIDE SECURITY

Staff describe this emphasis on safety as stemming not only from their professional duties and responsibilities but also as arising from their personal sense of accountability. A real sense of failure is described by staff in terms of letting down both the public and the organisation in which they work, amidst already negative public and media perceptions of secure hospitals and the “deviants” they contain. This level of responsibility in itself appears to be a motivating factor with regards to maintaining safety, security and upholding organisational rules and values:

‘It’s a lot easier to have somebody like that [in restraints], than have, as you know, whenever there’s any news in the newspaper it’s always negative isn’t it about the hospital, so if we’ve got one of our patients attacking one of the members of public, it’s going to make really bad headlines isn’t it’ (NA - male)

‘If a patient here runs away, I’m going to get into a lot of trouble, so you know, you’re not going to take many risks in this place, you’re just not, I mean, you can’t, the public would be furious if you were taking risks with patients who were multiple murderers in their eyes, you just can’t do it, however well you know them, however calm they are’ (RC - male)

‘People are really frightened of mentally ill patients who abscond, mentally ill broadly, so it’s a bit of both; protecting the patient from doing something stupid and protecting the public as well’ (RC - female)

COMMITMENT TO THE INSTITUTION

Juxtaposed to the ideas of those on the ‘outside’ were the contrasting experiences of those working on the inside. Ironically, for staff working within the organisation, individuals described feeling somewhat as much of an ‘outsider’ on the outside as those on the ‘outside’ would feel on the inside, revealing the levels of commitment required to working within such a seemingly detached organisation:

'We are detached from the rest of the world. We're in our own little bubble, so I'm an expert at Rampton but out there I'm a novice, I wouldn't know, I wouldn't cope out there, but in here I'm an expert, but out there (blows raspberry)... no' (SN - male)

'We don't see what happens outside, that within other services we just don't see, we don't deal with' (SN - male)

This compartmentalisation and detachment of professionals was not only apparent between the outside and inside worlds of the organisation, but also described by staff as occurring within the organisation itself:

'We have for instance a mental health department that deals with lots of things like referrals etcetera etcetera, so we don't see the whole picture, whereas outside now that's the nurse that accepts that referral, that does the leg work, that does all the planning, discharges, patients discharged from here, the majority of the paperwork for that discharge will be done for us. Outside, we'd have to formulate all that paperwork, we'd chase up this, that and the other, so you know, I think we're quite protected and we don't see a huge picture which there is, we see our own picture' (SN - male)

While staff are very much aware of the mystery and negativity surrounding their work, they themselves appear to struggle to talk to their friends and family about what it is they actually do, again highlighting the degrees of physical and emotional detachment that staff experience within their roles as specialised professionals:

'I mean maybe you might go home and talk to your family and friends about it... I mean, I don't personally... I don't, I like speaking to work, I think it's something that only people that work here can understand if you know what I mean, I wouldn't really try and discuss it with family or friends' (NA - male)

'You can't really tell people that don't understand, so you can't take it home with you, because they don't understand the

process, they don't understand the things that you're going through and that you're dealing with' (SN - male)

Where it appears impossible for staff to seek the understanding and support of 'outsiders', they turn instead to the support of colleagues. Staff describe a special bond that forms between those who understand and have experienced this strange and unique environment, viewing it as unfathomable and indeed unreachable for those who have never worked there:

'It creates a tighter... I think it creates stronger bonds between people when you've been involved in them sort of incidents together... I don't know why... I suppose, I can liken it I suppose to erm... I've got some friends who are in the army... and I think it's maybe like a less extreme version of that... I mean, I've got some friends that are in the army and they say... friends, you know, mates that they've made when they've been in war zones together, I mean, they say it's a relationship that other people can't understand... you know, I suppose it's like that but on a much extreme scale isn't it... do you know what I mean?' (NA - male)

'I think we gain most support from each other really, your colleagues' (NA - male)

'I mean, we've got a good, yeah, a good tight team you know, and I think that's something that you get from, you know, if you've worked for a long time with people and you have been involved in a lot of erm... a lot of incidents together, you know, and, you know that you're good at supporting each other and backing each other up, it's good team building and you form good strong relationships that you can't, you know, that you can't form any other way sometimes' (NA - male)

'It pulls you together so when something maybe unsavoury happens, it makes it easier to break it down a bit, it's not that bad, it's not that bad because I've been through it and they've been through it, we've all been through it and we can help each other a little bit' (NA - male)

The identification and distinctions made between the inside and outside seemingly contribute towards the creation of an insular community. As staff seek greater support from their colleagues working within the organisation, it becomes increasingly enigmatic and closed off to those on the outside.

Simultaneously, it seems, the organisation itself becomes an increasingly isolated, deviant community, physically shielded from the outside while hidden behind high fences, in turn becoming a rare but modern total institution (Goffman, 1961). While these emerging themes and ideas are representative of the wider background influences requiring the institutional and emotional work of staff, the organisational arrangements of the hospital, ensuing expectations, obligations and responsibilities of staff, will be explored next.

EVERYDAY REALITIES OF WORKING IN A HIGH SECURE HOSPITAL

Staff were eager to describe their working environment as a hospital rather than a prison, and to define themselves as working with patients not prisoners. Yet, in contradiction to this, staff also frequently described the priorities of security over care. The ownership and government of the hospital by the NHS, accompanied by auditing, benchmarking and close partnership working with the Home Office and Prison Services, have evidently created tensions amongst staff with regards their position, roles and contractual obligations:

'It used to be part of the Special Hospital Services or Authority, so we kind of came under the prison service. We were governed by the Home Office basically, so we were kind of under the Home Office-Prison sort of umbrella... we've always been a hospital but it came under that sort of, that umbrella of correctional services if you like and then eventually we moved into the NHS' (SN - male)

'When I first came here it was all governed by the Home Office, even though they were the Special Hospitals, they were like their own authority, over the years I've been here, they've been slowly integrated within mainstream NHS Trusts' (TL-male)

Being employed by the NHS whilst remaining answerable to the Home Office clearly creates anxieties amongst staff with regards their roles and responsibilities:

'We are answerable to more people than prisons are, the Home Office and that sort of thing, and people are really wary because you're answerable, whereas in prison, you serve your sentence and you go, if you reoffend, people aren't going to be asking questions about the prison officers or wardens, because you will be arrested and you will go back to prison. Whereas here, if people reoffend, questions are asked about us and our practice and what we are doing... we have to answer for those things... it's not a light thing, it's a very serious thing' (SN - male)

'[The] legal requirement of your detention, that's very much driven by the dictates of the home office and the security practices that the home office tell us that we have to adhere to' (TL-male)

The regulation and governance of staff practices under differing disciplines has seemingly resulted in competing priorities and agendas, revealed as conflicts and tensions within the organisation. Emphases on security, origins of staff training from the penal system along with expectations of healthcare staff in maintaining the safety of patients and the public have all been cited by staff as competing with caring logistics. Staff express that security measures have ironically increased since being employed and governed by the NHS, that a greater emphasis is now being placed on the enforcement of security, which staff perceive as being out of their control:

'That's the strange thing, when I first came here, Rampton was its own authority directed under the Home Office, they then got drawn into the Trust, which really tried to put across that the nature of the hospital is care and treatment and then all of a sudden as they've tried to do that, you've got this massive increase in assessments, risk assessments, big fences, personal alarm systems' (TL-male)

'It's imposing when you first approach now, it's something chronic. They're trying to create and increase the identity of this place as being hospital care and treatment centred and then what you see is two massive five metre fences, how can you sort of blend those together?' (TL-male)

'I suppose in a hospital like this you have to cover eventualities... trying to keep people safe, that's the way the hospital does it' (NA - male)

'When I first came here, we had a chain linked fence and a wall and like a ditch either side of it, whereas now, you've got all the high tech stuff haven't you' (TL-male)

'Security now is completely different, cameras - tremblers, none of that stuff at the front' (TL-male)

'I think there's an increasing emphasis on playing things safe, so overdoing it rather than being in a position of under-doing it. I don't always agree with the decision that's made but it's a security decision' (RC - female)

'The security stuff takes some getting used to' (SN - male)

PRIORITIES OF SECURITY

Despite staff reassurances that Rampton is a hospital not a prison and that those they contain are patients not prisoners, staff from all professional backgrounds describe their roles as healthcare professionals as being outweighed by those of security arrangements set out by the organisation:

'The security sometimes governs the nursing, if you know what I mean, so things that you might do in other hospitals, you have to do differently here because of the security measures' (NA - male)

'The major issue with the job is maintaining security and safety essentially... maintaining the security and safety of all is the primary role of this, the nursing is secondary' (SN - male)

'Security is the top of the list... you lose your keys, you don't come back, so in the great order of things, security then nursing (laughs), these can all be down with something terminal but if I've got my keys, I'm safe (laughs)' (TL-male)

'You've got a lot of security stuff to deal with and the nursing stuff as well... I suppose there is that conflict about maybe being too custodial... it's by virtue of you being here and having to lock the patients up on a night and unlock them and those things which are, like patting down patients, searching, stuff like that, it's very security orientated' (SN - male)

'Part of my job is just down to security, every day, without even thinking about it, I make sure that every door is locked, every key, you know, jangle the door, you make sure no cupboards are left open, you make sure things are signed for, you count things out, you count things back in again' (SN - male)

While staff were keen to point out that the environment in which they work is a hospital not prison, that they are nurses and care staff not prison guards or officers, and that the people they work with are patients and not inmates or prisoners, the conflicts and tensions between care and safety regimes were frequently apparent:

'Even though lots of the nursing staff are members of the Prison Officers Association, that's their union rather than Unison or something like that...they're not prison officers, they're nurses you know, so the patients are not inmates, they are patients, I think that's important' (RC - male)

'We're nurses, we're not bouncers, we're not soldiers, you know, we're nurses... it's a very different role, but we're not prison guards' SN - male)

'We're dealing with patients not prisoners' (SN - male)

'I think the thing is with Rampton, you look at prisons and you can sort of think it's a prison, it isn't a prison, it's a hospital and that's the difference, these people are poorly you know, and we have to remember that' (SN - male)

'Prisons are supposed to be about rehabilitation... we're a hospital which means we're about treatment' (SW - female)

'It does clash, especially the balance between somebody being safe and secure and the interventions that as a nurse you need to do... in some respects it's about doing the nursing stuff when it's okay to do the nursing stuff, and responding to the situation and keeping everybody safe and secure and you have to forget that [nursing] intervention' (SN - male)

'As a nurse, when you come to the field of forensics, one of the hardest things that you have to try and balance out is the security aspect of the job that you do, along with the nursing side of how you were trained. It's something quite different, and the two, I don't think, ever sit totally comfortably with each other' (TL-male)

'How you go about putting across your nursing care isn't always that easy a job within a contained area, a place with massive security practices, but you've just got to stay true to yourself' (TL-male)

'I think there's a real tension... I think there is this real custodial emphasis' (RC - female)

'Obviously with a high secure hospital, the emphasis should be on hospital, so we're not a prison, we are about treatment, but the clue is also in the high secure bit, so we are also working with people who do present a risk to others, and so you have to manage that risk, but again within a hospital environment which is about treatment, they're not always comfortable together I don't think' (SW - female)

NEED FOR TRAINING

Despite the hospital being owned by the NHS, the training that staff receive with regards the use of coercive measures continues to originate from that of the prison service whilst being adapted to the needs and demands of a high secure hospital:

'MVA, control and restraint as it was called many years ago, came in in the 80's from the prison system... basically we've followed the prison, prison sort of system of control and restraint... over the years our training has been modified and adapted and adjusted and changed to better suit our environment' (SN - male)

'We've kind of looked at all the incidents that we do have, and we've adapted the training now to reflect more of what's going on inside' (SN - male)

'Originally, it was a prison service model that was followed... quite often we'll go to civil defence and we'd do some training with their guys to make sure that our skills are adequate enough to train other people' (SN - male)

Staff are trained to different levels with regards responding to incidents, depending upon their role. All staff are required to undertake basic breakaway level training as a minimum standard requirement. Direct care staff identified as those who spend the majority of time on the wards, such as nurses and nursing assistants, are required to undertake further mandatory training in managing violence and aggression involving the use of restraints and seclusion. A further proportion of direct care staff are required to undertake additional training in personal and protective equipment (PPE). These distinctions between staff roles and training seemingly point towards notions of insiders and outsiders, even inside the hospital:

'It's the ward staff who would be the guys that would deal with any incident... The guys that are trained to a higher level with regards to PPE, that's a voluntary course because it's an extremely intense three day course, erm... and it's not for everybody... you know, not everybody because it's, we step up the

levels of aggression and violence and we deal with weapons and we deal with barricades and we deal with erm... hostage situations and medical emergencies and all that sort of stuff and scenarios through days training and not all staff want to part of that and that's fine you know but, there is a need for minimum number of staff in the hospital to be trained...' (SN - male)

'I'm not involved in restraint, I'm not fully MVA trained and that's a decision made by the clinical director and lead psychologist that psychologists within this service wouldn't because of the conflict between the detention and control versus the therapy and it's seen historically as being very contradictory so you can't do one and do the other at the same time because it would affect the therapeutic relationship, and I think it's probably a good idea actually, I think we need to be seen to some degree as being separate' (Psychologist - female)

'I think to some degree the patients need to see the psychologist as being independent from that process, and I think sometimes, that's something that the ward staff, the nursing staff find difficult because if something happened I guess the staff would want the psychologist to help in managing the risk, but actually we're not trained to do that so we would maybe stand back from that and how that's viewed. I think there's a lot of dynamic issues in relation to that and how it affects working relationships but it's a bigger question than how it affects the patients, but I think we're actually prevented from a very difficult situation by the fact that we don't do restraining' (Psychologist - female)

HIERARCHY

The different levels of training amongst staff, the types of ward that staff work on, along with the types of patients that staff work with, each contribute towards a multi-tiered workforce with regards status and esteem. The intensive care unit in particular was often described as accommodating the most dangerous of “deviants” with the most frequent incidences and potential need for using of coercive measures being an expectation amongst staff:

'In some cases, particularly if you look at this ward, you might have the individual that's been troublesome throughout the system if you like, they've been unmanageable elsewhere, there comes a point where they come here on the ICU in a high secure hospital where you have to manage it' (NA - male)

'This [the ICU] is the most secure ward within the hospital' (NA - male)

'On this ward we should expect some negativity, we are the ICU, these patients are deemed to be the worst in the hospital so it's about accepting, or finding an acceptable level that we're happy to nurse them outside of seclusion' (SN - male)

'I think in the hospital in general, compared to other hospitals by the very nature of it being high secure and the patients that we have, on paper, we are at more risk of that sort of behaviour than anywhere else, so we would see more, on paper, than anywhere else and experience that more and by the very nature of the patients being as disturbed as they are, especially on here, we can see the worst end of it' (SN - male)

'It's accepting that we have to take calculated risks and more so that we're expected to do so on here because we are the ICU, we have an expectation that the level of risk our patients pose is higher than it should be on any other ward' (SN - male)

'On here, it is an intensive care ward, it is different to other wards... on here, we get the worst of the bunch... because they are the worst of the bunch, they are volatile, they are unsettled, they are unwell and they are restricted to things' (SN - female)

OBLIGATIONS TO CONFORM

In order to work within such a highly controlled secure environment for any length of time, staff are required to accommodate and conform to societal values, institutional norms and organisational expectations. Through enacting and enforcing the boundaries of the institution, staff describe having to

consolidate institutional values, often in place of their own. Where the tentative questioning of organisational rules have occurred, staff have quickly sought to reconcile and accept these rules as being due to their personal lack of insights and understandings. In addition, staff have frequently sought to self-justify the reasons for such rules, regulations and their resulting actions, or have simply resigned themselves to following organisational policies, rules and regulations regardless of their personal feelings since they feel they have little or no choice in the matter:

'Some people will struggle, some people really really really struggle reading index offences. They tend to leave. So we tend to have a group of people here who, they might not like what they read and they might not like what the person's done, but they accept that we're here to treat that person' (SN - male)

'I remember starting here myself and thinking and being completely naive to everything and thinking why do they do this and why do they do that and why is it like this and why is it like that and generally, when we're in Rampton, there's always a reason, if there's anything you don't understand, there's always usually a reason for it, do you know what I mean, if something's done like that, it's for a particular reason, you know' (NA - male)

'Some staff might disagree with it... I think the majority just do it because we've been told to do it' (NA - male)

'You've got no choice so you accept it I suppose' (NA - male)

'I don't know, because we've always done it is the usual answer' (TL-male)

'That's one of the things you have to reconcile here, outwardly something might not see, like a nurse thing to do... but these aren't run of the mill patients really so you have to protect the public as well' (SN - male)

'I don't know, I mean, that must be the official line... there must be some kind of difference in perception but maybe I've just not

picked it up myself really, maybe I'm blind to that, but I can't really see' (SN - male)

'I find it hard to say something is acceptable when I feel uncomfortable with the idea of it' (SW - female)

COLLECTIVE MAINTENANCE OF BOUNDARIES

Staff frequently referred to the importance of establishing a unified set of rules in maintaining the institutional and organisational expectations of both staff roles and patient boundaries. In identifying, establishing and enforcing such rules, those patients who fail to conform were considered 'pushing boundaries' and 'disrupting organisation routines':

'There's this phrase 'pushing boundaries', it's a difficult balance sometimes between a patient doing something that they can't help and I think, sometimes, when they do things that are outside of the rules, the assumption is that they're being bad not necessarily that they're mentally ill or have PTSD' (RC - female)

'It's alright, once everybody knows what they're doing and we're all singing from the same hymn sheet' (NA - male)

'It's trying to teach patients, some of them need help on basic life skills really, so it's getting that structure and routine in... the structure and the boundaries that we have' (NA - male)

'I think you do need wards that have firm boundaries and structure because some patients have never had boundaries or structure in their lives, so they don't know where the boundary is or they don't know what they can do, how far they can go but if you put that in them when they first come into the hospital, then it's sort of set in them' (NA - male)

'I think wards with structure do work better... I think the patients respond better because they don't try and push boundaries as much because they know what the boundaries are, so they're not getting into trouble as much' (NA - male)

'Where they don't have the routine and the boundaries and the structure, they're causing chaos, so I think it does work well for patients in all honesty' (NA - male)

'Enforcing boundaries, rules about things, things to do with the dining room like counting the cutlery, patients have to stay put while that's being done, so there's lots of things like that about ward routine, where it's a bit military if you like' (RC - female)

'We manage by having boundaries, ward policies, and try to stick to them, if we have any movement around those, that's when there's some issues that have arose, where patients think that one's getting more than another, that can come into play, but we try and stick as a unified front really, we all sing from the same hymn sheet' (SN - male)

INDIVIDUAL MAINTENANCE OF BOUNDARIES

While staff are required to accommodate the institution through the enforcement of organisational rules and professional boundaries, individual levels of tolerance and acceptability are also described. Differences in staff personalities, ways of working and the ways in which staff identified with their roles were identified as influencing ward atmosphere on a day to day basis. While ward boundaries were seen as the enforcement of organisational rules, individual boundaries were in contrast viewed as arising from individual staff levels of acceptability. These were often referred to through the language of attitudes, culture, boundaries and tolerance:

'I mean you'll have difference in opinions, all staff are different... staff have different views don't they, same as anybody, so sometimes you'll get conflicting opinions' (NA - male)

'Generally we're all the same but obviously there are slight differences in the ways people work... some people are more hard-line, some people are more... hard-line - I don't mean that in a bad way (laughs), hard-line, and some people are more, what's the word, more, I don't know, they could be more therapeutic I

guess than others... that'll be the same on every ward, in every hospital, all over the country, it's a common problem' (NA - male)
'Different staff react to things differently, and the management, they make you work differently as well, like how the wards are run' (NA - male)

'I think it is all about whoever is present at the time and their interpretation, you know, different people are going to interpret different situations differently, and we all have, like I've said earlier, an accepted level' (SN - male)

'I think sometimes it's down to personalities, the ward runs better with a good mix of personalities and sometimes there's individuals and personalities and their personalities don't mix well on the ward... you're not going to get on with everybody but you will expect them to do their job as efficiently as possible' (SN - male)

'Some people are probably a little bit more taken with the application of rules and regulations whereas some people are maybe more therapeutic in how they go about their nursing duties' (TL-male)

'I think you've got a sort of continuum expressing the two extremes that there are some staff who are very custodially orientated and can be quite negative about the patients - the kind of patients we get here and almost punitive towards them, so they're here to be told what to do and there's that end, and can sometimes be quite aggressive and unsympathetic, and then there's the other extreme which is the more therapeutic, which has to be balanced' (RC - female)

Not only were differences between organisational and individual boundaries identified, but staff also highlighted differences in boundaries and tolerance towards individual patients:

'I think there's always going to be that thing, I think there's always going to be patients that we dislike. Where people are

*less able to tolerate him, they may react more quickly'
(Psychologist - female)*

'With the best will in the world, certain standards of [patient] conduct are acceptable and certain standards aren't, so I think there's something about boundaries when patients come in' (RC - male)

'There has to be a balance obviously, making sure that patients keep the boundaries and they tend to be perhaps more strictly managed but again I think there is a loss because I think the emphasis can too often be on security rather than therapy' (RC - female)

'I think the challenges are how a restrictive environment still allows people to progress within those restrictions and to get the line right between putting boundaries in to keep people safe but then not becoming oppressive. So I think the challenge can mean the challenges that come from patients but can also mean the challenges that come from the philosophy of the environment' (SW - female)

'Some of the staff I think might react more risk averse' (Psychologist - female)

RITUALS AND ROUTINES

In managing and coping with both personal and professional values, staff regularly refer to individual rituals that they undertake in preparing themselves for working within the high secure hospital organisation. The routines and rituals that staff identify are seemingly associated with varying degrees of detachment such as to remove or separate themselves from the patients that they work with, the crimes they have committed and the personal judgements that staff hold in relation to each of these:

'It's another hat that I've got on, that I have to wear when I come to work so I can put all my morals, or most of my morals and beliefs to one side and in a box because I have to put my work hat

on, which means that I have to deal with these patients and I know that patients come to Rampton because they've done horrendous offences' (SN - male)

'You learn to deal with situations and not let them affect you... if a patient died in hospital, I've got no love, feelings or emotions for that person, so it's easier for me to do all those things' (SN - male)

'You have to put all that sort of stuff in a box, I'm not saying it's easy or that it doesn't affect you or anything... it is hard, I think you just have to be aware of it and try and manage it to the best of your capabilities whether it be through supported supervision or you know, it's not easy' (SN - male)

'Some of them have done really nasty things but also, to actually manage those patients, if you think about those things too much, you will put barriers between yourselves and the patient you're trying to look after, but I'm not saying you forget about it because then you're forgetting about their risks and the risks to yourself and everybody else but you've got to put everything in context' (SN - male)

'You come into work every day knowing that there's a chance you might be assaulted or that you might have to restrain a patient... you don't get to Rampton hospital as a psychiatric patient really without having been violent and aggressive in some way or form, so with regards to violence and aggression, we're always aware that there's a possibility of that' (NA - male)

Staff identify the use of routines and rituals as being associated with the enforcement of rules, boundaries and ward philosophies. Through establishing such routines and ways of working, staff appear to not only detach themselves to a degree but to mechanise their work such as to prevent their personal emotions from interfering with the work required of them by their profession and the organisation in which they work:

'We just come on the ward with the day to day routines, it's been the same for the last six years, and we stick to the job for the day and that's it really' (NA - male)

'A lot of the patient group from the intensive care setting actually liked it I found, because they had a structure, because they knew when they were getting up, what they'd be doing, they weren't just left to sit in the day room all day' (SN - male)

'It's quite structured in the way that we approach it...it keep you quite busy, that's why I like it really' (NA - male)

'I enjoy it to be honest with you, it's always busy, so I think it's great on here, keeps you busy' (NA - male)

'I usually volunteer to do B jobs, I mean it keeps you out of the way, it keeps you busy so, making drinks all day, keeps you occupied, instead of, I don't like sitting in the day room all day, it gets a bit boring' (NA - male)

'I like the structure of the ward... it gets them [patients] off the ward, gives them things to do... I think it's a good regime that they've got things to do' (NA - male)

'It just seems to be a lot more structured than the other wards I've worked on, so I enjoy that' (NA - male)

'A good bit of the ward is the structure, getting up, everyone showered, we have a routine, we do a lot of activities together, that's really positive' (SN - female)

Although the rituals that individual staff employ are seemingly unique, there was a notable collective and somewhat idiosyncratic language of 'switching on' and 'switching off' used to describe a heightened degree of awareness, alertness and modes of dealing with incidents and crises situations. While individual differences have been identified amongst staff, a collective organisational identity is therefore also very much apparent:

'As soon as they need to be switched on, they do so, it's just like literally flicking a switch' (SN - male)

'You've got to be switched on with what you're doing' (NA - male)
'A constant state of, you know, like, just having to be prepared to whatever, which we tend to have on a daily basis anyway because of the types of patients we work with' (SN - female)

'You're trained, you're mind gets trained on it, you sort of anticipate when something's going to kick off and you're just trained to straightaway get in and just deal with it as quickly and efficiently as you can... you do get sort of trained and switched on to do it' (NA - male)

'I always come into work and I always try and switch on, as soon as you come through the fence, you switch on, because it has the potential to be a very volatile place... you're alert, you're there, why are they doing this for, constantly questioning things and stuff like that, so that's what I do to try and keep myself safe, is being alert to what can go on' (NA - male)

Throughout this section, the background influences to working within a very public institution; accompanying criticisms, vulnerabilities and commitments have been explored, along with the everyday realities of working within a high secure hospital; the priorities of security, obligations to conform to organisational expectations and maintenance of boundaries. These themes provide the backdrop to the conditions in which staff are expected to work, whilst the following section will explore how staff are expected to manage and maintain the security provisions set out within the high secure environment through the use of coercive measures.

PART 2: THE 'IMMEDIATE' PROLOGUE

From the interviews, it was apparent that staff found it difficult to identify any specific precursors to the use of coercive measures. What staff recognised instead, was the uniqueness and individuality of all incidents they had been involved in. Staff frequently expressed that coercive measures were only used as a last resort or when they felt they were left with no other option. A combination of both staff and patient factors however, contribute towards such decisions being made and such actions being employed, each of which will be discussed in the following.

NO TWO SITUATIONS ARE EVER THE SAME

Despite staff training, highly structured organisational rules, regulations, policies and procedures, staff describe their experiences of responding to incidents as each being different and unique:

'No two restraints are the same' (SN - male)

'Each one's different, each one's different because there are maybe lots of antecedents that have worked up to that incident... every incident and every reaction involves staff that are different or patients that are different' (NA - male)

'Every restraint from start to finish can vary so much depending on the patient's behaviour and how cooperative they are' (NA-RB)

'They tend to vary, all the ones that I've been involved with here have all been very different... it really does depend on who you're dealing with' (TL-male)

'It's just one of those things that you have to deal with when it happens, it's never the same' (NA - male)

'Everything's different, it never happens the same' (NA - male)

'It depends, it just totally depends on what the incidence is, there isn't one management plan, they're all different' (SN - male)

'No two seclusions are the same, no two patients getting out are the same' (NA - male)

'Every incident and every reaction involves staff that are different or patients that are different, so they are judged from it on an individual' (NA - male)

'Every situation's different' (SN - male)

'NO OTHER OPTION'

Staff spoke of coercive measures as being as used as a last resort, when feeling as though they were left with no other option:

'They're a last option, it's something that you're going to avoid if you can help it because it's not good for patient is it, you know, it can't be good for anybody's mental state, you know, we're trying to help them get better, it can't be good for anybody's mental state' (NA - male)

'Seclusion is very much in my experience done as a last resort' (TL-male)

'It would be used to protect themselves or others as a last resort' (SN - male)

'It's the last resort, it's not something we take lightly' (NA - male)

'As far as I'm concerned, you know, obviously none of us want that to happen, it's a last resort so to speak, you know' (SN - male)

'If there's nothing you can do to calm them down or talk them down or anything like that, then it's got to be done' (TL-male)

'We try and avoid it as best we can but sometimes we have no option' (NA - male)

'If somebody's attacking somebody you've got to intervene' (NA - male)

'We are a high secure hospital, we do have some very disturbed patients here and you know, they can be very violent, there's no way round it, they can be very very violent and if they are being violent we have to subdue that violence and the only way we can do that is to as quick as we can, get the patient to the floor to restrain, which we're taught on MVA and to get them away from the patient population to keep everyone safe' (NA - male)

'Sometimes, there's no other alternative' (NA - male)

'How else do you deal with somebody who wants to stand up in the middle of the day room and fight everybody, you know, I don't really know another, I can't really see another option at that time' (NA - male)

'Sometimes he keeps constantly pushing and pushing and pushing and pushing and leaves you with no option' (NA - male)

'They don't leave you anywhere to go' (TL-male)

STAFF FACTORS

The decisions made with regards whether or not, and indeed when, to intervene with the use of coercive measures seemingly stem from value judgements, dependent upon staff and patient factors. Staff identified individual staff personalities and individual levels of tolerance, understanding, acceptance and boundaries as all seemingly pointing towards subjective interpretations of incidents and decision making with regards to use of coercive interventions:

'I suppose you can only ever go on your opinion, you can never be certain, so I don't think you can ever be a hundred percent certain whether he wants to go to sleep, or normally the things he says

before, like he might say I can't be bothered to go to the gym today, and then half an hour later he'll say he wants to go to his room, so obviously it's a call for the staff nurse to make, whether to use segregation or not' (NA-RB)

'Different staff react to things differently' (NA - male)

'Generally we're all the same but obviously there are slight differences in the ways that people work, so , as I say, some people are more hard-line, some people are more, hard-line, I don't mean that in a bad way (laughs) hard-line, and some people are more, what's the word, more, I don't know, they could be more therapeutic I guess than others, but I wouldn't say there's too much difference really, but there have been occasions where there have been differences of opinion whether people should be secluded, but that'll be the same on every ward, in every hospital, all over the country, it's a common problem' (NA - male)

'I think it is all about whoever is present at the time and their interpretation, you know, different people are going to interpret different situations differently, and we all have, like I've said earlier, an accepted level' (SN - male)

'There's this phrase 'pushing boundaries', it's a difficult balance sometimes between a patient doing something that they can't help and I think sometimes when they do things that are outside of the rules, the assumption is that they're being bad not necessarily that they're mentally ill or have PTSD' RC - female)

'I think there is that thing, I think there's always going to be that thing, I think there's always going to be patients that we dislike, where people are less able to tolerate him, they may react more quickly, so I think there's lots of factors that impact on whether people make the decision to put him in seclusion or not' (Psychologist - female)

'I think the challenges are how you, how an intensive care environment, how a restrictive environment, still allows people to

progress within those restrictions, and to get the line right between putting boundaries in to keep people safe but then not becoming oppressive, so I think challenge can mean the challenges that come from patients but can also mean the challenges that come from the philosophy of the environment' (SW)

PATIENT FACTORS

Knowledge, understanding and relationships with patients, each appeared to influence the decisions made, the points at which to intervene, the types of interventions used, as well as the outcomes deemed most appropriate to those involved:

'[Patients are] probably just not able to cope with the agitation, their own mental state at the time, and they think it's probably best if they just get themselves locked up as it were' (NA - male)

'I think sometimes it's to do with the fact that they just can't seem to cope, either their illness, they can't cope with or just being part of the community type set up which all wards are and hence their escape from that' (TL-male)

'He was trying to set a scene, so he was trying to make himself untouchable, or trying to create that fear that we shouldn't go in and touch him because he is that person, but obviously we have to manage situations' (SN - male)

'They tend to vary... it could be down to the patient group, it could be down to the reasons if someone doesn't want to be in the day room, if they don't want to be down here... if it's a case of they're trying to attack another patient... it really does depend on who you're dealing with' (NA - male)

'You might have been assaulted, attacked, your colleague, some patients might be trying to assault each other' (NA - male)

'Sometimes, when somebody's not well, the violence that comes out of some of them' (NA - male)

MAD OR BAD

Staff broadly perceive the challenging of ward boundaries by those who are 'genuinely' mentally ill and by those who exhibit 'bad behaviours' in different lights:

'I really don't know what goes on in their minds bar the illness and that kind of stuff where they don't have a choice in the matter because they're ill but I know patients that aren't and that for whatever reason find themselves in restraint very frequently because of the behaviours that they're engaged in' (SN - male)

'When they first come in here there's a lot of kicking back against the establishment, all that kick back against authority, a lot of distrust' (TL - male)

'Like I said, just general misbehaviour, you know, some patients will just run wild some days and some just in different ways, all different really, different most days' (NA - male)

'I think people, the more mentally unwell you are, unfortunately, the less you know what you're doing, in general terms, people who are more mentally ill than maybe just not a very nice person' (NA - male)

'We call it 'behavioural' you know, it's behavioural stuff, so I'm just using layman's terminology when I'm saying mischief' (SN - male)

'Very often it's the nature of the illness, if it's illness related. Sometimes it isn't illness related, it's behaviours that they engage in' (SN - male)

'The patients that I work with here, some of them I see as extremely unwell, some of them I see as really difficult and really

really testing and trying, you know, some I see as really really nice people who've had really bad luck' (SN - female)

'We deal with some very poorly people but we also treat some extremely difficult people that present with some terrible behavioural issues, so in that sense it's quite a challenging environment to be involved with' (TL - male)

PATIENT REPUTATION

Staff further distinguish through patient reputation based upon patient behaviours that are exhibited under patient control and based on patient desire to enter seclusion contrasted with those that do not appear to be under patient control where neither staff nor patients have a choice:

'There's a couple [of patients] that would quite like to be in there [seclusion] and make it their business to try and get there' (NA - male)

'Sometimes they seem not to like it but sometimes they try to negotiate to get into that seclusion door' (SN - female)

'It's some form of control you know... people engineer restraint, engineer seclusion and being restrained for all manner of reasons' (SN - male)

'A patient, they obviously get themselves into that situation, they don't just go in there for no reason, they get themselves in that situation, so some patients will say please put me in seclusion, put me in seclusion before I do something because they know they're not right so they need to go somewhere that's safe because obviously they can't do no harm in seclusion' (NA - male)

'We try to discourage them so they don't keep pestering or doing things which will make them end up in there, you know, but sometimes, if they are determined to go in, it's just a nightmare because they will do whatever it takes so that they are put in there' (SN - female)

'When you know they're going to push and push and push until you do seclude them, and they don't leave you anywhere to go' (TL - male)

'You've just got to manage it haven't you, take it as it comes. I suppose it can be a bit annoying really when you know they're going to push and push and push until you do seclude them, and they don't leave you anywhere to go... if there's nothing you can do to calm them down or talk them down or anything like that, then it's got to be done' (SN - female)

'He will put you in a position where you will have to seclude him because ultimately he'll raise his hands and you've got to do it because if you don't he'll do it again and the next time he'll give you a smack, so he gets what he wants, he's controlling us rather than us controlling him... He knows we've got to react. He knows that if he raises his hands, we've got to take it that he will hit somebody' (TL - male)

'Some patients on here, and I don't mean to overstep the mark, but they do like seclusion. If their mental health is very very unstable, they do, as daft as it sounds, some patients do like to be in there and again that causes, that's a whole new problem' (SN - male)

'When he feels distressed, he doesn't know how to manage it and then will engineer a situation to go into seclusion' (Psychologist - female)

'There's often patients who feel a lot safer in seclusion, who almost prefer to be in a quiet room away from the rest of the ward rather than being on a ward with the rest of their peers for whatever reason that might be' (RC - male)

No amount of staff training, rules or regulations are therefore able to direct or manage those parts played by individual factors. Staff are seemingly still required to make value judgements based on their own personal opinions, knowledge and experience based upon unique situations. As such, staff are

reliant upon their own instincts in making decisions and directing appropriate interventions.

PART 3: 'THE ACT'

From the interviews, it was evident that the act of using coercive measures involve complex processes, demanding both the physical and emotional effort of staff. Different types of coercive measures appear to require different emotional work and efforts, whilst staff experiences of conducting coercive measures may be divided into two parts:

- i) Staff experiences of using restraint, seclusion and segregation
- ii) Factors influencing staff experiences of using restraint, seclusion and segregation

STAFF EXPERIENCES

'A NECESSARY EVIL'

Of all the staff who were interviewed, each member of staff viewed the use of coercive measures as a last resort, secondary to attempts to deescalate potentially violent situations via verbal means. Staff largely voiced negative feelings towards using coercive measures, viewing these as a necessity to prevent injury and to minimise harm, and preferring not have to undertake these measures as part of their role and duty given the choice:

'None of us want to be restraining patients because we like it to be really quite settled everyday but obviously there's situations where, well the place we work, that's never going to happen is it'
(NA - male)

'Nobody likes to be restrained really, we do it as a last resort, but unfortunately it's a necessity of the job and the clients that we work with' (NA - male)

'It's not a nice experience but it is a necessary evil' (NA - male)

'It's not something that you relish, you know it's a needs must, you have to step in for whatever reason to lessen the harm that they're doing, it's really for their safety, the safety of the victim that they're attacking be that another staff or another patient,

it's that part of the job that sometimes is necessary but not that you like, and then you do it to the best of your ability' (TL - male)

'It's not something either party enjoys I don't think, obviously you know it's an invasion of their privacy to a certain extent isn't it, you know, nobody likes it' (NA - male)

'It's not pleasant, but if you're using it for the right reasons I think it's bearable, I think that's the best way to describe it, it's something that's got to be done' (NA - male)

'It is so necessary, so necessary but it's not the most pleasant part, and believe me, I would avoid it at all costs, but equally I know when it needs to be used. I know when it needs to be used, and used appropriately, it's very effective, very effective' (SN - male)

'I will do it, I don't particularly, well I don't want to do it, but I will do it if I need to and if I think it's necessary. It's not a part of the job that I enjoy, I'd rather situations were deescalated in one way or another without having to go to a level that's kind of more extreme measures' (SN - male)

'It's not nice, I don't want anybody else to get hurt and I don't want to get hurt myself. When you're in a restraint procedure it's very sweaty, you're potentially touching dirty clothes, urine, faeces, there's loads of things that you don't want to be doing, and you know, ideally, that would be one part of the job I'd be quite happy never to do' (SN - male)

'I think it's a necessary part of the job, I think it's a necessary evil. It's not the most pleasant part of my job but it is so necessary, especially when you're talking about risk to other people. When you've seen violence and experienced violence and been at the receiving end of violence, you would wish somebody to be involved, and manage them, in a safe way, and when people are put at risk, you know you have to do something... the alternative is not acceptable, it is not acceptable that people can be subject

to or victim of violence, not just staff but other patients and there be no consequence and there be no management of that. I've seen patients who have been on the receiving end of an unprovoked attack, brutal unprovoked attack, and you have to manage that, you know, you have to manage that. We have a duty of care' (SN - male)

'I would say that having to seclude a person has to be a last resort in itself, you don't ever feel comfortable in having to do that to another person although I can see, so you're never comfortable with it, you sometimes see the need that there is to have that kind of a facility' (TL - male)

CHAOS, ORDER, CONTROL & COMPLIANCE

The initial challenges in maintaining order, regaining control and establishing compliance were often described by nursing staff of varying professional capacities. Staff regularly described the initial chaos they are confronted with when first attending the scene of an incident. This was often attributed to the differences between training and reality as previously mentioned, as well as actual differences between each incident that staff are called upon to attend. While staff did not identify any particular sets of antecedents leading up to or resulting in the issue of restraint, staff did all identify incidents as being different with no two incidents being the same:

'It happens in the blink of an eye and before you know it, you're all just in a pile on the floor you know, and then everyone grabs a limb and the patients are put into the correct holds you know, but initially, it's, it can be quite messy... I can't think of another word to describe it really, it can be quite messy' (NA - male)

'To get the initial control isn't usually always textbook stuff' (TL - male)

'It's hard to control somebody who is really violent and aggressive... you've got to be thinking about safety... you've got to try and get them secure without hurting them basically and that's easier said than done at times' (NA - male)

'You've got to get compliance and make it as less stressful as possible' (SN - male)

'A violent incident is extremely dynamic, the initial part of any restraint is to isolate patients in a safe manner, and isolate the arms and legs because obviously they are the danger' (SN - male)

'It doesn't always work, they can kick off, they can drop their weight, wherever they get their strength from they seem to develop an incredible powerful strength, sometime they can whip out of wrist locks... things can go wrong, but not intentionally' (TL - male)

'A BATTLE'

The notion of physical restraint as being the closest thing to a battle between staff and patient are highlighted by staff in the following quotes:

'Restraint I suppose is the nearest thing to a fight isn't it, they're trying to hurt us a lot of the time and you're trying to get control of them... quite often they say they're sorry after but for that brief time it's you against them' (TL - male)

'When you restrain, it's more like a battle, like it's them against you, that's what the patients see it as' (NA - male)

'I think when you're restraining someone it's a lot more intense, it's a lot more physical, personal, because obviously they don't really want you to touch them, you don't really want to lay hands on them' (NA - male)'

'The initial restraint is always a bit of a fracas because you don't know what's going to happen' (SN - male)

'LAYING HANDS ON'

The distinctive language of placing 'hands on' was frequently used to describe the act of physical restraint by staff as outlined in the following extracts:

'You need to try and deescalate first, you always, that's your first point of call, if that's not successful then you get your team up

and you get your staff ready and you have to sort of go in and manage it, you know, unfortunately lay hands on' (NA - male)

'Nine times out of ten it'll be an assault which requires restraint, but sometimes, usually you do always have to put hands on in that sort of situation but not all the time does it end up in seclusion, but we'll like put patients in their room and things like that if seclusion's not needed, but nine times, most of the time it will involve getting hands on and restraining patients' (NA - male)

'If a patient's becoming hostile and aggressive or has physically assaulted not just staff but patients or even assaulted themselves, you do have to lay hands on, we have to restrain' (NA - male)

'You just have to respond and put hands on and remove him from the area where he is and deescalate the situation' (NA - male)

'Within the MV&A restraint training, we have three levels of holds, basically, holds being if you're going to put hands on a patient, so you have a passive hold, you have a swan neck and you have a full restraint hold given the level of aggression, violence you're being faced with... Just because we put hands on a patient doesn't mean to say that it's going to be full restraint' (SN - male)

TRAINING AND REALITY

Frequent distinctions were made between training, on the one hand, and the intensity of experiencing and enacting approved holds within the ward environment during actual incidents. Staff attributed these distinctions in part to the lack of resistance that staff put up against their colleagues during training, as well as to the speed, intensity and potential for injury with which real-life incidents occur:

'It's nothing the same at all, it's nowhere near... when you're practicing, you're just practicing with each other and nobody ever puts up any resistance or anything, so you've got time to do it all

properly whereas in a restraint, a patient never stands there and lets you grab them, they're trying to fight you, so it's totally totally different, totally different... most of the time, you just have to do it, you just have to try and do what you're trained to do, and just do it as quickly as you can but you haven't got time to think about it... if a patient comes at you swinging his arms and trying to punch you, you just have to, you can't think, hang on a minute, I need to put my hands there, you just get on with it' (NA - male)

'In a way, what you're taught down there is never the same, you never get the reality of it, there's no, because nobody really struggles when you're doing the training, if you do the shield training that's slightly different because when you do the shield training, the instructors there, they really make you have it they do, metal batons and baseball bats and it's quite difficult it is, quite scary as well when they're whacking you with a baseball bat on a plastic shield' (NA - male)

'You can talk about approved holds and how you should take people, but when limbs are flying everywhere and people are scrapping or somebody's just been hit and they've hit the floor, especially if the patient's putting up a struggle, sometimes it's just grabbing onto something and holding it still and when everything's stopped moving, then one at a time, get them into the appropriate holds' (SN - female)

STAFF ROLE: AUTHORITY & RESPONSIBILITIES

A definite hierarchy was apparent within the multidisciplinary team and in the decision-making process with staff seeming to pass on responsibility, particularly to those they saw as being senior, having greater authority or simply spending more time with patients on the wards. Those decisions made with regards to using coercive measures seemed often to be based on professional role. While nursing assistants did not feel they had the authority to make decisions regarding the use of seclusion, doctors often felt that the decision to seclude and reintegrate patients depended upon nursing staff and nursing staffs' confidence since it was ward staff who ultimately had to

manage the situation. As such, the task of restraining was most often managed by nursing assistants since they were most often first on scene. Seclusion was felt by nursing assistants and doctors to be, most often, a decision made by a nurse or nurse in charge, and segregation to be a decision made conjointly by the multidisciplinary team:

'If say I was sat in the day room and there was four nursing assistants in the day room and one of our lads got up and attacked another, we can't wait for the nurse in charge, we've got to stop the other lad from getting hurt' (NA - male)

'On the ward, on a day to day, there's usually the qualified or IC [Nurse 'in charge'] of the ward, and they take charge and we just run round and do whatever it is they tell us to do most of the time' (NA - male)

'As a nursing assistant I don't have the authority to put someone in seclusion' (NA - male)

'The nurse in charge, the nurse who is controlling the shift, as nursing assistants we wouldn't make that decision that these are going in seclusion because they've done this. I've been in the day room on this ward and other wards where a patient has had a pop at staff. It might only be a group of nursing assistants in the day room at that time. Now you would take hold of the patient, you've probably gone onto the floor, you've gone to a safe place, you're in the rest position, sort of, we have techniques for keeping hold of somebody but in a position that's a lot less stressful for staff or the patients, so that decision has been made itself almost, it's got to the point where, well we've had to put hands on a patient to stop them assaulting somebody, the patient's made that decision almost, and sometimes the only option is, well we need to remove that patient until we can take stock of why the patient attacked someone, but most certainly the nurse in charge is making the decision to lock that patient in' (NA - male)

'I'm a nursing assistant, I would never make that decision, I'd look to a nurse in charge and they would decide if seclusion was necessary' (NA - male)

'It's the nurse in charge who decides that that patient would be coming out and that would be in consultation with the MDT... there'll be a consultation of how to manage the patient more safely once they're out of seclusion but ultimately it's the nurse in charge who's saying, right, we're going to unlock the door and we're going to terminate seclusion' (NA - male)

'Seclusion, nurses can make a decision, nurses decide about a seclusion so you don't have to get that approved by anybody if somebody hits somebody or if they threaten violence, you can say, right that person's going into seclusion, lock them up for short term, report to everybody what's happened, whereas segregation is pre-planned' (SN - female)

'You're very much guided by the nursing staff and what the nursing staff say about how the patient has been because they are the eyes and ears on the ward. I rely upon them for clinical information' (RC - male)

'To actually lock a patient in a side room you need to have a segregation plan in place, that plan, that management plan is quite a lengthy plan that needs formulating, it needs putting forward to the doctor, okaying with the doctor then it still needs to go forward to the segregation panel. The segregation panel has then got an independent doctor to yours, they will look at the plan with other people, they will discuss it and they will either accept it or deny it' (SN - male)

'Long term seg is more planned and that's for the doctors and the nurses to get together and sort of plan a segregation' (NA - male)

TEAMWORK, AVERSION & OTHERNESS

Staff support was an important feature identified by staff throughout the process of conducting coercive measures. Mutual trust and support were key factors in establishing good team relations and in conducting coercive measures safely. There is an implied sense of dependency between staff, while trust appears to be a major factor in working as part of a team. Indeed, some staff have felt 'let down' and angry when colleagues have not responded to incidents in ways that would be expected, or have not supported colleagues in a manner felt appropriate. Teamwork, esteem and respect for colleagues are therefore not only associated with levels of training and experience, but also staff willingness to get involved when colleagues are placed in vulnerable or precarious situations. Those who had a fear or aversion to using coercive measures were therefore often ostracised by other members of staff and seen as being unreliable, untrustworthy and undependable:

'I think if I had never done this job before, if I came from the outside, if I'd been working in a factory or a shop and took this job on, I might have been tempted to hang my keys up because it was, I thought, you come to Rampton, staff will back you up, staff will always be there no matter what happens, and the first time it happens [being attacked by a patient], I'm on my own' (NA - male)

'I know people, I personally know people that are fearful, fearful of restraint, fearful of that kind of, can I, and when those incidences do happen they shy away from being involved... some people sometimes develop an aversion, I know quite a few people here that have, and it's not healthy, it's not healthy, you're in the wrong environment to be here to develop an aversion to that' (SN - male)

'Some people, I mean you hear of some people where if there's a situation some people just go and lock themselves in the toilet or just disappear, the staff anyway, in some circumstances... they're scared, so they just go and do a runner and just go and lock themselves in the toilets' (NA - male)

'If somebody's kicking off and they're close to it, they just run away and hide or whatever and bury their head in the sand and run away from it all' (NA - male)

PART 4: THE 'AFTERMATH'

Following the use of coercive measures, staff describe a period of stillness and deliberation. This indicates a time of contemplation, reflection and consolidation, seeking justification for their actions and considering what, if anything, they might have done differently. In a sense, this time is for staff to manage their personal emotions, to look towards other staff for support and reassurance regarding their professional role and to seek and reaffirm their place within the institutional framework in which they are professionally bound. Staff describe three parts to this concluding section of their personal experiences, these relate to; i) Patient Reintegration; ii) Passing of Time; the changes of emotions, outlooks and challenges that staff are faced with; and iii) Recuperation; the processes by which staff prepare themselves for the eventualities of having to go through this whole process again. Each of these parts of staff experience will now be considered under a range of subheadings.

ASSIMILATING EXPERIENCES

Staff describe how, over time, their attitudes, perceptions and emotions towards their practice undergo significant change. Through learning the rules of the organisation, staff in a sense become institutionalised. They become more emotionally prepared to deal with incidents requiring coercive measures, and more confident and proficient in their roles, whilst seemingly developing the skills to separate the personal and professional selves to a greater degree through viewing their actions as being 'part of a job':

'There is always that apprehension because of the inexperience, the lack of experience, that kind of stuff' (SN - male)

'You do kind of get used to it, it is part of the job, you don't enjoy it but you know it's there and you deal with it, try and make a bit of light of it afterwards, as a coping mechanism more than anything' (NA - male)

'It's just trying to deal with it isn't it, and not letting, not judging people on it and I suppose the difficulty then is working with somebody if you've been attacked but that's part of the skill in

working in this environment, you can't hold it against anybody, it's part of the job isn't it' (NA - male)

'I just take it as part of the job' (NA - male)

'It's just part of a job isn't it. It's a high secure hospital' (NA - male)

'It's just my job, I'm not here to criticise, society needs somewhere to put people who have done this and I just work in that environment' (NA - male)

'A lot of the time it's just part of the job and you respond to what you need to do at the time, so apart from the particularly violent ones or ones that are completely out of the ordinary, it just gets to be one of those things, you just do it' (SN - female)

'I think you have to remind yourself that you're here to do a job and you have to do the best job' (SW - female)

VALIDATING ACTIONS

Staff appear to validate their roles and actions in terms of 'doing the best they can' in conducting often uncomfortable practices. In 'doing the best they can' in often physically and emotionally demanding situations, staff seek justification for their actions and locate themselves within institutionally prescribed norms:

'I just did the best I can' (NA - male)

'It's stressful but at the end of the working day, you kind of feel, you know, satisfied that you've got through it and everyone's safe, patients are safe, staff are safe and you've dealt with everything you need to deal with, and you know, everybody's got through the end of the day you know without being injured or without being upset really' (NA - male)

'That sense of, it could have been me on the receiving end, did I do my best, and then you have to deal with the fear, you know,

fear sets in and it's fear of there being another incident, what if the worst incident, what if I can't help, what if, you know, could I have got there quicker... you're working with, you're dealing with those things, those thoughts of could I have got there quicker, what if, what if, I should have got there quicker, you know, and he was within arm's length of me, you know, what could I have done, I should have been more attentive and all those sorts of things, you know, and it's what ifs that you're dealing with, and that sense that you've let somebody down... it could have been so different, if I had got there a second quicker, you know, and the fear of should it happen again, can I be relied upon, am I dependable, you know, am I good at this and all that kind of stuff, so it's a range of things you're battling and dealing with... I remember for weeks, carrying this, you know, and you have to make your peace with it, I tried my best, I did my best, there was nothing more I could have done, you know' (SN - male)

'What always plays on your mind is just to make sure you are doing things right, you know, it's a volatile situation whereby emotions are running high, up and down, but still as a staff, you just keep on reminding yourself that, you know what, you have to do things right, it's to make sure the patient is put to a safe place' (SN - female)

'It's just pure adrenaline, because then it's like, now how am I going to manage this, because you don't want to let your colleagues down, you don't want to let anybody down, you don't want to let yourself down, you certainly don't want to let anybody else get hurt, and you endeavour to effectively use the techniques you've been taught, as well as you've been taught' (SN - male)

'Your heart's absolutely racing, you think, oh god, I just want to get it right' (SN - female)

'I think you just have to be aware of it and manage it to the best of your capabilities whether it be through supported supervision or you know, it's not easy' (SN - male)

CONSOLIDATING PERSONAL AND PROFESSIONAL VALUES

In order to function within an organisation where coercive practices would not be acceptable, staff describe their attitudes and perspectives as having to change in order to cope with the institutional and emotional demands of their working environment:

'I've seen people with a negative attitude about it be involved in restraint, and it's a very dangerous mix because your personal feelings always come into it, so you always have to be detached about how you feel about it and just do the job in hand, you know, you've got to think about people's safety, the patient's safety, other people's safety, you know, they are paramount' (SN - male)

'I found my attitude towards it changed, when I experienced it first-hand, when I witnessed it first-hand, my attitude towards it, the necessity of it changed, because the alternative is not acceptable, it is not acceptable that people can be subject to or victim of violence, not just staff but other patients and there be no consequence and there be no management of that. I've seen patients who have been on the receiving end of an unprovoked attack, brutal unprovoked attack, and you have to manage that, you know, you have to manage that. We have a duty of care' (SN - male)

'It's not easy when you see it for the first time, and then when you see violence against staff, you know, people that you work with, colleagues, friends, especially some of the attacks I've seen, quite brutal attacks on staff, that can be quite disturbing. You have to contend with that, you've got to put it in the right context and you have to process and deal with it' (SN - male)

'It's not the easiest of jobs, sometimes, it's very difficult to, when you have to be physically involved in restraining patients, that doesn't initially sit very easily with how you're first educated to what nursing is, it doesn't, you know, they don't sit comfortably together' (TL - male)

'As a nurse, when you come to the field of forensics, one of the hardest things that you have to try and balance out is the security aspect of the job that you do, along with the nursing side of how you were trained, it's something that's quite different, and the two, I don't think ever sit totally comfortably with each other' (TL - male)

'I think you've got to sort of, you've got to stay true to yourself as to what brought you into nursing and then how you go about putting across your nursing care isn't always that easy a job within a contained area, a place with massive security practices, but you've just got to stay true to yourself' (TL - male)

STAFF SUPPORT & COHESION

Finally, staff seek the support of fellow colleagues and those working on the inside, who recognise those similar institutional and emotional demands. They seek understanding from those who have experienced and who can appreciate and rationalise this process with them:

'You've got to support each other otherwise it just wouldn't work, you just wouldn't be able to work with each other, especially as I say, in the intensive care scenario' (NA - male)

'I did that based on working with very experienced, very good staff who will take you under their wing and explain things to you and say, well, you know, and you can go through all the emotional stuff with them and put it in the right context and say, yeah, it's pretty normal to go through that, that's normal' (SN - male)

'We all work really well, we all work really closely together, we've got a good staff group on here, I've got a lot of confidence in the staff I work with, we're very supportive and we do have a good debrief, not officially, but we'll all talk to each other if something hasn't gone particularly smoothly, we'll say, right, let's all go and get a cup of tea and we'll just have a bit of a talk about it and we

make sure we try to split the jobs as well so it's not always the same people who are in that area because it can get quite tiring' (SN - female)

'You are conscious of how dangerous it can be and how much you rely on other people to keep you safe, but then again, they rely on you as well' (TL - male)

'You've got to be there for each other' (TL - male)

'We're a close bunch really... it pulls you together so when something maybe unsavoury happens, it makes it easier to break it down a bit, it's not that bad, it's not that bad, because I've been through it and they've been through it, we've all been through it and we can help each other a little bit' (NA - male)

'It's a difficult time for anybody to go through an incident... when you come out the other side of that, you know, it's supporting your staff' (SN - male)

PEACE AND RECONCILIATION

Where staff have previously described the challenges of working within a high secure hospital and having to manage difficult situations in a workplace that 'outsiders' do not understand, the outlet for such emotions have been described as 'making peace with' their personal and professional roles and identities. Staff describe a sudden lull in their emotions, following the heightened tensions in dealing with and managing incidents, such that staff require time to manage their own emotions before continuing with their usual work:

'You kind of have to take it in your stride, and I think there's a certain element where you have to make your peace with it... you have to make your peace with it irrespective of your feelings about it, and do it to the best of your abilities, you know' (SN - male)

'You have to make your peace with it and you have to find a way of dealing with the emotions and everything else for afterwards' (SN - male)

'You're working with people at the end of the day, you're dealing with people. Patients are people and it's violent at the worst, it's a violent act, it's a violent process and you have to wade through the mist, the red mist and process it, and do things professionally and all of those things. The adrenaline's going, you know, your senses are heightened and then afterwards you almost crash, you know, yeah, you almost crash' (SN - male)

'It can be difficult, it can be very difficult, it can be quite tiring, it can be quite emotionally and mentally draining, I think the hardest part of the job is you have to be forever watching, listening, being prepared, I mean we do this for thirteen hours, it can be quite tiring, especially if you've got a lot of demanding patients... it can get very draining, very repetitive' (SN - female)

'Everybody is a little bit pumped up, so there is almost a little bit of post seclusion sort of not blues, but phew, that was phew, what happened then, but then you sort of take off, evaluate it' (NA - male)

HEIGHTENED EMOTIONS VERSUS EMOTIONAL BLUNTING

Staff often expressed the fear and anxieties they had to manage and overcome in dealing with traumatic situations at work. While some staff would feel these immediately during the process of using coercive measures, others would describe a sense of detachment, going on 'automatic' and leaving these emotions aside to be dealt with after the incident had occurred in order to be dealt with after the incident had occurred:

'From a staff point of view, it's nerve wracking at times... you do kind of get used to it, it is part of the job, you don't enjoy it but you know it's there and you deal with it, try and make a bit of light of it afterwards, as a coping mechanism more than anything' (NA - male)

'It happens that quick, you don't get time to think, you're just trained to do it' (NA - male)

'I think, because I've done it for so long, you're almost on an automatic, you just do it, don't think about it anymore. You think about what you're doing and everything else that come with the patient but it almost just happens effortlessly now' (SN - male)

'At the time, you just don't think about it there and then, I mean, your adrenaline's pumping, so you just deal with whatever happens... you're just doing it, you just respond and then afterwards there'll be debriefs' (NA - male)

DESENSITISATION

'You do get desensitised to it the more incidents you get involved in. If I revert back to the first incident when I worked on acute, I was shaking afterwards, sort of like what's happened there sort of thing, whereas now, you just kind of get on with it you know, I know that might sound a bit mechanical but that's how I react now' (NA - male)

'The first one I did I was a bit, not shook up afterwards but a bit, wow, you know, but now it's just, it's just your job... for me personally, it's just, part of, it's my job so it doesn't bother me at all' (NA - male)

'When I first came to work on here, I found it quite daunting at times, the thought of being attacked, the thought of restraining patients... For want of a better phrase, I suppose I found it quite scary you know, it used to make me anxious... I'd feel anxious, my palms used to sweat... it would not be a pleasant experience really, but I suppose as you work on here and you're getting more experience working with these sorts of patients, it becomes second nature to you really... I still get anxious at times if I know something's going to happen but you just kind of, like I say, develop a certain set of skills where you don't really let anything, you don't really let it bother you too much I suppose' (NA - male)

'It doesn't affect you after a certain amount of time, you just have to, you learn to deal with situations and not let them affect you if that makes sense, through, the more than you do it. If a patient died in hospital, I've got no love, feelings or emotions for that person, so it's easier for me to do all those things, but if it was a family member, then it would be different, I think it's the same as in this situation, I can put all those things to one side because it's not directly related to me, I've got a job to do, it's another hat that I've got on, that I have to wear when I come to work... I can work around it by making sure that I'm coming here to try and do a job' (SN - male)

'I don't get as bothered by aggression as what I used to do, if somebody before my nurse training and before I came to Rampton, if somebody came up to me... I'd have been very anxious and wanting to leg it, or fight or flight, whatever you want to say, but since I've been here, it happens that often that, I won't say that I don't get anxious with the situation, but because it happens so regularly, my anxiety is nowhere near as high and I can, I would say, appear calm but like a duck under water, I'm going like mad' (SN - male)

CONFIDENCE

'Once you've done the first one, it's kind of a relief, you know the procedure, if anything, it makes you feel more confident' (NA-RB)
'You have to put it in the right place for you, because you're going to have to do it again tomorrow, or another day, so you have to make your peace with it and put it in a place where you've dealt with it and you move on from it' (SN - male)

'You have to get to a point where you get over it because the next one is just going to be the same again' (SN - male)

'I think with time, you get used to it, you get used to it' (SN - female)

PHYSICAL AND EMOTIONAL TOLL

'At this point, it's draining... I've had enough, it's repetitive, if I've been here a lot, it can seem quite soul destroying, it just gets too much to bear after a little while... you can only take so much, so much arguing, so much abuse, so much violence, so much of this every day before it starts wearing you down... I think it should be short term plan for staff as well as patients, a couple of years I think in this sort of environment' (SN - female)

'It is a tough environment, you've got very difficult patients down there and you do have to be very careful of a) your own stress levels and b) the stress levels of other staff that you're with... I'm a big believer that in that really stressful environment, everyone has their shelf-life date' (TL - male)

The interviews with staff reveal a wealth of information relating to staff experiences of working in, and conducting coercive measures, within a high secure hospital environment. Through examining staff interviews, individual and collective emotions, expectations and demands become evident. These highlight the challenging processes that healthcare professionals experience in working with 'deviants within deviant spaces'. The strengths and limitations of this study will next be explored. Findings from the study will then be discussed in relation to theories of institutional and emotional work, at the levels of the institution, the organisation and the individual.

CHAPTER 11: STUDY CHALLENGES AND LIMITATIONS

This section will provide an overview of the challenges faced in conducting this study and the limitations of the data collected. Through highlighting the restrictions of this study, an honest and open account will be offered to the reader; providing transparency with regards the study's strengths and weaknesses. These will be presented in three stages in line with the research process, namely; hospital level data, standardised questionnaires and interviews.

HOSPITAL LEVEL DATA

The collection of hospital level data relied solely on information recorded by the hospital for the purposes of patient records and hospital audits, rather than specifically for the purposes of this study. Whilst the initial aim of the study was to analyse the prevalence of restraint, seclusion and rapid tranquillisation within the hospital, data for incidents of restraint only were not available via hospital database records. This was, in part, due the assumption that restraint and seclusion are used in combination. The 'reasons' for using seclusion and rapid tranquillisation were pre-defined by the hospital, such that for seclusion, these included; 'threatening behaviour'; 'violence to staff' and 'violence to fellow patient'; and for rapid tranquillisation, these included all of the above with the addition of 'self-harm'. These categories, while useful, might be somewhat limited to the 'actual reasons' why coercive measures might have been used when examined in more detail. Had the researcher sufficient access to this information, these categories might have characterised differently for the purposes of this study. It is also important to note that the hospital records for rapid tranquillisation were not for the prevalence of rapid tranquillisation per se, but rather from the recordings of 'serious and untoward incidents' (SUIs) where rapid tranquillisation had been used.

One way to have collected potentially more accurate data on the reasons for using coercive measures and the prevalence of rapid tranquillisation would have been to examine each patient's notes within the hospital. Whilst in theory, this might have provided more accurate data, in practical terms, this would have required the permission of each individual patient to access their medical records. This process would have been both arduous and time consuming, with no guarantees of how many patients would give their

consent, and thus this alternative method of data collection would also have been limited albeit in different ways. The collection of data using pre-recorded hospital databases was therefore the most pragmatic option for this study.

STANDARDISED QUESTIONNAIRES

It is important to note that a purposive sampling approach was used to collect data for stages two (standardised questionnaires) and three (semi-structured interviews) of this study, and that participants were self-selecting; choosing themselves whether or not to take part. Maykut and Morehouse (1994) outline the careful balances between studying complex phenomena and the limits of generalisability. So, whilst this study is weighted more heavily in the former; specifically examining staff and patient experiences of coercive measures in a high secure hospital, there is an acknowledgement that findings from this study may not be generalisable, particularly due to the specificity of the location and context. Since the sample was self-selecting, considerations must also be given towards those who chose not to be involved; the possible reasons for this as well as the experiences and perspectives that were not captured as a result.

As previously outlined, the ways in which the questionnaire data were collected varied between each ward. While this captured the differences between ward rules, philosophies and environment, providing interesting observations of the study context, this may have impacted particularly upon patient responses. For example, whether the patient completed the questionnaire alone or with the researcher or member of staff present; the time lapsed between last experience of coercion and completion of the questionnaires; and participants' motivations behind choosing wither or not to participate, might each contribute towards the answers given. While these are perhaps methodological considerations, all three of the questionnaires (ACMQ, ATAS and EssenCES) have been standardised, providing the most comprehensive measures in addressing this study's research questions.

It is interesting that the most responses, proportionate to the ward population, came from staff and patients on the ICU, whilst least responses came from the pre-discharge ward. It may be argued that relationships between the researcher and staff/patients might have been different on each

of the four wards. The issue of compliance may also be raised given that the ICU was often seen as the 'strictest' of wards within the hospital, being the most regimented and having the strictest of boundaries. Patients on the pre-discharge ward in contrast have the greatest freedom within the hospital. They have most likely spent the longest periods of time as residents within the hospital, are about to be discharged and move on, and so may feel at greatest liberty not to comply with additional demands requested of them, since they have 'served their time' and given enough of themselves to the hospital already.

INTERVIEWS

The interviews with staff were conducted using a purposive, self-selecting sample, for which the limitations have been previously outlined. While the researcher acknowledges that a semi-structured approach may have limited the direction the interviews might have taken were they completely unstructured, a semi-structured design has the benefits of providing a focal point from which to conduct and analyse the interviews; and as such, is in line with adopting a constructivist approach to grounded theory (Charmaz, 2011; Coyne, 1997; Cutcliffe, 2000; Lincoln & Guba, 1985). The researcher acknowledges that had an alternative methodological design or theoretical framework been used, the findings arising from this study may have been interpreted and presented quite differently. However, the approach taken has been considered the most pragmatic in answering the study's research questions. A constructivist approach has allowed for the study of complex interactions; examining how actions, emotions and institutions influence one another; specifically the actions and emotions of staff associated with the conduct of coercive measures within high secure institutions. Furthermore, this novel approach to conducting, analysing and interpreting data has made a contribution towards greater understandings of this field, and was best suited to exploring the research questions proposed.

In common with many explorations of the social world this study would have been improved by a more explicitly ethnographic approach. For practical and ethical reasons this was not possible. Nevertheless conducting the research as it was carried out led to numerous informal but informative observations and many interesting conversations with members of staff. Glimpses of these observations can be found amongst quotations from the interviews – the

language of 'tremblers' to describe the cameras (see page 165), the fears, anxieties and responsibilities surrounding the scrutiny of their roles (see page 158), the levels of security outweighing those of the caring profession (see page 167). The most illuminating of these observations are outlined within the researcher's personal account of her experiences and reflections of her time within the hospital (see page 97). Thus, although these experiences and observations provide rich and interesting data, ethical constraints and respect for those individuals mean that these can only be reported informally.

Studying the history and development of high secure hospitals provides insight into why and how these institutions became established in the social control of deviants. Exploration of changes to the Mental Health Acts enables deeper understanding of some of the wider socially evolving attitudes towards those contained. Finally, findings from the investigations, reports and inquiries into these services, unveils prior inherent working cultures and reasons for some of the contemporary forms of governance, management and practice.

CHAPTER 12: DISCUSSION

Despite the limitations of this study, the findings have contributed towards the exploration of using coercive measures within the unique environment of a high secure hospital. Analyses of hospital level data have provided insights into the prevalence of seclusion and rapid tranquillisation within Rampton Hospital, reaffirming that age and gender differences occur. Differences in rates and frequencies of seclusion and rapid tranquillisation have been found between wards and directorates indicating context, ward philosophies and environment as being key contributing factors towards such variations. The questionnaires have allowed staff and patient perspectives to be compared across four different wards, highlighting greater variances between staff attitudes towards containment measures and accompanying perceptions of the high secure hospital environment than patients. Furthermore, the interviews have allowed rare insights into the personal experiences of staff who practice coercive measures; revealing the processes which they go through, the internal tensions, conflicts and dilemmas between their personal and professional identities; contributing towards the institutional and emotional work that they are frequently confronted with. Whilst the examination of hospital databases and the use of questionnaires are perhaps not nuanced approaches to exploring this topic, rarely are these mixed methods combined within a single study in exploring the use of coercive measures. Nor are there many studies that allow direct comparisons to be made between staff and patient experiences of coercive measures. Such a detailed, comprehensive and in-depth study examining the use of coercive measures within a single hospital is therefore innovative in itself, and seen as being a vital component towards the contribution of knowledge within this area. Moreover, the application of an institutional-emotional framework towards the study of staff experiences of using coercive measures enables new insights to be studied and explored. Each of these stages of the study will be discussed in more detail as follows.

HOSPITAL LEVEL DATA

Statistical analyses of hospital data examining the uses of seclusion and rapid tranquillisation, have provided important insights into the prevalence and practices of coercive measures within Rampton Hospital. These data have

allowed detailed analyses of coercive measures used in the hospital while allowing comparisons with other studies.

SECLUSION

During this section, explorations of gender, and length of admission will be discussed in relation to other study findings. Ward acuity, ethnicity and reasons for seclusion will also be discussed. Considerations will be given towards any similarities and differences between study findings and suggestions for further research proposed.

GENDER

Findings from this study revealed that a greater proportion of females were secluded than males. Of those secluded females were secluded significantly more times than males, although there were no significant differences for length of time spent in seclusion between females and males. These findings are consistent with the research hypothesis and in general support of previous studies (Ahmed & Lepnurm, 2001; Mason, 1998; Pannu & Milne, 2008).

When examining more closely the proportions of female and male patients secluded previous studies report between 45% and 68% of females being secluded (Mason, 1998; Pannu & Milne, 2008) and between 25% and 30% of male patients being secluded (Ahmed & Lepnurm, 2001; Mason, 1998). While comparisons of these findings suggest the proportions of secluded patients as being higher within this hospital than within other forensic hospitals (females = 73.8%; males = 38.3%), the study settings, time frames and methods used to obtain and record data must be considered. The study conducted by Ahmed & Lepnurm (2001) was conducted over a 30 month period within a multilevel secure hospital, suggesting differing levels of risk, challenges and need for coercive measures. The studies conducted by Mason (1998) and Pannu & Milne (2008) were each conducted over a one year period although data were collated using case note documentation rather than hospital databases. Mason's (1998) study was conducted at Ashworth Hospital prior to the national reconfiguration of Women's Services to Rampton Hospital. Comparably, the study by Pannu & Milne (2008) conducted within Rampton Hospital excluded all patients from the then newly set up DSPD Service as well

as women on trial leave from Ashworth since the process of reconfiguration had begun by then.

These differences in study design may go some way to explaining the differences in proportions of patients secluded between the studies. The higher proportions of female seclusions in comparison with males may well result from the reconfiguration of high secure services in terms of Rampton Hospital now being the only high secure hospital to accommodate female patients, thus representing those females with most challenging behaviours across all the secure hospitals within the England. Another reason for these gender differences might result from society's perceived roles of women and the disproportionate reactions that ensue when female behaviours depart from these social norms and expectations (Becker, 1973; Cicone & Ruble, 1978; Pannu & Milne, 2008; Lemert, 1951; Scheff, 1999). Studies have found that while males are more violent than females in the general population, this is not necessarily the case amongst psychiatric inpatient settings (Krakowski & Czobor, 2004). Relating these findings to the social theories of deviance and social control, gender may be considered a variable influencing how 'deviants' are identified, managed and treated differently. The unique milieu of the high secure hospital environment, encompassing its own rules and norms thereby influences and is influenced by the practices of coercion (Brunt & Rask, 2007; Lawrence & Suddaby, 2006; Lawrence et al., 2008).

AGE

Patients who were secluded were significantly younger than those who were not secluded. This is consistent with this study's hypothetical predictions and with the studies reviewed (Ahmed & Lepnurm, 2001; Pannu & Milne, 2008; Thomas et al., 2009). Ahmed & Lepnurm (2001) suggest that younger patients might be perceived as being more energetic, physically fit and therefore a greater threat of aggression or violence and more difficult to control. Less is known with regards to younger patients (Ahmed & Lepnurm 2001). Younger patients are likely to have spent less time in psychiatric services, especially high secure services, and so less is known about their potential triggers, early warning signs and best approaches to deescalate them when incidents occur (Ahmed & Lepnurm, 2001; Beck et al., 2008; Flutttert et al., 2010; Pannu & Milne, 2008; Thomas et al., 2009). As such staff perhaps feel more vulnerable and perceive greater threats from younger patients, not only because they

have less knowledge of them but also because they have had less time to build therapeutic relationships.

Younger patients who have spent less time within forensic hospitals are still learning the rules and boundaries of the institution. Few people have had experiences of secure hospitals as a whole and even fewer have experienced a high secure hospital environment. These patients may feel particularly vulnerable being in a place that is so far removed from their usual experiences (Beck et al., 2008). Indeed some studies suggest that it is not only perceptions of younger patients as being more violent and aggressive but that actual acts of violence and aggression occur more frequently amongst younger patients and those who have been admitted for shorter periods (Beck et al., 2008) While staff might view younger patients as being greater threats to the established rules and regimes of the organisation, younger patients are perhaps more likely to feel like outsiders in unusual places. The fear and anxiety surrounding the lesser known on behalf of both staff and patients are suggested to each contribute towards increased use of coercive measures amongst this population Beck et al., 2008; Thomas et al., 2009). Violent and aggressive acts, staff and patient attitudes, actions and reactions therefore all need to be addressed and are themes that will be revisited during discussions of questionnaire and interview findings.

LENGTH OF ADMISSION

An inverse relationship was found between the number of seclusions and time spent in seclusion. Patients were found to be secluded more times during the initial stages of admission, although secluded for longer periods as their length of stay in the hospital increased. Fear and anxiety on behalf of both staff and patients have been suggested as probable reasons for greater numbers of seclusion episodes particularly during the initial stages of admission (Beck et al., 2008; Jacob & Holmes, 2011a; Jacob & Holmes, 2011b; Thomas et al., 2009). For staff, new patient admissions can be anxiety provoking times, particularly since little is known about the patient; staff and patient have not yet had opportunities to establish a therapeutic relationship, and ward dynamics may be altered (Beck et al., 2008; Brunt & Rask, 2007; Thomas et al., 2009). For patients, particularly those new to a high secure environment, equally little is known with regards to other patients, ward boundaries and routines (Beck et al., 2008; Brunt & Rask, 2007; Thomas et al.,

2009). Staff are thus required to learn the early warning signs, triggers and risks posed by newer patients while new patients are required to learn their place amongst the routines, rules and boundaries of the institution. Once this knowledge and relationship becomes more established between staff and patient, these fears and anxieties may diminish (Beck et al., 2008; Thomas et al., 2009). Staff are better able to recognise when periods of seclusion are required and when reintegration can safely take place (Thomas et al., 2009). Similarly, patients are better able to recognise institutional rules, boundaries and consequences of when these are violated (Thomas et al., 2009)

With regards to increased durations spent in seclusion over time, this could be related to the lack of options available to manage and contain patients who are already in the most secure of hospital provisions available (Maguire et al., 2012). Studies have suggested a cycle of aggression and coercion whereby the employment of coercive interventions paradoxically escalates rather than diminishes aggressive behaviour (Daffern et al., 2003; Goren et al., 1993; Morrison et al., 2002; Patterson & Forgatch, 1985; Thomas et al., 2009) More concerningly, staff have reported feelings of increasing anger and frustration towards patients who repeatedly require coercive interventions, voicing thoughts of punishing patients and the guilt associated with these thoughts and emotions (Sequiera & Halstead, 2004). These increasing periods of seclusion certainly warrant further investigation. Explorations are required as to whether alternative interventions might be more viable; the provisions of support available to staff; as well as further investigations into any evidence of punitive treatment towards those patients continually deemed to require coercive measures.

WARD ACUITY

Examinations of ward acuity focused exclusively on male patients where each ward was assigned a specific function that could be divided into four categories, namely; ICU, admission, treatment and or pre-discharge. Female patients were excluded from this part of analysis since the Women's Service does not include any pre-discharge wards and so would have skewed the data. Amongst the male wards, greatest proportions of patients were secluded on the ICU ward, and most times. The patients on the admission ward in contrast were secluded for the longest durations.

The proportions of patients secluded, number of times secluded, as well as durations spent in seclusion each indicate the intensities of working with patients on the ICU and admission wards in this hospital. While these findings were perhaps to be expected, they hold important implications with regards the support required by staff working in such a hostile and potentially vulnerable environment, while necessitating further explorations as to how working in a high secure hospital might influence staff attitudes, emotions and actions (Exworthy et al., 2001; Hochschild 1983; Klinge, 1994; Lawrence et al., 2009; Sequiera & Halstead, 2004). Theories of labelling need to be considered, particularly with regards staff expectations of those accommodated within these increasingly challenging ward environments; the effects this may have upon patient treatment and equally upon staff when working in an environment of heightened emotions. These factors will be further examined during discussions of the standardised questionnaires and interviews.

ETHNICITY

Analysis of ethnicity in this hospital is of particular importance and relevance given the widely documented overrepresentation of black and minority ethnic groups within psychiatric services and associated perceptions of dangerousness (Benford Price et al., 2004; Keating & Robertson, 2004; Prins, 1993; Spector, 2001; Vinkers et al., 2010). Due to the small numbers of patients of black and minority ethnic groups within the study sample, ethnicity was divided into 'white' and 'non-white' categories. When examining the overall population of this hospital, an 82.2% majority of patients were of 'white' ethnic group whilst the remaining 17.8% minority were of 'non-white' ethnic group, in contrast to the expected norm (Bhui et al., 2003; Leese et al., 2006). This difference in hospital population will ultimately affect analyses presented in this section and provides the context by which to explore the rates and frequencies of seclusion according to patients' ethnic backgrounds.

Statistical analyses revealed no significant differences in the proportions of 'white' and 'non-white' patients secluded. In contrast however, patients of 'non-white' ethnic origin were secluded significantly more times and for significantly longer durations than patients of 'white' ethnic group, where taking into account whole hospital populations.

Only two previous studies have reported ethnicity in relation to the prevalence of seclusion within forensic settings. A study conducted by Benford Price et al., (2004) in the United States and a study conducted by Pannu & Milne (2008) in the UK, each found that patients of 'Asian' and 'black' ethnic groups were secluded more often although not to significant degrees. Studies conducted within general psychiatric settings however, repeatedly report significant differences in the use of coercive measures between different ethnic groups, with patients of black and minority ethnic groups being coerced more frequently (Bond et al., 1988; Bowers et al., 2005; Flaherty & Meagher, 1980; Gudjonsson et al., 2004; Hendryx et al., 2010; Soloff & Turner, 1981).

While drawing upon studies from the general psychiatric literature suggests evidence of racial bias in the use of coercive measures, comparisons of findings within forensic psychiatry remain inconclusive due to a lack of studies in this specific area. These lack of conclusive findings are perhaps indicative of the inconsistencies in ethnic categories used between studies and also of the variations in ethnic compositions between hospitals (Bowers et al., 2005).

REASON

Methods and reported reasons for using seclusion differ widely between studies perhaps reflecting differences in national policies and guidelines (Ahmed & Lepnurm 2001; Daffern et al., 2003; Paavola & Tiihonen, 2010; Pannu & Milne, 2008; Thomas et al., 2009). These differences have however created difficulties in making direct comparisons between studies. For example, Ahmed & Lepnurm (2001) report self harm as being the most common reason for initiating seclusion in a Canadian hospital; a reason for which seclusion is not condoned within the UK (Department of Health, 2008) Discussions of these reasons for seclusion will therefore draw upon wider literature including those from general psychiatric settings.

Reasons for seclusion within Rampton were determined by the hospital's incident reporting system rather than categories assigned by the researcher. These were divided into one of three categories, namely; attacking fellow patient, attacking staff or threatening behaviour. Of these categories, threatening behaviour was the most often recorded reason for initiating seclusion, whilst patients attacking staff accounted for the longest periods

spent in seclusion. Female patients were significantly more likely to be secluded for attacking staff and for threatening behaviour than male patients. Patients of 'non white' ethnic group were more likely to be secluded for attacking staff than patients of 'white' ethnic group. Each of these will be discussed in turn.

With regards to threatening behaviour being the most common reason for seclusion, ongoing debates continue surrounding the timing of when seclusion should be initiated (Ching et al., 2010; Maguire et al., 2012). In secluding too early, patients are not given the opportunities to take responsibility and control over their own actions (Maguire et al., 2012). In secluding too late however, injury may occur that might otherwise have been avoidable (Maguire et al., 2012). Policies act as general guiding principles only since it is not possible for policies to state each of the specific situations during which seclusion should be employed. As a result, staff are reliant upon their training and personal judgements as to decide when a situation poses sufficient risk as to warrant seclusion; a call which is largely subjective (Elbogen et al., 2001; Exworthy et al., 2001; Harris et al., 1989; Klinge, 1994; Mason, 1993; Spector, 2001). The questions of what constitutes threatening behaviour, how staff perceive aggression and the processes of deciding when to intervene therefore all warrant further investigation and are topics that will be later revisited during discussions of the questionnaires and interviews.

It is both interesting and of note that attacking staff accounted for the longest periods spent in seclusion, especially since attacking staff or attacking patient each involve a victim. Studies have suggested that female patients are more likely to attack females and males patients more likely to attack males (Daffern et al., 2003), although for this study, the gender of staff victims were not known. Few, if any studies, have compared the severity of intentional injuries inflicted on staff and patients (Daffern et al., 2003). Furthermore, studies examining staff injuries do not always distinguish between those injuries arising from patient violence and those resulting from accidental injury during coercive intervention (Daffern et al., 2003) While seclusion should not be used for punitive reasons, studies have reported staff feelings of fear, abjection and thoughts of punishing those patients who are continually challenge ward rules and boundaries (Jacob et al., 2009; Sequiera & Halstead, 2004). Questions are therefore raised and further investigations required, into whether there are any differences in the extents of staff and

patient injuries; whether staff are attacked any more frequently than patients, whether those injuries are any more severe when sustained by staff or patients and whether longer periods spent in seclusion might be related to fear, abjection, and perhaps more importantly as punishment.

In light of earlier discussions surrounding institutional overrepresentation of black and ethnic minority groups within psychiatric services, it is interesting to note that patients of 'non-white' ethnic backgrounds were more likely to be secluded for attacking staff than patients of 'white' ethnic backgrounds. Studies suggest that young black men continue to be perceived as being more dangerous, often even when their behaviours mirror those of young white men (Hillbrand & Hirt, 1988; Moodley & Thornicroft, 1988; Singh et al., 1998; Spector, 2001). Keating & Robertson (2004) suggest that prejudice and misunderstanding fuel 'circles of fear' between black and minority ethnic communities who access psychiatric services and staff who work within psychiatric institutions. This is supported by multiple authors who propose that misconceptions often lead to 'fear-punitive cycles' whereby patients' fear of services and staff fear of patients result in limited engagement and greater restrictions, each impacting upon care and treatment (Bhui et al., 2003; Keating & Robertson, 2004; Leese et al., 2006; Vinkers et al., 2010). Greater work thus needs to be done in exploring how these institutional attitudes and practices might be challenged and changed, how unmet needs might be met and moreover how these institutional cycles can be broken (Bhui et al., 2003; Keating & Robertson, 2004; Leese et al., 2006; Vinkers et al., 2010).

RAPID TRANQUILLISATION

GENDER

Findings from this study revealed that more female patients were rapid tranquillised than males when proportions of male and female patients were controlled for. Of those rapid tranquillised, female patients were also rapid tranquillised more times. One female was rapid tranquillised a total of 41 times over the one year study period. These findings confirm the general assertion that females experience coercive measures more frequently than males (Ahmed & Lepnurm, 2001; Mason, 1998; Pannu & Milne, 2008).

In light of guidelines calling for a reduction in the use of coercive measures, using only the least restrictive measures where possible, the use of rapid

tranquillisation poses associated complexities. Rapid tranquillisation given via intramuscular administration is most often enforced under physical restraint (Currier, 2003; Jarrett et al., 2008). Furthermore, close observations are required post rapid tranquillisation due to serious risks of side effects, thus adding towards the number of interventions used (Currier, 2003; NICE, 2005; RCN, 2006). Rapid tranquillisation is arguably more invasive than other modes of coercive intervention, not only because it involves forcibly injecting an individual but also the co-occurrence of at least one other method of restriction and/or monitoring (Currier, 2003; Jarrett et al., 2008). Despite such invasiveness, staff in a state forensic hospital in the USA report preferences towards using rapid tranquillisation over other coercive interventions (Klinge, 1994). Cross-cultural comparisons of coercive measures used between countries also cite the UK as using medication more frequently than those of other European countries (Raboch et al., 2010; Steinert & Lepping, 2009).

Given the differences in rates and frequencies of rapid tranquillisation used between male and female patients, and between countries, questions are raised as to whether different methods of coercive interventions might be associated with varying degrees of effectiveness under differing conditions; whether staff themselves have individual preferences for different methods and whether male or female staff perceive and experience such interventions any differently (Harris, et al., 1989; Klinge, 1994; Sequeira & Halstead, 2004). The scenarios, conditions and contexts of incidents therefore need also to be taken into consideration alongside the choice of coercive measure itself. These are factors and influences that will be later explored during discussions of questionnaire and interview findings.

REASONS

Reasons for administering rapid tranquillisation were divided into four categories according to hospital records pertaining to; 'disruptive and threatening behaviour', 'self-harm', 'violence to fellow patient' and 'violence to staff'. Self-harm and violence to staff were the most frequent reasons recorded for the use of rapid tranquillisation. These findings at first glance suggest probable differences in the indications for the use of seclusion and rapid tranquillisation, given that the reason for using seclusion was largely recorded as threatening behaviour. Whilst these findings suggest possible differences, such indications should be taken with caution. Differences in

reason were assigned to the indications for using seclusion and rapid tranquillisation within the hospital. Self-harm is not an indication for using seclusion within the UK (Department of Health, 2008). These figures do not take into account the wider differences between the wards, such as staff variables, whether or not staff gender and gender ratios between staff and patients might also influence staff perceptions of threat and safety. In addition, staff confidence or preferences in the use of particular coercive measures might alter their frequencies in use. These influences each require further analyses and exploration.

STANDARDISED QUESTIONNAIRES

Given the differences in rates and frequencies of coercive measures experienced by male and female patients, the decision was made to focus on a single sex patient population to avoid any gender bias. The male patient population was chosen as this gave a much larger sample. Amongst this sample, four wards from the Mental Health Directorate were selected, in accordance with the four stages along the treatment pathway, namely; admission, Intensive Care, treatment and pre-discharge. Through sampling these four wards, any relationships between attitudes and ward function might be compared. Furthermore, by selecting a male only patient population, findings might be more comparable with those of the other high secure hospitals within the UK.

The Attitudes Towards Aggression Scale (ATAS), Attitudes to Containment Measures Questionnaire (ACMQ) and Essen Climate Evaluation Schema (EssenCES) have all been previously standardised and validated for use within psychiatric settings (Bowers et al., 2004; Howells et al., 2009; Jansen et al., 2005; Schalast et al., 2008). Whilst detailed, these questionnaires were considered neither too invasive nor demanding of staff and patient time. The ATAS was designed specifically to measure staff perceptions of five types of aggression, namely; offensive, destructive, intrusive, communicative and protective (Jansen et al., 2005). The ACMQ was designed to measure both staff and patient attitudes and experiences of eleven different containment methods; each of which are used in at least one European country (Bowers et al., 2004). The EssenCES questionnaire was designed to measure staff and patient experiences of ward atmosphere with regards to patient cohesion,

experienced safety and therapeutic hold (Howells et al., 2009; Schalast et al., 2008). Findings from each of these questionnaires will be discussed in turn.

ATAS

Findings from the ATAS questionnaire revealed no significant differences between male and female staff. Neither were there differences between ward-based and non-ward based staff, although this possibly reflects the small numbers of non-ward based staff taking part in the study. Overall, staff most often perceived aggression as being a destructive type of behaviour, although aggression was least often viewed as being communicative. While there is a lack of comparable studies using this scale within secure hospitals, these findings are in support of studies where this scale has been used within non-forensic psychiatric services (Jansen et al., 2006; Jonker et al., 2008).

It is perhaps unsurprising that staff view aggression negatively, and particularly destructively, since it is staff who are required to manage and deal with such behaviours that not only place themselves, but also colleagues and other patients at risk. Where comparing findings between the four wards, staff working on the pre-discharge ward scored aggression as being offensive and destructive more so than staff working on the other three wards. In contrast, staff on the treatment ward perceived aggression as being significantly less intrusive than staff working on the other three wards. These findings indicate differences in attitudes depending on the type of ward on which staff predominantly work.

The role of the pre-discharge ward is to accommodate patients who are assessed as nearing the completion of their treatment programme at the high secure hospital and at the stage of being ready to move on to a medium secure unit. Staff would therefore expect less patient aggression at this stage of a patients' treatment pathway, since any acts of aggression at this stage would not only be detrimental and destructive to ward function and atmosphere, but would also hinder the patient's progress and discharge from the hospital. Similarly, the role of the treatment ward is to provide continuing care for those patients with longer-term challenging behaviours. Patients on this ward are likely to have been residents for longer periods of time, thus regarded as having greater awareness of ward rules and boundaries. Staff, having had greater time in getting to know patient individually, coupled with

patient understanding of ward rules and boundaries, perhaps each result in less aggressive behaviours and attitudes towards aggression as being intrusive (Ahmed & Lepnurm, 2001; Beck et al., 2008; Fluttert et al., 2010; Pannu & Milne, 2008; Thomas et al., 2009). Given time, staff are perhaps better able to identify and recognise patient triggers for aggression as well as techniques for effective individual patient de-escalation (Fluttert et al., 2010; Olofsson & Norberg, 2001). Staff may also feel less threatened by those aggressive behaviours from whom they know well, each contributing towards such acts of aggression being viewed as less intrusive (Fluttert et al., 2010; Olofsson & Norberg, 2001).

An alternative interpretation of these findings might be associated with fear, anger and expectations. Staff working on the pre-discharge ward might perceive aggression as being most offensive and destructive given the time and investment taken to 'rehabilitate' patients to this stage of care. The pre-discharge ward is based outside of the main hospitals building with lower staff-patient ratios and so these higher scores might, to some degree, be associated with fear. Were an incident to occur on this ward, not only would there be fewer resources to manage aggression, but greater time would be taken for staff to arrive from the main building. These scores might therefore be associated with anger, fear and frustrations, which will be further explored during the analysis of interviews.

While previous studies have suggested that staff role, education and experience might influence staff attitudes and experience (Exworthy et al., 2001; Jansen et al., 2006; Klinge, 1994), no significant differences were found between staff attitudes and experience or staff levels of education. Perhaps this lack of significant findings again reflect the relatively small numbers of participants taking part.

ACMQ

STAFF

Findings from the ACMQ revealed that staff perceived intermittent observations, time out and use of prn medication as being the most acceptable types of containment measure, whilst the use of a net bed, open area seclusion and mechanical restraint were equally ranked the three least acceptable methods. The scores for the top three most acceptable

containment measures are comparable to previous study findings, however, previous studies found open area seclusion to be greatly more acceptable than those scored within this study (Bowers et al., 2004; Bowers et al., 2007; Muir-Cochrane et al., 2009). Such differences may reflect the study setting as well as participants, since previous studies have largely been conducted within general psychiatric settings, amongst psychiatric clinicians who may or may not have had forensic experience (Bowers et al., 2004; Bowers et al., 2007; Muir-Cochrane et al., 2009). Furthermore, such findings appear to be indicative of staff familiarity with such methods; being reflective of hospital culture, institutionally accepted practices and norms (Bowers et al., 2004; Bowers et al., 2007; Muir-Cochrane et al., 2009). Net beds are not used within the UK. Mechanical restraint is a fairly new phenomenon having only been reintroduced to the hospital as a whole over the past year prior to data collection and there is currently no hospital policy for the use of open area seclusion.

The finding of the net bed, open area seclusion and mechanical restraint being equally undesirable is of particular note; especially surrounding calls to use 'the least restrictive measure' (Department of Health, 2008; Harris et al., 1989; NICE, 2005). Questions are raised as to why these methods are considered least desirable; whom they are least desirable and indeed least restrictive for. The net bed and mechanical restraint, for example, might be justified in being considered the most restrictive method for a patient given the lack of freedom of movement afforded to patients contained by each of these methods. Open area seclusion however, is arguably lesser restrictive for the patient of the three methods, although perhaps more demanding of staff. Open area seclusion requires a staff member to observe and to be in close proximity to the patient at all times (Bowers et al., 2004). In the event of violence or aggression, this close proximity to patients places staff at increased risk of potential physical injury. Where staff are reported to both fear and abject forensic psychiatric patients, this close proximity may further heighten staff anxieties, thus requiring greater emotional work in managing these feelings whilst maintaining a professional persona and the outward appearance of coping (Haas, 1977; Hochschild, 1983; Jacob et al., 2009; Jacob & Holmes 2011a; 2011b). The physical and emotional effort of both staff and patient in experiencing each of these containment methods therefore need to be considered in contemplating what might be deemed the least restrictive

method while weighing up the physical and emotional costs of employing these interventions.

With the exceptions of the net bed, open area seclusion and mechanical restraint, familiarity with the containment measures was positively associated with staff scores of acceptability in their use. Staff who had experience of using those containment measures depicted, were more likely to score them as being more acceptable than those staff who had not used them. This is in support of the study's research hypothesis. These positive associations between experience and acceptability have been proposed as being due to containment measures being perhaps less unpleasant and restrictive than generally perceived (Harris et al., 1989). Staff may have become habituated or institutionalised into perceiving these methods as being more acceptable (Harris et al., 1989; Lawrence et al., 2009). Furthermore, staff who use, authorise or employ these containment measures may score them as being more acceptable by way of seeking justification for their actions (Exworthy et al., 2001; Harris et al., 1989; Lawrence et al., 2009).

The associations between institutionalisation, justification of actions and acceptability is supported by the finding that physical restraint was scored as being significantly more acceptable amongst staff working on the admission and Intensive Care wards than the treatment and pre-discharge wards. Due to the nature of the admission and Intensive care wards; the challenging patients that they contain, coupled with the assertions that younger, more newly admitted patients most frequently require containment, there is an inherent expectation that containment measures would be more frequently required (Ahmed & Lepnurm, 2001; Beck et al., 2008; Pannu & Milne, 2008; Thomas et al., 2009). These expectations become part of the accepted rules, norms and practices of these wards (Lawrence & Suddaby, 2006; Lawrence et al., 2009). In turn, staff expectations, attitudes and actions become intertwined; thus mutually forming and reinforcing the ward culture of what is acceptable (Lawrence & Suddaby, 2006; Lawrence et al., 2009).

PATIENTS

Patients ranked use of prn medication, time out and intermittent observations as being the three most acceptable methods of containment. Compulsory intramuscular sedation, mechanical restraint and use of a net bed

were ranked least acceptable. No significant differences were found between patient scores across the four wards, indicating less variance in patient perceptions than those of staff.

Patients' rankings of the three most acceptable containment measures are interesting given that they refer to different types of containment, neither of which require physical contact nor involuntary interventions. This is in keeping with other study findings where patients value respect, privacy and procedural justice where coercion is deemed necessary and patients are given opportunities and responsibilities to share in the decision-making processes surrounding their care (Brunt & Rask, 2007; Harris et al., 1989; Keski-Valkama et al., 2010; Olofsson & Jacobsson, 2001; Olofsson & Norberg, 2001).

Where forced medication by way of intramuscular sedation has been previously discussed as being complex and most likely involving more than one coercive intervention, prn medication as depicted within this questionnaire has emphases in being 'accepted voluntarily' and as such is less intrusive and more of a consensual arrangement. The symbolic meaning of agreement and compliance rather than necessarily the treatment effects of medication and coercive interventions are therefore perhaps of greater importance and value in determining the least restrictive outcomes from a patient perspective (Brunt & Rask, 2007; Harris et al., 1989; Keski-Valkama et al., 2010; Olofsson & Jacobsson, 2001; Olofsson & Norberg, 2001).

Patient scores of voluntary interventions being more acceptable than involuntary interventions is hardly surprising given the institutional sanctions and emphases on security imposed on them already. Time out as the next most acceptable option, described as a 'patient asked to stay in a room or area for a period of time without the door being locked' also suggests greater freedom than if a patient were to be secluded. While intermittent observation, described as including the 'allocation of responsibility to an individual nurse or worker' might be perceived as patients having greater time and contact with staff. Positive and therapeutic contact with staff are perhaps lesser known and experienced to patients given the often negative perceptions and attitudes towards them (Jacob & Holmes, 2009; Jacob & Holmes, 2011a; 2011b). Patient scores of acceptability of containment measures therefore appear to be related to choice, freedom and respect in being able to make decisions and opportunities to form relationships with

others (Brunt & Rask, 2007; Harris et al., 1989; Keski-Valkama et al., 2010; Olofsson & Jacobsson, 2001; Olofsson & Norberg, 2001).

STAFF & PATIENTS COMPARED

Where comparing staff and patient scores for acceptability of containment measures, significant differences were found between nine of the eleven containment measures; the exceptions being use of the net bed and open area seclusion. Staff scored the other nine containment measures as being significantly more acceptable than patients.

It is perhaps unsurprising that staff score these containment measures as being more acceptable than patients, since it is those patients considered 'deviants', in the theoretical rather than the pejorative sense, who are subject to such measures. Whilst staff and patients both experience the use of these containment measures, the "subjector" and the "subjectee" are likely to experience such methods in different ways. Patients, on the one hand, are subject to containment measures when they challenge the rules and boundaries of the organisation. Staff, on the other hand are obliged to enforce institutional rules and reinforce greater sanctions in the form of containment measures when patients do not conform. Patients who are considered "deviants" and rule-breakers and staff who are considered rule enforcers, therefore each experience containment measures from opposing sides. If staff are to work within such institutionally prescribed roles, they must first accept and accommodate such values and beliefs in order to sanction them effectively (Lawrence & Suddaby, 2006; Lawrence et al., 2009). Patients, in contrast, choose whether or not to conform to such institutional rules, however, failure to conform result in consequences and greater sanctions being imposed upon them. Already accommodated under the most extreme conditions of secure hospitals and already considered the most extreme of deviants, coercive measures are the greatest sanctions that patients will experience if they continue to break rules. Thus, in order for staff to work in secure settings, they must accept such institutional rules and expectations of them or leave. For patients however, who do not have a choice of whether or not to leave the hospital, they must choose to either behave and conform, or face the consequences of greater sanctions placed upon them. Those staff who accept these rules stay. Those patients who accept these rules behave. Those staff who do not accept these institutionally

prescribed rules may well be considered 'deviants' themselves within the organisation, and those patients who do not accept these rules may further be considered extreme 'deviants amongst deviants'. These conformers and rule-breakers therefore all work towards creating the internal organisational environment, working either with or against institutional norms. Such internal environments created, maintained or else disrupted by individuals each contribute towards the actions, experiences and uses of coercive measures (Lawrence & Suddaby, 2006; Lawrence et al., 2009). These will be further discussed through findings of the EssenCES questionnaire.

ESSENCES

STAFF

The EssenCES questionnaire was used to measure ward atmosphere, categorised by patient cohesion, experienced safety and therapeutic hold. Staff scored patient cohesion and experienced safety as being higher amongst the treatment and pre-discharge wards in comparison with the admission ward and ICU. No significant differences were found in scores between the four wards for therapeutic hold and scores were not related to gender. Where comparing staff scores with previous studies, staff scores on the treatment and pre-discharge wards tended to be higher than average with regards patient cohesion and experienced safety, whilst staff scores on the admission ward and ICU tended to be lower than average compared with previous findings (Schalast et al., 2008). While such findings are consistent with comparing staff scores across the four wards with Rampton Hospital, possible reasons for this need to be considered.

The treatment and pre-discharge wards are both regarded longer stay wards than the admission ward and ICU. For this reason, staff may score patient cohesion as being higher than average, perceiving patients as having greater opportunities to get to know one another and to build relationships over time. Staff may also feel safer over time since they have better knowledge and experience of the patients that they are required to work with (Ahmed & Lepnurm, 2001; Brunt & Rask, 2007; Fluttert et al., 2010). Where wards and the patients they contain remain constant, staff are likely to become habitualised to their environments (Brunt & Rask, 2007; Emirbayer & Mische, 1998). Routines, ward function, roles and ways of working become normalised, all contributing towards feelings of safety and security (Brunt &

Rask, 2007; Emirbayer & Mische, 1998; Scott, 2001). Over time, these staff and longer stay patients become institutionalised to their environments (Emirbayer & Mische, 1998; Lawrence et al., 2009; Scott; 2001). In a sense, these staff and patients become desensitised to the things that they once might have felt uncomfortable with, thus accepting everyday occurrences as being the norm without question (Emirbayer & Mische, 1998; Lawrence et al., 2009; Scott; 2001).. This sense of being at greater ease with ones environment over time, perhaps also contribute towards the higher scores amongst those staff working on longer stay wards.

The ICU and admission wards in contrast might be considered more volatile and unpredictable. Indeed, findings from the hospital data reveal uses of seclusion to be significantly higher amongst the ICU and admission wards in comparison with the treatment and pre-discharge wards respectively. The relatively constant changes to patients on these wards perhaps contribute towards a lack of consistency in ways of working. As a result, staff on the ICU and admission wards perhaps do not become habitualised in the same way as those working on treatment and pre-discharge wards due to the continual changes in environment in which they work. This lessened opportunity for habitualisation along with the potential for greater harm in the managing of incidents, perhaps contribute towards greater emotional work and lower scores of perceived safety and patient cohesion amongst staff working on the admission ward and ICU since staff are constantly challenged to adapt to changes in ward dynamics.

In addition to the above being potential influences on the lower scores for patient cohesion, the ward regime on the ICU is somewhat stricter than other wards within the Mental Health Directorate due to greater emphases on safety and security. Patients are expected to spend more time together through doing ward activities as a whole. Expectation rather than choice may in itself be a contributing factor to lower scores. The aim of the ward is to manage patients during acute phases and is thus seen as a short term requirement. The admission ward is similarly a place for shorter admissions, where patients are potentially admitted either through the courts, prisons or from other hospitals for periods of assessment. Again, this ward might be viewed as volatile and unpredictable due to the acute phases of patient admissions and lack of knowledge and experience of working with these patients as individuals. Patients on each of these wards are perhaps perceived

as investing less into relationships during this time, either as a result of their mental state preventing them from doing so, or as a result of the ward being viewed as too volatile a place for relationships to be formed. Perhaps where patients are perceived as being dangerous and as deviants at their most extreme, less emotional investments are made into working with such patients either intentionally or unintentionally (Batillana & D'Aunno, 2009; Emirbayer & Mische, 1998; Lawrence, Suddaby & Leca, 2009). Not only are patients accommodated on these wards as a short stay measure, but staff may also physically and emotionally detach themselves by way of self-preservation (Hochschild, 1983). Where this occurs, scores for patient cohesion will be lower, reflecting the greater emotional efforts and institutional demands placed upon staff working within the ICU and admission wards.

PATIENTS

Significant differences were found in patient scores of experienced safety between each of the four wards. Patients on the treatment and pre-discharge wards scored experienced safety as being significantly higher than those patients on the ICU and admission wards respectively, indicating that patients residing on the treatment and pre-discharge wards felt significantly safer than patients on the ICU and admission wards according to the EssenCES scale. Where comparing these scores with those of patients from previous studies, patients on each of the four wards were found to score experienced safety as being between average to higher than average (Schalast, 2008). No significant differences were found between patient scores of patient cohesion, or therapeutic hold across the four wards.

Perhaps patients feel safer on the treatment and pre-discharge wards due to having spent longer periods of time on those wards. Where comparing these findings with incidents of seclusion on the wards, the number of incidents requiring seclusion were significantly higher amongst the admission ward and ICU in comparison with the treatment and pre-discharge wards. Only one incident of seclusion was recorded on the treatment ward over the one year study period, whilst no incidents on the pre-discharge ward were recorded since the pre-discharge does not have seclusion facilities. There were no significant differences in reasons for seclusion between patients attacking fellow patients and patients attacking staff. Whilst patients on the admission and ICU wards may not necessarily be involved in seclusion incidents per se,

patients were therefore still likely to have been victim to patient attacks or been witness to such incidents at some point during their stay, thus impacting upon patient perceptions of safety.

STAFF & PATIENTS COMPARED

Where comparing staff and patient scores for ward atmosphere, patients were found to score patient cohesion and experienced safety significantly higher than staff; indicating that patients perceive both ward environment to be more supportive and safer. Staff however, perceived ward environment as being more therapeutic than patients. These findings are in support of previous studies, although there is an apparent paradox between those 'being controlled' seeming to feel more at ease than those doing the 'controlling' (Martin, 1984; Schalast, 2008).

Patients perhaps perceive patient cohesion more favourably than staff as a result of micro-communities formed amongst deviants themselves (Becker, 1963; Lemert, 1951). Becker (1963) proposed that while rule-breakers might be considered outsiders and deviants amongst the majority, these deviants in turn find roles for themselves within deviant spaces. These roles are comparable to those of wider communities and society as a whole (Becker, 1963). Patients perhaps feel safer than staff in this environment for the reason that they are deviants within their own deviant community. Not only are they shielded from the outside world where their extreme deviant status would be more apparent, but also, because it is the staff, rather than other patients that have to deal with, manage and control any rule-breaking behaviours. Within the confines of the high secure hospital, the onus of responsibility is shifted from the patient to staff in dealing with, managing and controlling any rule-breaking behaviours. Staff are bound by institutional expectations and are required to actively manage their personal and professional selves within the workplace. Although patients are expected to conform to institutional rules or else experience the consequences of coercion, within the confines of the restrictive regimes of a high secure hospital, patients are passively subject to the institution, while staff hold professional, legal and ethical duties in their roles as healthcare workers and security agents. The expectations of staff to maintain institutional rules and boundaries are not only demanding in terms of levels of responsibility and emotional effort but also in terms of risk of harm and injury in managing

incidents. Even during coercive interventions and security procedures, staff are expected to perform their duties in a therapeutic manner, etched within their roles as healthcare professionals. Staff experiences of their roles in working within a high secure hospital; managing security, care and conducting coercive measures will therefore be explored throughout discussions of interviews with staff.

INTERVIEW ANALYSIS

From the interviews with staff it is apparent that working within a high secure hospital environment is both physically and emotionally demanding. While staff are trained into the institutionalised processes of security procedures, assessing risk and managing violence and aggression, these practices do not sit comfortably with their roles as healthcare professionals. Staff highlighted recurring conflicts and tensions between their personal and professional selves; revelatory of the levels of the institutional and emotional work undertaken on a daily basis. The conflicting roles, values and identities were most often apparent where institutional and emotional work were at a peak; most notably during the management of incidents requiring the employment coercive measures. The influences upon the institutional and emotional work undertaken by staff will be explored and discussed at three levels; the institution, organisation and the individual.

THE INSTITUTION

At the institutional level, staff frequently made distinctions between the 'inside' and 'outside', referring to those who make assumptions with regards to what happens within secure hospitals in contrast to those who have real lived experiences. Such divisions between the inside and outside contribute towards several themes; i) the notion of a 'total institution' (Goffman, 1961); ii) staff knowledge, experience and expertise; and iii) the legitimisation, reinforcement and reproduction of the institution and its inherent values.

THE TOTAL INSTITUTION

The distinctions made by staff between the inside and outside of the institution draw attention towards what Goffman (1961) would refer to as a 'total institution'. This total institution is not only apparent in the physical sense of the hospital being surrounded by prominent high fences, effectively shielding itself from those on the outside, but also through staff's sense of isolation from outsiders and what is often perceived by outsiders as the enigmatic nature of the work conducted within. Staff often spoke of not being able to speak to outsiders who do not understand their work and roles, and also of secure hospitals being mysterious places to those on the outside, with frequent misunderstandings of secure hospitals being prisons or places of punishment. Staff also highlighted the negativity through which the media

portrayed high secure hospitals and those residing within, along with the negative attitudes and lack of understanding from those of the public.

For those on the outside, where staff are unwilling or unable to talk about their work, the media is perhaps the most accessible source of information regarding secure hospitals that is readily available to the public. From informal conversations with staff, their fears of talking publically about their work appear to continue as a result of the hospital's previous scandal history, with the mistrust and suspicion of newcomers and outsiders being reporters remaining rife. This coupled with public fears conflated by the media, result in a deepening cycle of physical and emotional distancing, exclusion and alienation. Although the information portrayed by the media may neither be accurate, reliable nor representative of what actually occurs, the emphases and proliferations of dangerousness reinforce public fears and anxieties surrounding those deemed to require containment, as well as the hospitals constructed to contain them. Such perceptions of dangerousness, coupled with public fears, anxieties and apprehensions support and in turn create and legitimise the need for high secure hospitals, while the staff working within such organisations are expected to deal with, manage and contain such violent, dangerous and unpredictably deviant individuals so that the public do not have to.

High secure hospitals as means of social order and control, thus have the effects of both isolating 'deviants' as well as the staff employed to contain them. The physical separations of 'deviants' inside the hospital from 'non-deviants' on the outside foster the notion of 'out of sight, out of mind'. The societal negotiations and requirements for such institutions are maintained, whilst the expectations, responsibilities and demands placed upon those staff working within such organisations are easily overlooked and forgotten about. The public's distancing of deviants therefore not only has the effects of marginalising the 'mad, bad and dangerous' from wider society, but also in marginalising those individuals working within. As such, an increasingly isolated, insular community is created between patients and staff inside secure institutions as previously discussed in Chapter 1 and the notion of inside and outside adopted and maintained through the physical separation of the organisation behind high walls and fences (Becker, 1963; Goffman, 1961; Lemert, 1951; Martin, 1984).

Staff spoke of their specialised roles, expertise and knowledge of working in a high secure hospital as being twofold. On the one hand they were seen as those most specialised in working within secure hospitals and thus holding a degree of kudos and esteem within such organisations. On the other hand however, such specialist knowledge appeared to come at the price of feeling increasingly isolated, distanced and detached from others outside of the organisation. In becoming such specialised practitioners, staff frequently voiced the challenges they face in talking about their work to outsiders, and even to close family and friends. There was a real sense here that staff in their professional roles felt as closed off to the outside world as the patients they work with. In working with deviants, staff too inadvertently become deviants themselves; creating ironic parallels between the deviant roles of staff and patients within society. This stark realisation is perhaps a motivating factor for staff to remain working within an organisation where the rules, philosophies and practices expected of them may not always be agreeable with their personal values or training as healthcare professionals but which provides the safety of being 'somebody' rather than 'nobody'. The status afforded to those working in a high secure hospital reinforce justification of the coercive actions that staff perform and are expected to perform. The feelings of safety and security in remaining within the organisation are seemingly also associated with staff knowing their place, role and having some authority, rather than to risk working on the outside where their skills and knowledge are not necessarily required, desirable or transferable. Moreover, perhaps while there are fears and dangers of working within the potentially violent and hostile organisation, the fear of the unknown is greater than the fear of the known.

From a staff perspective, the challenges faced in talking about their work appears to be several-fold. At the forefront, there appears to be an apparent lack of understanding from those outside of the organisation. The actual difficulties in talking about their emotions and emotional challenges in working in such an environment may also be attributed to the institutional demands and expectations of staff to maintain public order and safety, in a way that to reveal any emotional distress might be seen as to reveal some kind of 'weakness' or fallacy in coping with such a specialised role, coupled with a fear of losing this status. An internal investigation occurring during the time of these interviews, served to reinforce staff fears of needing to follow

strict institutional orders and the fallibility of this status where tightly governed rules are disobeyed. Staff may feel a duty to protect the public not only from the people that they work with but also from the emotional work and actions they engage in. Finally and ultimately, staff are duty bound by their profession not to breach the confidentiality of those that they care for, manage and contain, and as such their very profession requires of them a degree of discretion surrounding their work. The fears and anxieties surrounding their roles, responsibilities and justifications for their actions may stem not only from the ongoing traumas of investigations and constant public scrutiny but also from the continued levels of strong governance resulting from such inquiries (Martin, 1984). These factors all contribute towards the emotional work conducted by staff in managing such stressors and emotions, either internally or collectively with colleagues and other staff who understand.

INSTITUTIONAL LEGITIMISATION, REINFORCEMENT AND REPRODUCTION

Where staff seek the mutual support and understanding of fellow colleagues, relationships and support systems are formed within the organisation. In this sense, the organisation becomes exclusive and partially 'closed' to the outside world since such mutual understandings between staff can only be appreciated through their specialised roles and shared experiences. Each of these factors then arguably have the effects of legitimising and further maintaining the ideologies of the institution, the isolation and the internal workings of the organisation. The media's conflated ideas of dangerousness coupled with staff inabilities to talk about their work to outsiders renders the public reliant upon the media as their only source of information regarding high secure hospitals. This in turn results in the perpetuation of the enigmatic yet perilous nature of high secure hospitals and of the people that they contain. Staff themselves in feeling like 'outsiders' in the outside world become alienated and estranged, instead seeking the support of their colleagues and as such reinforce the organisation as specialist, unique and detached. The internal culture of the hospital remains concealed, emotions remain hidden and actions of containment and coercion continue relatively without question. Thus, this cycle of mystery, enigma and exclusivity all work conjointly towards creating, preserving and maintaining the legitimacy of the forensic psychiatric institution and high secure hospital organisation without

questions and exposure to and from the outside world (Martin, 1984; Lawrence & Suddaby, 2006; Lawrence et al., 2009).

THE ORGANISATION

Institutional work at an organisational level appears to serve two primary functions. Staff most notably refer to that of organisational structure relating to the order of the organisation, and that of organisational role relating to that of order within the organisation. Staff spoke of the order of the organisation in terms of the hospital's governance, professional role and training. Order within the organisation in contrast was spoken about by staff in terms of how such structures, rules and practices are abided by, practiced and maintained. Whilst the order of the organisation is largely dictated by the institution and organisation itself, order within the organisation is therefore largely influenced by the actions of those within; each recursively influencing the other. Each of these will be discussed in turn.

ORDER OF THE ORGANISATION: STRUCTURE, HIERARCHY, ROLE

Staff frequently referred to secure hospitals as being unusual places, often being misunderstood and mistaken for prisons, with staff themselves being challenged in balancing care with the security arrangements expected of them. Staff regularly spoke of the security requirements taking a priority over nursing, with security measures dictating the care and treatment given. Given that secure hospitals were created since both prisons and psychiatric services were deemed insufficient places for those considered 'mad, bad and dangerous', it is perhaps unsurprising that such confusions are apparent, particularly to those on the outside. What these challenges also illustrate however, are the underlying conflicts, tensions and dilemmas internal to an organisation constructed of pluralistic disciplines, namely; legal and psychiatric systems regulated by the Home Office and NHS. While the Home Office has a major role in the security arrangements of secure hospitals, legal and penal systems, the NHS should instead hold priorities in care. In taking over the ownership and management of the hospital however, staff were noted to criticise the NHS in overemphasising the role of security in place of care, such that nursing became secondary to safety and security.

For staff from healthcare backgrounds to be working within a hospital setting where security measures are required, dissonance is created between general expectations and actual institutional practices. As Kraatz and Block (2009) state: “pluralism in the institutional environment has the effect of creating *persistent internal tensions* within the individual organisation itself. Contending logics interpenetrate the pluralistic organisation, and different people within its boundaries project different identities and purposes upon it” (p 71). The tensions and conflicts arising from working within a pluralistic institution is revelatory of the work and effort required by individuals in attempting to bridge the legal and psychiatric disciplines. While the overall institution and organisation remains relatively stable through the dominant regulative mechanisms of the hospital’s governing bodies, the individuals working within the organisation similarly hold influences on the internal workings of the organisation that each work towards influencing whether institutions are created, disrupted or maintained (Lawrence & Suddaby, 2006; Lawrence et al., 2009).

The majority of staff working within the hospital are of healthcare backgrounds and seemingly identify themselves as such. Once employed by the hospital however, staff are required to undertake various levels of training in the management of violence and aggression. Staff of different professional roles are braced with different expectations, such that ward-based staff are required to undertake the higher levels of training, while non-ward-based staff would only be required to undertake basic level training. Levels of training, associated staff roles and expectations all appear to influence and be influenced by institutional work. Indeed levels of training, the types of wards on which staff work as well as the frequencies of which they are required to conduct coercive measures appear to be associated with kudos and esteem. Staff distinctions made between those who restrain and those who do not, is comparable to those distinctions previously made with regards insiders and outsiders; those who have experienced and therefore understand, in comparison with those who have not experienced and therefore considered unable to understand and appreciate the role, responsibilities and processes of being called upon to contain violent incidents. Despite the act of conducting coercive measures being within the organisation, the notion of insiders and outsiders within the institution therefore remains and the concept of institutions within institutions and

deviants amongst deviants, suitably applied here (Becker, 1963; Lemert, 1951).

Ward-based, or otherwise termed 'direct care staff' included nurses and nursing assistants whose time are largely spent on the wards with the greatest responsibilities in maintaining institutional rules, boundaries and control. Non-direct care staff in contrast include psychologists, social workers, occupational therapists and responsible clinicians; those who spend time on the wards but are not based on the wards as such. Whilst the psychologist viewed their lack of involvement in coercive measures as being a positive factor in being prevented from difficult situations where detention and control versus therapy conflict, there is the sense that nurses and nursing assistants are then left to do the 'dirty work'; work that is expected, necessitated, and required but not one that anyone likes to do. Furthermore, there is an irony in that those who spend most time with patients are also those whom enforce the greatest sanctions upon them. These sanctions serve to reinforce not only the levels of security and control involved in staff's individual roles but also collectively as an organisation and, more broadly, an institution.

Staff identified status and esteem as being associated with their professional role as well as by the ward in which they are located within the hospital. Ward function and the patients they are designed to contain each serve to support, create and legitimise staff kudos, status and hierarchy within the organisation. Staff working on the ICU for example, frequently stated they were working with 'the worst of the worst'. Those on the pre-discharge ward however, were not only located outside of the main block and without seclusion facilities but were less restrictive since the pre-discharge wards serve as the last staying point within the hospital prior to patients being discharged and transferred to lower secure services.

Ward functions as well the physical localities in which staff are based therefore seemingly preserve these notions status and hierarchy further. The physical environment of working and being based within the 'main block' of the hospital was often referred to as the 'inside' and therefore seen as the most restrictive and highly controlled part of the hospital. Those located outside of the main block however, are seen as less restrictive both physically and in ward function amongst the Mental Health Directorate. Whilst the

majority of the nursing staff interviewed were located within the main block of the hospital, the doctors, social workers and psychologists were located on the 'outside'; serving to reinforce the distinctions and elite statuses of those who are required to conduct restraint and seclusion. Not only were non-ward based staff therefore considered outsiders in terms of their role and not having to physically conduct coercive measures, in addition, their offices were also located on the outside. Institutional influences and expectations upon staff role and ward function therefore seem to work conjointly with staff actions in mutually reinforcing such status and hierarchy within the organisation.

ORDER WITHIN THE ORGANISATION: BOUNDARIES, RULES, CONTROL

In order to work within an organisation of such highly structured practices, rules and boundaries, staff are seemingly first required to accommodate the values and philosophies of the institution in order to perform their duties effectively. Through the language of 'knowing', 'knowledge' and 'experience', staff talk about accommodating the institution in terms of internalising organisation values; taking on the rules, principles and norms of the institution in order to work there. The power of the institution, institutional values and practices were very much apparent during the interviews where staff would tentatively question yet justify the ways of the institution. There was very much the sense that staff must believe in the values of the institution in order to perform the actions expected of them within such a highly regimented organisation, even though this often required staff to put their personal feelings and morals to one side whilst adopting a work identity, much in common with Hochschild's writings on emotional labour (Hochschild, 1983) Placing the values of the institution in front of one's own requires great effort, institutional and emotional work (Hochschild, 1983; Lawrence & Suddaby, 2006; Lawrence et al., 2009). While both institutional and emotional work are invariably interlinked, institutional work in this context may refer to the internalisation of institutional values, whilst emotional work may refer to the displacement of personal feelings in relation to the work required of staff (Hochschild, 1983; Lawrence & Suddaby, 2006; Lawrence et al., 2009).

Through the internalisation of organisational values; becoming institutionalised and accommodating institutional rules and boundaries, staff are expected to enforce such rules on each of the wards. Throughout the

interviews staff refer to staff and patient knowledge and awareness of organisational rules, boundaries and expectations as being important in upholding and maintaining such structures, ward functions and routines. Staff refer to the concept of 'knowing'; relating to both staff and patient knowledge and awareness of organisation rules, values, boundaries and expectations. In applying organisational routines, rules and boundaries to the workplace, indeed these are only relevant if individuals are aware of them. However, despite staff attempts to establish 'firm boundaries', staff describe differences in ward boundaries as collective phenomenon as well as differences in staff boundaries individually. While there is an overarching organisational structure imposed through policies and procedures, ward boundaries are invariably established and maintained by the staff working within.

The variations between wards boundaries are therefore revelatory not only of the differences in ward roles and functions, but also of individual staff values and the patients they contain. According to Hochschild's (1983) theory of emotion work, these differences may be indicative of the degrees of detachment from personal feelings and values, namely, whether individual members of staff are surface acting, or whether they have become so deeply detached from their personal feelings and values that institutional rules and expectations have come to dominate their working life resulting deeper level acting. This personal dimension highlights the inescapable nature of an individual's personal self amidst those institutional demands placed upon them, whilst working within such a highly controlled environment. The differences that staff identified between institutional boundaries and individual levels of acceptability and tolerance, perhaps not only reflect individual challenges in maintaining organisational expectations of order and control, but also the challenges of conducting institutional and emotional work. Whilst it would be difficult to establish or indeed measure how much institutional and emotional work is required by staff performing such roles, it is nevertheless evident that such work and effort is demanded of staff.

Where staff personalities and individual levels of tolerance were identified as influential factors to the enforcement of rules, these may be seen as subtle disruptions to the overarching ward level boundaries, creating variances in ward rules whilst tentatively challenging those dominant organisational values. The 'pushing of boundaries' similarly highlight the role of patients in negotiating control, resisting and disrupting organisational arrangements.

While the institution imposes its own set of values, norms and beliefs, the organisation itself therefore has the role of establishing these through governance, policies and procedures. Staff in turn are expected to maintain these rules through the enforcement of patient boundaries and patients are expected to behave in certain ways as to abide by these rules, norms and values. The tensions and relationships between social control and deviance may therefore be seen as mutually interactive (Foucault, 1978; Cohen & Scull, 1983). Where organisational expectations and individual values and actions are misaligned, individuals are shown to resist and disrupt such institutional norms and expectations. Staff may do this through establishing subtle shifts in ward boundaries, rules and routines, while patients may behave in ways they know are outside of what is expected of them; each culminating in decisions as to whether or not to enforce coercive sanctions.

THE INDIVIDUAL

It is at the individual level where institutional and emotional work can be seen and identified most readily through staff discussions and revelations about their own personal experiences of working within a high secure hospital and being called upon to conduct coercive measures while balancing care, safety and security. Staff describe processes of developing routines and rituals as methods of coping, becoming detached from their work in order to perform actions and practices expected of them by the institution that are in contention with their personal ideals while masking their personal fears and anxieties in order to conform, all of which take their toll upon staff members. Each of these will be discussed in turn.

ROUTINES, RITUALS, DETACHMENT AS COPING

Throughout the interviews staff refer to the use of coercive measures as a 'necessary evil', used as a 'last resort' when they are left with 'no other option'. This highlights the use of coercive measures as the greatest sanction enforced within this already highly controlled environment. Such necessities seem revelatory of staff emotions surrounding such practices, feeling as though they have no choice but to enforce such levels of control in maintaining safety and security. The concept of not wanting to conduct a task but feeling forced and duty bound to have to, is indicative of the levels of institutional and emotional work staff are confronted with when managing

incidents and conducting coercive measures. On a personal level, staff appear to feel uncomfortable with the idea of using coercive measures, however, the alternative would be to condone violence and risk further injury to the self, staff and other patients. As a result, staff instead develop routines and rituals to manage such work.

JP Martin (1984) writes about the challenges staff experience when called upon to conduct actions so at odds with their perceivably caring roles. The processes by which staff seek justifications for their actions might be interpreted as expressions of institutional and emotional work. Staff speak of 'switching on and switching off' from their work roles as they walk through the fence into and out of work. This apparent change in role and mind set of leaving their personal feelings to one side seemingly illustrated the routines, rituals and processes by which staff perform institutional and emotional work; detaching and separating their personal selves from those required of them within their professional capacities. A degree of detachment appears to be required in order to satisfy professional expectations, with staff fostering routines and rituals in order to cope with the everyday demands the institution places upon them. Detachment not only from expectations but also from the fear and anxieties so that they can perform the roles, functions and methods of containment expected of them. The establishment of routines and rituals may represent staff attempts at becoming detached and dissociated from their work through habituation (Batillana & D'Aunno, 2009; Emirbayer & Mische, 1998; Lawrence, Suddaby & Leca, 2009). Habitualised actions are seen to require less work and effort since they become routinised in such a way that the actions and efforts required of individuals become diminished; they in effect become 'habits' requiring less thought (Emirbayer & Mische, 1998). The role of routines and rituals may therefore be seen as making work life easier for staff.

In undertaking institutional and emotional work through routinising and ritualising however, staff detach themselves from their personal values and risk objectifying the patients that they work with and supposedly care for. In creating rituals and objectifying their care roles, staff remove the sentiments of the patient and themselves as a person whilst distancing themselves from their work and actions. Whilst this division between the personal and professional self may be a coping strategy, professional duty and professional objectivity may also risk becoming a by-word for distancing and detachment

from personal feelings. The distancing of oneself from personal values may further serve not only to overcome the traumas of patient index offences and the conduct of coercive measures where patient behaviours challenge ward rules and boundaries, but may also serve to overcome those organisational values that conflict with one's own. Through objectifying patients and the care staff purport to provide, acts of coercion and containment become more readily accepted, condoned and justified. These justifications are enabled via the 'switching on and switching off' that staff describe, viewing patient accommodated in high secure hospitals as being 'the worst of the worst', along with policies which allow these coercive measures to be sanctioned. In this sense, rituals and routines each work together in not only detaching oneself from work effort but also in dissociating the self from having to maintain institutional and organisational rules where these conflict with those of the personal self. Through the examinations of routines, rituals and boundaries, the interrelations between staff, patients, organisation and institution are demonstrated. Staff detachment from their work through the establishment of routines and rituals may be viewed as coping strategies and methods of self-preservation. In detaching oneself from one's work and in prioritising institutional values over one's own, institutional values are accepted and maintained rather than being challenged; thus becoming enforced without question and preserved through ritualised behaviours and routine. Whilst it may be arguably easier for staff to go along with the dominant ideals of the institution, rather than risk being considered a 'deviant' within an already deviant organisation, the rules and values of the institution proceed to dominate and be maintained.

MASKING FEARS AND ANXIETIES

During the interviews, staff openly talked about the fears and anxieties they experience during the process of using coercive measures. Such fears, anxieties and apprehensions were particularly apparent during the initial phases of restraint, which were seen as the 'nearest thing to a fight', as well as during the process of reintegrating patients either from seclusion or segregation back onto the main vicinity of the ward. These times of particularly heightened emotions and perceived vulnerability by staff draw attention towards the levels of self-control that staff are required to engage in; reigning in their personal feelings and preventing these from getting in the way of their professional roles and responsibilities. Staff descriptions of

heightened emotions also point towards times when greatest dissonance is experienced between the personal and professional self; most notably when greatest effort is required in maintaining professionalism; controlling one's own personal emotions through increased institutional and emotional work and effort. This dissonance is also representative of the conflicts between their roles as healthcare professionals yet working in an institution where coercion and containment are condoned, reinforced, justified and professionalised.

The connotations of physical restraint being compared to a confrontation, fight, struggle and battle is suggestive of a time when staff emotions are at their peak, yet institutional and professional requirements dictate that personal emotions cannot enter the institutional arena or influence the use of coercive measures, thus being a time that requires the greatest emotional work from staff. Indeed, if a person was being attacked anywhere other than work, their instinctive reaction would be to fight or flight; an option which is not afforded to professionals working in this environment. Not only are staff required to maintain control of their own personal emotions during this time but they are also required to maintain the standards of their professional governing bodies and the institution they work for, thereby suppressing their own emotions whilst working towards maintaining the expectations and standards of the institution (Hochschild, 1983; Lawrence et al., 2009).

During these times, staff spoke of the importance of maintaining professional integrity towards colleagues and the need to demonstrate reliability and dependability since all staff rely upon each other for support; particularly during violent, aggressive and potentially dangerous incidents. Despite all staff speaking of incidents as being particularly chaotic, vulnerable and anxiety provoking times, they also felt apparently unable to talk about or reveal such feelings and emotions to their colleagues; instead masking and managing such feelings through banter, bravado and machismo. To demonstrate fear and aversion in managing incidents and employing coercive measures was seen to risk being shunned by colleagues as unreliable and undependable; being a deviant or outsider (Becker, 1963; Haas, 1977; Lemert, 1951). As a result, these emotions were often suppressed and shielded from colleagues at the expense of 'fitting in' and not becoming a 'deviant' in a place where deviants are commonplace. The paradox of this masked behaviour is that each of the interviewees expressed this fear and

concealment of real feelings, yet felt unable to reveal such fear and anxieties to their colleagues, in turn maintaining these cycles of fear, masking and hidden burdens.

Such bravado associated with their work and apparent coping with their role highlights distinctions between those hidden personal emotions and reactions of staff with those that are observable. The idea of the personal self and the displayed self is greatly in accordance with the theory of emotional work as previously discussed, while this sense of bravado and machoistic behaviour amongst staff is comparable to the study conducted by Jack Haas (1977) 'Learning Real Feelings'. Haas's (1977) study explored high steel iron workers' reactions to fear and danger, observing that these workers would often perform 'dangerous ballets' while playing towards an audience. Haas identified that within an environment that relies so heavily upon colleagues' and co-workers' trust and competency, 'it becomes necessary for them to make continuous demonstrations of their fearlessness in their work situation. To act afraid increases the dangers and reduces trust among workers whose security depends on such trust being developed' (Haas, 1977; 167). Displays of fearlessness, bravado, and confidence thereby serve to create and maintain a collective identity of staff working within institutionally prescribed norms; allowing coercive actions to be performed efficiently and effectively whilst being an insider who is supported and respected by colleagues (Becker, 1963; Haas, 1977; Lemert, 1951). It is the suppression of uncomfortable emotions which allows staff to work within an environment of fear driven anxieties and to perform coercive actions contradicting care. In suppressing one's personal emotions and allowing those of institutional order and control to dominate, the uses of coercive measures remain bearable, justifiable and permissible, despite such actions conflicting with one's personal values, real feelings and roles as healthcare workers. Great efforts are therefore required of staff in working on their personal emotions such that team camaraderie may be maintained; staff cohesion, team work and trust sought as a collective, and institutional work and actions managed and carried out in ways that are expected; each contributing towards the maintenance of institutional values and order.

The processes and acts of working within a secure environment, particularly where staff are required to manage incidents and implement coercive measures, involve complex processes demanding both the physical and emotional effort of staff. The expectations placed upon staff to engage in security measures; to contain violence and aggression and to employ coercive methods appear to have detrimental effects on their personal health and well-being over time. Staff describe their emotions as transient processes through which they learn to manage their personal feelings in order to work within a high secure hospital and to perform the tasks required of them. The daily challenges faced by staff were highlighted as working with patients they are called upon to contain, the safe conduct of coercive measures and the maintenance of safety and security in every day practices. Staff describe their roles as being several-fold; that of protecting the public, patients and colleagues. This sense of responsibility may be a motivating factor for maintaining institutional integrity and serve as reasoning and justification for the uses of coercion and containment. The experiences of isolation, sense of status and bravado each work towards reinforcing the importance of maintaining this institution, its internal structures and cohesion.

To work in a high secure organisation, staff must invest in the values of the institution or else their personal roles and the tasks they are called upon to perform would be deemed redundant (Lawrence & Suddaby, 2006; Lawrence et al., 2009). In order for their work to be considered meaningful, staff must then adopt the values and beliefs of the institution whom they work for (Lawrence & Suddaby, 2006; Lawrence et al., 2009). On the one hand, staff working in this hospital are isolated. On the other hand, in being isolated, the existing structures are not challenged. The culture of this environment is then not only to contain those within, but also to keep outsiders out. Deviants within the hospital are deemed deviants to those on the outside, yet those on the outside are perhaps equally seen as deviants by those working within. 'Outsiders' are seen as threats to this social order, and as such are challenged through processes of initiation (see page 97) before being accepted to work in this tightly controlled environment. Thus, the processes of institutional order, institutional control and institutionalisation are created, maintained and perpetuated, without the necessary exposures and influences from outsiders to allow the developments and progression required.

The very personal nature of staff emotions were accessed during the interviews, many of which revealed the emotional toll that staff experienced in dealing with and managing the feelings associated with their actions; particularly those of employing restraint, seclusion and segregation and the decisions made surrounding such actions. Staff frequently described a period of heightened emotions coupled with emotional blunting either concurrently or over time. Their heightened emotions tended to be associated with fear, adrenaline and automatic responses to volatile situations, whilst emotional blunting tended to seemingly occur through processes of detachment or desensitisation. Detachment was spoken about by staff in terms of separating and distancing their personal selves from their professional work, such that they adopted a different identity; removing their personal sense of self from the often difficult situations they are required to manage and engage with through taking on a work persona. Desensitisation in contrast, appeared to happen over time and often unintentionally. The more often staff were called upon to manage incidents, the more adept they became in not only managing the situation through their physical actions but also in managing their personal feelings and emotions associated with those actions required of them. Whilst both of these processes require institutional and emotional work, they appear to be revealed in different forms and to differing degrees. Detachment is suggested as an intentional result of staff's institutional and emotion work and effort. Desensitisation, in comparison, appears to be a lesser intended outcome of institutional and emotional work, albeit one that enables staff to cope in working within the high secure environment. In adopting the language of Hochschild (1983), each of these processes require levels of emotion work. Detachment may be seen to align with surface acting; being aware of one's real feelings but working to separate oneself from these in order to suppress and overcome heightened tensions and discomfort between emotions and expectations. Desensitisation may represent deep surface acting where real feelings are lost in place of acquiring and conducting institutional values, norms and actions.

At the end of each incident, staff describe a period of recuperation; 'making peace' with their emotions. Implicit within this were staff seeking validation for their actions; justifying the need for coercive measures and hence their involvement in employing these interventions despite not always feeling comfortable engaging in such actions. Staff spoke of seeking the support of colleagues who understand and who have been through the same or similar

processes in consolidating their personal and professional values. In addition, staff frequently referred to their actions as being 'part of a job'; not only transferring the onus of their actions to their work but also detaching their real feelings and personal selves from those of their actions. This sense of detachment and distancing of the personal self from their work again seems to highlight the institutional and emotional work that staff engage; internalising institutional values in legitimising their work, roles and actions. The process of institutionalisation therefore appears to have several functions. The accommodation of institutional values appears to allow justification for staff actions. Through placing the responsibility of their actions upon institutional requirements, staff detach themselves from the situation. This detachment from their personal selves simultaneously enables staff to function in otherwise uncomfortable situations. The accommodation of institutional values, encompassing institutional and emotional work and effort is therefore required in working within such a highly controlled environment with deviants whom are 'mad, bad and dangerous' and requiring the greatest sanctions within healthcare organisations. On the one hand, the individual staff member must believe in the values of the institution in order to perform those duties and tasks required of them. They must accommodate the institution through processes of institutional and emotional work. In taking on the values of the institution, the individual may seek justification for those actions they feel uncomfortable conducting. In becoming institutionalised however, the individual's personal values and emotions become increasingly removed and perhaps, eventually lost within the dominant values of the highly regimented secure environment. These pose important questions with regards the capacities to care within such a highly controlled environment. Whether it is possible to demonstrate compassion, real feelings and personal values, or whether such anxiety-provoking, fear-driven environments inadvertently have the effect of controlling the workers as much as, if not more so, than the deviants they purport to control and contain, Ultimately, questions are raised as to how such cultures can progress beyond one of bleak isolation so remote and closed off from the outside world, such that these negative cycles of fear and isolation can be broken and justifications for coercion and containment be opened to critique and transformation.

While the studies of institutional and emotional work are well documented within the literature, rarely are they documented within a single study.

Institutional and emotional work theories have been applied to the contexts of business studies, cabin crew, construction workers, nursing homes, palliative care, prisons and soldiers (Crawley, 2004; Fineman, 1993; 1996; 2003; Haas, 1977; Hochschild, 1983; Lopez, 2006; Plamper, 2009). To the author's knowledge however, neither of these theories have been applied specifically to the context of forensic psychiatry in secure hospital settings. The explorations of staff experiences of working within a high secure environment, their conduct of coercive measures and particularly the institutional and emotional of staff working within this specialised environment, are therefore considered valuable and original contributions to knowledge. Interviews with staff have demonstrated that working within a high secure environment is challenging and demands institutional and emotional effort in adopting and abiding by institutional rules, rituals, values and beliefs; often at the expense of one's own. The institutional and emotional work and efforts of staff are particularly apparent where incidents emerge and coercive measures are employed; revealed as complex challenges, processes and interplays between staff's actions and emotions; their personal feelings and professional selves. Staff are therefore required to recognise their own personal 'shelf life' when working within a highly demanding organisation which requires the often contentious and continually pluralistic practices of security and care. Staff are reminded to seek support in such a desperately isolated and isolating environment, and to recognise and take ownership of their real feelings in order to step out of the internally embedded cultures of fear and anxieties, towards a culture of openness, honesty and support, such that they can be reminded to care rather than contain within such a highly ordered environment.

CHAPTER 13: CONCLUSIONS AND RECOMMENDATIONS

Coercive measures are considered unavoidable necessities in managing and containing violence and aggression. The actions and emotions associated with their conduct are complex, particularly within high secure hospital environments, where healthcare professionals are expected, and indeed required, to both care and contain. This thesis has set out to explore patient, staff and environmental factors that might influence variations in the use of coercive measures across different wards and patient groups; a sociological exploration of emotions and actions within a forensic psychiatric context. A synergistic sequential mixed methods approach was used, organised in three stages. Firstly, a quantitative component explored the characteristics of patients subject to coercive measures. Secondly, standardised questionnaires were used to examine staff attitudes towards aggression, as well as staff and patient attitudes and experiences of containment measures and ward atmosphere. Thirdly and finally, interviews were conducted with staff to investigate how institutional and emotional work contribute towards staff approaches to using coercive measures.

These areas of exploration are of particular interest given the lack of empirical research into the highly controversial practice of coercive interventions, specifically within the forensic hospital environment. A literature review revealed multiple definitions and associated practices of seclusion, restraint and rapid tranquillisation (Davison, 2005; Jarrett et al., 2008). These often related to differences in policy, legislation and governance between countries (Alty & Mason, 1994; Soloff, 1984). Great variances were also found in the rates and frequencies of coercive practices between hospitals, suggesting differences in attitudes, perceptions of acceptability, social and cultural norms (Bowers et al., 2004; Bowers et al., 2007; Muir-Cochrane et al., 2009; Steinert & Lepping, 2009).

Empirical research into the use of coercive measures has predominantly focused on the characteristics of patients (e.g. Ahmed & Lepnurm, 2001; Beck et al., 2008; Benford Price et al., 2004; Heilbrun et al., 1995; Mason, 1998; Paavola & Tiihonen, 2010; Pannu & Milne, 2008; Thomas et al., 2009). Comparisons between studies have been challenging however, due to

differences in research questions, design and methods employed (Ahmed & Lepnurm, 2001; Beck et al., 2008; Benford Price et al., 2004; Heilbrun et al., 1995; Mason, 1998; Paavola & Tiihonen, 2010; Pannu & Milne, 2008; Thomas et al., 2009). While there is a general consensus that younger, newly admitted females tend to be those most often experiencing coercive measures, little is known with regards the influences of staff attitudes and hospital environment (Brunt & Rask, 2007; Exworthy et al., 2001; Harris et al., 1989; Klinge, 1994; Sequeira & Halstead, 2004). Staff and patient experiences are frequently overlooked and underexplored (Grant et al., 1989; Klinge, 1994; Keski-Valkama et al., 2010; Sequeira & Halstead, 2004). While studies allude to staff, patient and environmental factors as being interconnected in influencing the uses of coercive measures, these factors have seldom, if ever, been examined within a single study (Brunt & Rask, 2007). The three stage sequential mixed methods design of this thesis therefore aims to address some of these shortfalls.

Given the hypothesis that patient population and hospital environment may each influence the rates and frequencies of coercive measures used, the analyses of hospital level data allowed explorations of patient characteristics and hospital context. The standardised ATAS questionnaire allowed staff attitudes towards aggression to be compared between wards, while the ACMQ and EssenCES questionnaires allowed comparisons between staff and patient attitudes and experiences of both containment and ward environment. Finally, interviews with staff provided insights into how staff process and manage their personal feelings and professional roles. Staff interviews were analysed and interpreted through the theories of institutional and emotional work; examining how institutions might be created, maintained or else disrupted through the actions and emotions of those working within (Hochschild, 1983; Lawrence, Suddaby & Leca, 2009).

Findings from this study confirmed that younger, newly admitted females were proportionately more likely to experience seclusion and rapid tranquillisation than males. The ATAS questionnaire revealed that staff overall perceived aggression as being destructive, and that this was particularly the case for staff working on the pre-discharge ward. While it is unsurprising that staff viewed containment measures as being more acceptable than patients,

the ACMQ revealed significant differences in staff and patient views of the least acceptable methods. The net bed was found to be the equally least desirable method of containment for both staff and patients. Constant observations however, was amongst one of the least acceptable methods of containment as rated by patients, although one of the most acceptable methods of containment as rated by staff. These findings create interesting dilemmas for those lobbying for lesser coercive interventions, and point towards whether the least restrictive methods necessarily equate to being the most therapeutic (American Psychiatric Association et al., 2003; National Mental Health Working Group, 2005; NICE, 2005). While findings from these questionnaires allude towards familiarity with methods being positively associated with levels of acceptability, further research is required into reasons for difference between staff and patient perceptions of the least restrictive methods, justifications for such actions, along with the implications of this for practice outcomes.

Findings from the EssenCES questionnaire illustrated that staff perceive ward environment as being more therapeutic than patients. Patients however, perceive ward environment as being safer and more cohesive. These findings are suggestive of an exclusive patient community formed within the hospital, in support of Becker's (1963) theory of deviant communities within deviant spaces. Where patient communities are formed, staff paradoxically become the peripheral agents of institutional order and control within the organisation. Using Becker's ideas of insiders and outsiders, it is the patients who become the insiders within the organisation, whilst staff, the outsiders, merely work within the same environment where their roles are to maintain institutional order, boundaries and control. Questions are raised with regard to the physical and emotional efforts of those being controlled and purported to control. Furthermore, it is worth considering whether controlling is required or whether it is the effects of such controls that lead towards 'deviant behaviours' within these environments (Cohen & Scull, 1983; Lemert, 1967). Through examining the high secure context through an insider/outsider perspective, the institutional and emotional work of staff become apparent, since staff are paradoxically the outsiders within the environment they purport to control. As such, great efforts of required by staff in overcoming not only the pluralistic notions of care and security within

a high secure hospital, but also in managing their personal feelings and professional roles where coercive measures are justified, accepted and indeed expected interventions, being employed by staff where patients challenge institutional rules.

Staff speak of both of the personal and professional challenges they face when being expected to conduct coercive interventions; the machismo and bravado required in creating and maintaining trust between colleagues, yet the emotional turmoil and ensuing processes of detachment and desensitisation in coping with, managing and overcoming the feelings associated with their actions. Rarely does any society condone or indeed justify the use of physical coercion against another individual, rare examples being the military and other armed forces. Yet within a high secure hospital, institutional arrangements govern, justify and condone the use of coercive interventions as a means of sanctioning violence, aggression and risk of injury (Department of Health, 2008; NICE, 2005). Staff working in high secure hospitals are charged with the role and responsibilities of managing highly dangerous patients within these institutions; those that have been defined as 'tertiary deviants'. At the same time they are implicitly expected to detach themselves from their personal beings, such that any personal feelings, emotions and responses do not contaminate their professional work. Through these processes of detachment, staff become institutionalised beings; accepting institutional rules, values and beliefs in place of their own, in being able to perform the challenging actions of coercing and containing that they are expected to conduct (Hochschild, 1983; Lawrence, Suddaby & Leca, 2009). Furthermore, staff are expected to make decisions of when to intervene; a subjective judgement based on past experience and seemingly at odds with this detached self, but nevertheless that staff must reason with, reconcile and justify.

Through these processes, staff become increasingly isolated. These levels of isolation become problematic not only in terms of personal detachment from one's real feelings, true values and sense of self, but also in the social and geographical sense. Whilst isolation may be in defence of the stigmatisation felt by those working in such a highly stigmatised environment with patients who are doubly stigmatised, JP Martin (1983) warns of the dangers of

isolation of being closed to outside influences, questioning and development. This isolation may be at an individual, ward or institutional level, as considered within this thesis. At an individual level, the fears and anxieties of working with 'deviants' in such a highly ordered environment appear to have detrimental effects upon the person. At ward level, staff emotions and institutional expectations are manifest as influencing decisions and actions, as well as the ward environment, atmosphere and culture. Finally, at the institutional level, the ways in which high secure hospitals are organised, governed and managed ultimately effect public perceptions as well as those accommodated and working within. Each of these factors, at all levels, are therefore interactive and mutually influencing.

While this thesis has made a start on generating new insights to the unique environment of the high secure hospital, and has used a novel approach of combining institutional and emotional work theories, greater research is required into examining staff and patient attitudes regarding the least restrictive methods and the implications this will have for practice. The internal dynamics within high secure hospitals warrant further attention, examining; i) what it means for staff to be working in an environment where patients feel more supported by being contained than staff do when containing them; ii) what methods of support can be put in place for staff experiencing conflict between their personal feelings and professional roles, and iii) whether anything can be done to relieve the tensions of healthcare professionals expected to care, coerce and contain.

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APPENDICES

APPENDIX 1: ATTITUDES TOWARD AGGRESSION SCALE (ATAS)

Attitudes Toward Aggression Scale (ATAS)®

Instruction:

You are asked to rate how much you agree with each statement. Please base your opinion on your experience with aggressive patients of the ward you work on at the moment. You can give your opinion by circling the number that corresponds with your judgment.

Aggression.....	strongly agree	agree	uncertain	disagree	strongly disagree
1 is an example of a non-cooperative attitude	5	4	3	2	1
2 is the start of a more positive nurse patient relationship	5	4	3	2	1
3 Is unpleasant and repulsive behaviour	5	4	3	2	1
4 is an impulse to disturb and interfere in order to dominate or harm others	5	4	3	2	1
5 cannot be tolerated	5	4	3	2	1
6 offers new possibilities in nursing care	5	4	3	2	1
7 is a powerful, mistaken, non-adaptive, verbal and/or physical action done out of self-interest	5	4	3	2	1
8 is unnecessary and unacceptable behaviour	5	4	3	2	1
9 is when a patient has feelings that will result in physical harm to self or to others	5	4	3	2	1
10 is to protect oneself	5	4	3	2	1
11 in any form is always negative and unacceptable	5	4	3	2	1
12 is violent behaviour to others or self	5	4	3	2	1
13 is threatening to damage others or objects	5	4	3	2	1
14 is destructive behaviour and therefore unwanted	5	4	3	2	1
15 is expressed deliberately, with the exception of aggressive behaviour of someone who is psychotic	5	4	3	2	1
16 poisons the atmosphere on the ward and obstructs treatment	5	4	3	2	1
17 helps the nurse to see the patient from another point of view	5	4	3	2	1
18 is the protection of one's own territory and privacy	5	4	3	2	1

APPENDIX 2: ATTITUDES TOWARDS CONTAINMENT MEASURES
QUESTIONNAIRE (ACMQ)

ACMQ STAFF

ACMQ PATIENTS


Attitudes to Containment Measures (Staff)

We'd like to know what you think about different methods used to contain disturbed behaviour. Please read each statement carefully, and then tick the box that applies. Not all these containment methods are in use in the UK, but all of them are in use in at least one European country. We will describe each one (you can refer to the photographs as well), and then ask you to rate your responses to how acceptable each method is. It is important that you complete this questionnaire by yourself, without conferring with others or trying to find out what their answers are. When the questionnaire is complete you may discuss it with others. Please answer all questions. If you are not sure about your response, please make a judgment as best as you can. As a last resort, it is better to guess than to leave a question unanswered. If you do not wish to complete the questionnaire just leave it blank. If you change your mind at any time you can stop.

PRN MEDICATION: Medication given at the nurses discretion, in addition to regular doses, by any route, and accepted voluntarily.

Q1a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable


Q1b. I have used PRN MEDICATION

YES NO

SECLUSION: Isolated in a locked room.

Q4a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable


Q4b. I have used SECLUSION

YES NO

PHYSICAL RESTRAINT: Physically holding the patient, preventing movement.

Q2a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable


Q2b. I have used PHYSICAL RESTRAINT

YES NO

TIME OUT: Patient asked to stay in room or area for a period of time, without the door being locked.

Q5a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable


Q5b. I have used TIME OUT

YES NO

INTERMITTENT OBSERVATION: An increased level of observation, of greater intensity than that which any patient generally receives, coupled with allocation of responsibility to an individual nurse or worker. Periodic checks at intervals.

Q3a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable


Q3b. I have used INTERMITTENT OBSERVATION

YES NO

COMPULSORY INTRAMUSCULAR SEDATION: Intramuscular injection of sedating drugs given without consent.

Q6a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable

Q6b. I have used COMPULSORY INTRAMUSCULAR SEDATION

YES NO


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PSYCHIATRIC INTENSIVE CARE: Transfer to a specialist locked ward for disturbed patients.

Q7a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree

Is acceptable




Q7b. I have used PSYCHIATRIC INTENSIVE CARE
YES NO

NET BED: Patient placed in a net bed enclosed by locked nets, which he or she is unable to leave.

Q10a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree

Is acceptable




Q10b. I have used NET BED
YES NO

MECHANICAL RESTRAINT: The use of restraining straps, belts, or other equipment to restrict movement.

Q8a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree

Is acceptable




Q8b. I have used MECHANICAL RESTRAINT
YES NO

OPEN AREA SECLUSION: Isolated in a locked area, accompanied by nurses.

Q11a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree

Is acceptable




Q11b. I have used OPEN AREA SECLUSION
YES NO

CONSTANT OBSERVATION: An increased level of observation, of greater intensity than that which any patient generally receives, coupled with allocation of responsibility to an individual nurse or other worker. Constant: within eyesight or arms reach of the observing worker at all times.

Q9a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree

Is acceptable



Q9b. I have used CONSTANT OBSERVATION
YES NO

Thank you for taking part


Attitudes to Containment Measures (Patient)

We'd like to know what you think about different methods used to contain disturbed behaviour. Please read each statement carefully, and then tick the box that applies. Not all these containment methods are in use in the UK, but all of them are in use in at least one European country. We will describe each one (you can refer to the photographs as well), and then ask you to rate your responses to how acceptable each method is. It is important that you complete this questionnaire by yourself, without conferring with others or trying to find out what their answers are. When the questionnaire is complete you may discuss it with others. Please answer all questions. If you are not sure about your response, please make a judgment as best as you can. As a last resort, it is better to guess than to leave a question unanswered. If you do not wish to complete the questionnaire just leave it blank. If you change your mind at any time you can stop.

PRN MEDICATION: Medication given at the nurses' discretion, in addition to regular doses, by any route, and accepted voluntarily.

Q1a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable


Q1b. I have been subjected to PRN MEDICATION

YES NO

SECLUSION: Isolated in a locked room.

Q4a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable


Q4b. I have been subjected to SECLUSION

YES NO

PHYSICAL RESTRAINT: Physically holding the patient, preventing movement.

Q2a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable


Q2b. I have been subjected to PHYSICAL RESTRAINT

YES NO

TIME OUT: Patient asked to stay in room or area for a period of time, without the door being locked.

Q5a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable


Q5b. I have been subjected to TIME OUT

YES NO

INTERMITTENT OBSERVATION: An increased level of observation, of greater intensity than that which any patient generally receives, coupled with allocation of responsibility to an individual nurse or worker. Periodic checks at intervals.

Q3a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable


Q3b. I have been subjected to INTERMITTENT OBSERVATION

YES NO

COMPULSORY INTRAMUSCULAR SEDATION: Intramuscular injection of sedating drugs given without consent.

Q6a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable

Q6b. I have been subjected to COMPULSORY INTRAMUSCULAR SEDATION


YES NO

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PSYCHIATRIC INTENSIVE CARE: Transfer to a specialist locked ward for disturbed patients.

Q7a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable


Q7b. I have been subjected to PSYCHIATRIC INTENSIVE CARE

YES NO

NET BED: Patient placed in a net bed enclosed by locked nets, which he or she is unable to leave.

Q10a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable


Q10b. I have been subjected to NET BED

YES NO

MECHANICAL RESTRAINT: The use of restraining straps, belts, or other equipment to restrict movement.

Q8a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable


Q8b. I have been subjected to MECHANICAL RESTRAINT

YES NO

OPEN AREA SECLUSION: Isolated in a locked area, accompanied by nurses.

Q11a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable


Q11b. I have been subjected to OPEN AREA SECLUSION

YES NO

CONSTANT OBSERVATION: An increased level of observation, of greater intensity than that which any patient generally receives, coupled with allocation of responsibility to an individual nurse or other worker. Constant: within eyesight or arms reach of the observing worker at all times.

Q9a

Strongly agree
Agree
Uncertain
Disagree
Strongly disagree



Is acceptable

Q9b. I have been subjected CONSTANT OBSERVATION

YES NO

Thank you for taking part

APPENDIX 3: ESSEN CLIMATE EVALUATION SCALE (ESSENCES)

I agree

		not at all	little	somewhat	quite a lot	very much
1	This ward has a homely atmosphere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	The patients care for each other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Really threatening situations can occur here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	On this ward, patients can openly talk to staff about all their problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Even the weakest patient finds support from his fellow patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	There are some really aggressive patients on this ward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Staff take a personal interest in the progress of patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Patients care about their fellow patients' problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Some patients are afraid of other patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Staff members take a lot of time to deal with patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	When a patient has a genuine concern, he finds support from his fellow patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	At times, members of staff are afraid of some of the patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Often, staff seem not to care if patients succeed or fail in treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	There is good peer support among patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Some patients are so excitable that one deals very cautiously with them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Staff know patients and their personal histories very well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Both patients and staff are comfortable on this ward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

APPENDIX 4: SEMI-STRUCTURED INTERVIEW SCHEDULE



The Use of Coercive Measures within Forensic Psychiatry
Miss Ada Hui, Dr Hugh Middleton & Dr Birgit Völlm

Semi-Structured Interview Schedule
(Final Version 1.0: 18th August 2011)

- What are your thoughts about the use of coercive measures (restraint, seclusion and/or rapid tranquilisation) within forensic psychiatry?
- Are these methods necessary? Why?
- How do you feel about using these methods?
- How are decisions made about whether to use these methods or not?
 - When are decisions made?
 - Who decides?
- Can you think of a scenario either recently or one that stands out for you where you have had to use one or several of these methods?
 - Please can you talk me through what happened?
 - What were your thoughts and feelings about this?
 - What happened afterwards for you and the patient?
 - How did you feel about working with the patient after?
 - How did other staff and patients react to you and the patient who was restrained/secluded/rapidly tranquillised?

APPENDIX 5: NATIONAL RESEARCH ETHICS SERVICES COMMITTEE
APPROVAL



National Research Ethics Service

NRES Committee East Midlands - Nottingham 1

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839390 (Direct Line)
Facsimile: 0115 9123300

26 September 2011

Dr Hugh Middleton
Associate Professor/Consultant Psychiatrist
University of Nottingham
School of Sociology, University of Nottingham
University Park
Nottingham
NG7 2RD

Dear Dr Middleton

Study title: The use of Coercive Measures within Forensic
Psychiatry: Professional Practice and Perspectives
REC reference: 11/EM/0322

The Research Ethics Committee reviewed the above application at the meeting held on 13 September 2011. Thank you for attending with Miss Ada Hui to discuss the study.

Ethical opinion

Discussion

- The Committee asked for clarification regarding the sample size in the study as the figures were confusing. They asked if it was only taking place in the UK. You confirmed that the study is only taking place in the UK at Rampton Hospital. You confirmed that there are several stages to this study and the overall sample size (1150) stated is for data collected on the whole activity of the hospital i.e. all patients and staff. You also confirmed that interviews will only be undertaken on staff and the patient's involvement is completion of the questionnaires.
- The Committee asked you if there is potential for any unprofessional conduct to be identified. You confirmed that there is potential for this, and you were asked to include a statement regarding this in the Participant Information Sheet as to how this will be dealt with etc.
- You were asked what origin the questionnaires are e.g. American etc. You confirmed that they are from Germany and the Netherlands, but have also been validated in the UK. The Committee relayed their concerns over the images of restraint in the Attitudes to Containment Measures Questionnaire, in that they may cause distress as not all methods are used at Rampton Hospital. You stated that it is clear at the beginning of the questionnaire that not all methods identified are used in the UK. You also confirmed that the questionnaire was to most appropriate one for use in this study. The Committee also agreed that if it was changed it would not be a validated questionnaire. Therefore, they considered it satisfactory.

This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority
*The National Research Ethics Service (NRES) represents the NRES Directorate within the
National Patient Safety Agency and Research Ethics Committees in England*

WPH 1370

- The Committee asked you regarding the recruitment of staff i.e. how many Psychiatrists would be taking part? You confirmed that 5-6 Psychiatrists would be taking part.
- The Committee asked what pseudonyms will be used for the interview transcripts. You confirmed that initials will not be used, but you may use another name for each individual or a number, but nothing identifiable. The Committee agreed that this was satisfactory as long as you ensure that the name of another participant is not used.
- The Committee asked if approval has been given from the Trust's Medical Director for staff to take part in the study. You confirmed that approval has been given from the Trust.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Additional Conditions:-

1. It should state in the Participant Information Sheets that 'if any potential malpractice or unprofessional conduct is identified this will be reported to....', and include who it will be reported to.
2. It should be made clear in the Participant Information Sheet that the study is

being undertaken for a PhD.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering Letter		18 August 2011
Covering Letter		09 August 2011
Evidence of insurance or indemnity		26 July 2011
Interview Schedules/Topic Guides	1	18 August 2011
Investigator CV	Hugh Middleton	
Investigator CV	Birgit A Vollm	
Investigator CV	Ada Man Ling Hui	09 August 2011
Letter from Sponsor		09 August 2011
Other: Staff Contact Details Form	1.0	01 August 2011
Participant Consent Form: CF - Interview	1.0	01 August 2011
Participant Information Sheet: PIS - Staff	1.0	01 August 2011
Participant Information Sheet: PIS - Patient	1.0	01 August 2011
Protocol	1.0	01 August 2011
Questionnaire: Attitudes to Containment Measures (Staff)		
Questionnaire: Attitudes to Containment Measures (Patients)		
Questionnaire: Essen CES		
Questionnaire: Attitudes Toward Aggression Scale (ATAS)		
REC application	83840/239283/1/763	09 August 2011
Referees or other scientific critique report	Peer Review	20 July 2011

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed

guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

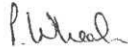
You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

11/EM/0322	Please quote this number on all correspondence
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With the Committee's best wishes for the success of this project

Yours sincerely



PP
Reverend Keith Lackenby
Vice-Chair

Email: trish.wheat@nottspct.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments
"After ethical review – guidance for researchers"*

Copy to: *R & D Dept - Nottinghamshire Healthcare NHS Trust
Miss Ada Hui – Student*

NRES Committee East Midlands - Nottingham 1

Attendance at Committee meeting on 13 September 2011

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Walter P Bouman	Consultant Psychiatrist	Yes	
Dr Glenys Caswell	Research Fellow	No	
Professor Cris Constantinescu	Professor of Neurology	No	Sent written report for REC reference 11/EM/0322
Ms Helen Crow	Research Midwife	No	
Mr Robert Johnson	Research Coordinator	No	
Reverend Keith Lackenby	Lay member/Vice-Chair	Yes	Chairing the meeting
Mrs Sarah Lennon	Expert member	Yes	
Mr Jon Merrills	Barrister / Pharmacist	Yes	
Mr Robert Oldroyd	Lay member	No	
Dr Noble Philips	General Practitioner	Yes	
Dr Ian Ross	Consultant Physician	Yes	
Mr Ian Thompson	Lay member	Yes	
Mrs Shirley E White	Lay member	No	
Ms Fran Willis	Teacher	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Sheila Oliver	Deputy Head of Operations, NRES - Observing
Ms Trish Wheat	REC Committee Co-ordinator

APPENDIX 6: NHS R&D ETHICAL APPROVAL

positive

Nottinghamshire Healthcare 
NHS Trust

Positive about mental health and learning disability

Research Management and Governance
Institute of Mental Health
2nd Floor, Duncan MacMillan House
Porchester Road
Nottingham

E-mail: emma.pearson@nottshc.nhs.uk

Local Ref: CSP/27/10/11
Rec ID: 11/EM/0322

Date: 27th October 2011

Dr Hugh Middleton
Nottingham University
School of Sociology and Social Policy
Law and Social Sciences Building
University Park
Nottingham
NG7 2RD

Dear Dr Middleton

I am writing to confirm that NHS permission for research has been granted for the following study.

Title: The use of Coercive Measures within Forensic Psychiatry: Professional Practice and Perspectives

Sites/ services that have been given NHS permission: Rampton Hospital

NHS permission for the above research has been granted on the basis described in the application form, protocol and supporting documentation. The following documents were reviewed:

Document	Version Number
Evidence of insurance	26/07/11
Interview schedule	18/08/11
CV	Hugh Middleton
	Birgit Vollm
	Ada Hui
Letter from sponsor	09/08/11
Consent form: Interview	01/08/11
PIS – Staff	28/09/11
PIS – Patient	28/09/11
Protocol	01/08/11
Questionnaire – Staff	
Questionnaire – Patient	
Questionnaire – Essen CED	
Questionnaire – attitudes towards aggression scale	
REC application	09/08/11
Peer Review	20/07/11

Start Date: 27th October 2011 **End Date:** 31st October 2013

Study Outline:

The aim of the study is to gain a deeper understanding of the relationships between incidents, use of coercive measures including restraint, seclusion and rapid tranquillisation and ward atmosphere. The study will explore how these might be associated with staff attitudes, experiences and perceptions.

Staff members including staff nurses, nursing assistants, psychiatrists and social workers will be invited to complete a number of questionnaires and undertake a semi structured interview that will last approximately 90 minutes in total.

Service users will be invited to complete a number of questionnaires that will take approximately 50 minutes in total.

Service Support Costs at a total of £323.99 have been agreed for the identification of 50 potential patient participants that meet the necessary inclusion criteria by a band 7 member of the ward team.

Please note that Nottingham Healthcare NHS Trust is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research and requesting the completion of a brief progress report every 6 months.

You can now proceed with your study in accordance with the agreed protocol. Please keep this letter with you during the course of your research to confirm that you have Directorate and RMG Department approval, to gain access to the areas where your research is taking place.

If you or others have concerns please contact the RMG department on 0115 9691300 ext 10661 or by email to emma.pearson@nottshc.nhs.uk

We wish you well with your work.

Yours sincerely



Dr Peter Miller
Medical Director
Nottinghamshire Healthcare NHS Trust

Cc:
Academic Supervisor: Birgit Vollm
Principal Investigator: Ada Hui
Sponsor: Nottingham University

Conditions of Trust approval are as follows.

1. All members of the research team should familiarise themselves with all relevant policies and procedures, including the Trust policy GG/CG/04 – staff conducting, hosting or collaborating in research (note, currently being revised).
2. The Chief Investigator, and all other members of the research team, should comply with any regulations applicable to the study, including, but not limited to: The NHS Research Governance Framework for Health and Social Care (2005), The Declaration of Helsinki (2000), The UK Medicines for Human Use (Clinical Trials) Regulations (2004), ICH Good Clinical Practice guidelines (1997), The Human Tissue Act (2004), The Data Protection Act (1998), The Mental Capacity Act (2005).
3. The Chief Investigator should ensure that all members of the research team are suitably qualified and experienced, and adequately supervised. This should include training in informed consent procedures and GCP, where necessary.

4. Research governance should be notified within the same timeframe of notifying REC of any major changes to the study, which may include changes to the team, requiring honorary contracts or letters of access to be issued, changes to timescales or changes in procedures.
- a. Any changes in the protocol or documentation should be approved by the ethics committee and research governance.
5. Care professionals should be informed of their patients' participation in the research.
6. The protocol should be adhered to; any deviations should be notified to research governance.
7. Suitable arrangements for archiving should be made in accordance with the guidelines of the sponsor, and research governance should be kept informed of any changes or failures in archiving arrangements, including failures in safe preservation of electronic data. Failure to report such losses will result in disciplinary investigation of Trust staff, and a disciplinary enquiry of external researchers, which could result in the rescinding of rights to carry research in the Trust.

APPENDIX 7: NRESA AND NHS R&D APPROVED FORMS

PATIENT PARTICIPATION INFORMATION SHEET

STAFF PARTICIPANT INFORMATION SHEET

STAFF CONSENT FORM



Patient Participant Information Sheet
(Final Version 1.1: 28th September 2011)

The Use of Coercive Measures within Forensic Psychiatry
Miss Ada Hui, Dr Hugh Middleton & Dr Birgit Völlm

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

The purpose of this questionnaire is to look at individual experiences and perceptions of ward atmosphere and different factors that may influence this.

Why have I been invited?

You have been invited to take part because you are currently a patient at Rampton Hospital and we would be interested to know your thoughts on how you find the ward.

Do I have to take part?

You are under no obligation to take part. If you choose to take part, a copy of this information sheet will be kept in your notes for you to access when you wish. You will be free to withdraw from the study at any time without giving reason. A decision not to take part in the study or to withdraw at any time will not affect your care in any way.

What will happen to me if I take part?

If you decide to take part, you will be given two short questionnaires to complete. These questionnaires completed together will take around 30-45 minutes of your time. A confidential-stamped envelope addressed to the research team will be provided for the return of your completed questionnaire. A member of the research team will be visiting your ward on a regular basis where you will have the opportunity to return your completed questionnaire directly to them. Alternatively, your completed questionnaire may be handed to a member of your clinical care team who will ensure that this is returned to the researcher if you so wish. Your return of a completed questionnaire to the research team will be taken to indicate your consent to participate in the study. Once your questionnaire has been returned to the research team, the information you have given cannot be erased and may be used in the reports of this study.

Expenses and payments

There will be no payments or incentives for participating in this study.

What are the possible disadvantages and risks of taking part?

It is very unlikely that any risks will result from taking part in this research study. You will not be expected to disclose any information you would prefer not to. If taking part in completing the questionnaire does cause you any unexpected distress, the researcher may inform a member of staff from your clinical team where the matter can be taken further if necessary.

What are the possible benefits of taking part?

This study is unlikely to have any direct benefits for those participants taking part. However, it is hoped that findings from this study will help inform future research and service development.

Page 1 of 2

What if there is a problem?

If any potential malpractice or unprofessional conduct is identified, this will be reported to appropriate persons in accordance with Trust policy. If you are concerned about any aspects of this research study, please speak with one of the researchers who will do their best to answer your questions (Dr Völlm, ext. 6677 internal). If you remain unhappy and wish to complain formally you can do this through the Nottinghamshire Healthcare NHS Trust Complaints process by contacting the services liaison department on Tel: 0115 993 4542. The patient advice and liaison (PALS) service may also be contacted on 0800 015 3367.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence. If however, you were to reveal something that indicated risk to yourself or someone else, an appropriate person may need to be informed in accordance with local policy. This would be discussed with you beforehand.

If you join the study, some parts the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the hospital will have your name and address anonymised and a unique code will be used so that you cannot be recognised from it.

Your personal data (ward name and any other contact details) will be kept for up to three months after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.

What will happen to the results of the research study?

The results from this study will be written up as part of a thesis aimed to improve mental health services. They will also be circulated to a wider audience through published papers and are likely to inform future research. Personal details will not be included in any of the reports.

Who is organising and funding the research?

This research project has been organised by the University of Nottingham and the Nottinghamshire Healthcare NHS Trust. This research study is being undertaken as part of a PhD and has been funded by the Economic & Social Research Council and the Institute of Mental Health.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Nottinghamshire Research Ethics Committee.

Thank you for taking the time to read through this information sheet.

For further information regarding this study, please contact a member of the research team (Miss Ada Hui, Dr Hugh Middleton or Dr Birgit Völlm) at: Rampton Hospital, Retford, Nottinghamshire. DN22 0PD.

Tel: 01777 248321 ext. 6677.

Page 2 of 2



Staff Participant Information Sheet
(Final Version 1.1: 28th September 2011)

The Use of Coercive Measures within Forensic Psychiatry
Miss Ada Hui, Dr Hugh Middleton & Dr Birgit Völlm

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

The purpose of this study is to investigate the use of restraint, seclusion and rapid tranquillisation within forensic psychiatry. The study is divided into two parts. Part one involves the completion of questionnaires looking at individual attitudes towards aggression, containment measures and perceptions of ward atmosphere. Part two involves interviews exploring staff experiences of managing incidents through the use of restraint, seclusion and rapid tranquillisation. The study will compare four wards where frequencies of these differ.

Why have I been invited?

You have been invited to take part because you are one of the multidisciplinary staff within Rampton Hospital and we would be interested to know your thoughts on these different aspects.

Do I have to take part?

You are under no obligation to take part. If you choose to take part, a copy of this information sheet will be given to you to keep. You will be free to withdraw from the study at any time without giving reason. A decision not to take part in the study or to withdraw at any time will not affect you or your legal rights in any way.

What will happen to me if I take part?

If you decide to take part, you will be given three short questionnaires to complete. These three questionnaires completed together will take up to 60 minutes of your time. A confidential-stamped envelope addressed to the research team will be provided for the return of your completed questionnaire. A member of the research team will be visiting your ward on a regular basis where you will have the opportunity to return your completed questionnaire directly to them. Alternatively, your completed questionnaire may be placed in a box located on your ward which will be emptied by the research team on a regular basis. Your return of a completed questionnaire to the research team will be taken to indicate your consent to participate in the study. Once your questionnaire has been returned to the research team, the information you have given cannot be erased and may be used in the reports of this study.

If you are working either in the role of a senior staff nurse, staff nurse, nursing assistant, psychiatrist or social worker, you will also be asked if you would like to take part in the interview phase of the study. In order to be contacted by the researcher, you will be asked to complete a short form providing your contact details and permission to be contacted.

Only seven members of staff from each ward will be selected for interview. These will be chosen on a first reply basis. If you decide to take part in the interview, you will be asked to sign a consent form and take part in an interview, lasting up to 60 minutes. The interview will be conducted at a time and place that is

mutually agreed between you and the researcher. This will either be within Nottinghamshire Healthcare NHS Trust premises or at a location belonging to the University of Nottingham.

The interviewer will be interested to hear about your views and experiences relating to incidents you have been involved in managing and/or deescalating as well as your views and experiences of using restraint, seclusion and rapid tranquillisation within a high secure forensic hospital setting. With your permission, the interview will be audio-recorded so that the researcher can listen back on the interview in detail. The recording will be transcribed and anonymised for analysis. Once the interview has been conducted, the information you have given cannot be erased and may be used in the reports of this study.

Expenses and payments

There will be no payments or incentives for participating in this study. The questionnaire will be completed in work time and will contribute towards the commitment that Nottinghamshire Healthcare NHS Trust has made to support this project.

What are the possible disadvantages and risks of taking part?

It is very unlikely that any risks will result from taking part in this research study. You will not be expected to disclose any information you would prefer not to. If taking part in completing the questionnaire does cause you any unexpected distress, you may seek further support from your manager or the staff counselling service if necessary.

What are the possible benefits of taking part?

This study is unlikely to have any direct benefits for those participants taking part. However, it is hoped that findings from this study will help inform future research and service development.

What if there is a problem?

If any potential malpractice or unprofessional conduct is identified, this will be reported to appropriate persons in accordance with Trust policy. If you are concerned about any aspects of this research study, please speak with one of the researchers who will do their best to answer your questions (Dr Völlm, ext. 6677 internal). If you remain unhappy and wish to complain formally you can do this through the Nottinghamshire Healthcare NHS Trust Complaints process by contacting the services liaison department on Tel: 0115 993 4542.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence. If however, you were to reveal something that indicated risk to yourself or someone else, an appropriate person may need to be informed in accordance with local policy. This would be discussed with you beforehand.

If you join the study, some parts the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the hospital will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (ward name and any other contact details) will be kept for up to three months after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.

What will happen to the results of the research study?

The results from this study will be written up as part of a thesis aimed to improve local services. They will also be circulated to a wider audience through published papers and are likely to inform future research. Personal details will not be included in any of the reports.

Who is organising and funding the research?

This research project has been organised by the University of Nottingham and the Nottinghamshire Healthcare Trust. This research study is being undertaken as part of a PhD and has been funded by the Economic & Social Research Council and the Institute of Mental Health.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Nottinghamshire Research Ethics Committee.

Thank you for taking the time to read through this information sheet.

For further information regarding this study, please contact a member of the research team (Miss Ada Hui, Dr Hugh Middleton or Dr Birgit Völlm) at: Rampton Hospital, Retford, Nottinghamshire. DN22 OPD.

Tel: 01777 248321 ext. 6677.

Interview Consent Form
(Final Version 1.0: 1st August 2011)

Title of Study: The Use of Coercive Measures within Forensic Psychiatry

REC ref: 11/EM/0322

Name of Researchers: Miss Ada Hui, Dr Hugh Middleton & Dr Birgit Völlm

Name of Participant: _____

Please initial box

1. I confirm that I have read and understood the Staff Participant Information Sheet (Final Version 1.1: 28th September 2011) for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.
3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.
4. I understand that the interview will be audio-recorded and that anonymous direct quotes from the interview may be used in the study reports.
6. I would/would not*like to receive a summary of results from this study
(*Please delete as appropriate)
7. I agree to take part in the above study.

Name of Participant Date Signature

Name of Person taking consent Date Signature

2 copies: 1 for participant and 1 for the project notes

DECLARATION

I declare that this thesis is the result of my own work which has been undertaken during my period of registration for the degree of Doctor of Philosophy, School of Sociology and Social Policy, at the University of Nottingham. I have complied with the word limit for my degree as stated in the Quality Manual.

Word Count: 85,882

Signature of Candidate:

Date: