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Establishing an occupational milieu in aged mental health units: An occupational ethnography

A thesis submitted in fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

by

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FACULTY OF HEALTH SCIENCES
THE UNIVERSITY OF SYDNEY
2002
Declaration

This is to certify that this thesis has not been submitted for a higher degree to any other university or institution. This is also to declare that the source of the information contained herein is original and is solely the work of the author, except as directed in the text.

[Signature]

Tracy Fortune
Dated: 6 December 2002
Abstract

This thesis, an occupational ethnography, is the report of a two-year study that evaluated change associated with recent mental health policy initiatives such as mainstreaming. In particular, the study explores the division of one large in-patient aged persons' mental health unit into two smaller units. The prime reason for engaging in this study was to describe and analyse the ways in which staff and patients' engagement in occupations were either enabled or constrained by the broader socio-cultural environment operating prior to, during, and after the division and relocation process. As a researcher who is also an occupational therapist, the study explored the mechanisms by which valued occupational experiences are enabled by the organisation and its members. Engagement in occupations that are perceived as meaningful have been closely associated with health and well-being (Wilcock, 1998). Perspectives from staff informants in this study also support the idea that restrictive patient management practices are less likely to be required when patients are occupationally engaged.

The principle methods of data collection were the field research techniques of participant observation and interviewing. The aim of an ethnographic study is to produce a coherent account or credible story of the observed social environment (Clifford & Marcus, 1986; Emerson, Fretz, & Shaw, 1995; Spradley, 1979). In this study, the social environments observed were the original unit, Port Edward, and the two smaller units, Janson and Brennan units. The findings of this study clearly indicate that one unit, Janson, is not operating in a manner that could be described as occupationally engaging. Brennan unit, on the other hand, provides a stark contrast. The comparatively engaging environment at Brennan provides sufficient clues as to what needs to happen to alter the custodial and restrictive environments that Port Edward (to a large extent) was, and Janson appears to be.

As this study progressed, it became increasingly apparent that the occupational tasks and roles, attitudes and relationships of and between staff, determined how engaged patients were in their environment. Throughout the chapters, the occupations of key staff working in each unit are described and analysed. At a micro
level, it is clear that the work of one group of staff, and their relationship with others, is crucial to the establishment of a warm, engaging and least-restrictive environment. At the increasingly macro level, it becomes apparent that sufficient resources, respectful relationships and perceived professional support are required to enable interdisciplinary cooperation between ward, allied health and medical staff. The importance of leadership to the establishment of an engaging supportive treatment environment, or what I call an "occupational milieu" is uncovered, as is the need for strategic capacity building that focuses on all levels of the organisation.

The findings of this study have informed the development of a framework that describes the interrelationships between key factors that I believe, determine whether an environment such as an aged persons' mental health unit is constraining or enabling of patients' occupations. I have called this framework "Establishing an Occupational Milieu through Organisational Capacity Building." This framework draws substantially from work commenced within the fields of health promotion relating to capacity building (NSW Health 2000; Paul, 1995).

This study recommends that if an occupational milieu is to be established and maintained, organisational capacity must be built. A number of clear strategies associated with quality service development and provision are outlined. These capacity building strategies relate to organisation and workforce development, leadership, resource provision and partnership building. The relevance of capacity building and the utilisation of the ethnographic method are particularly related here to a study of occupation within aged mental health units. The utility of such frameworks in both research and planned change processes in other health and human service environments is also supported.
Acknowledgements

This study began early in 1998 during my time as an occupational therapy lecturer at Charles Sturt University (CSU) in the New South Wales border town of Albury. I had barely got myself into the swing of being a lecturer and researcher, before I was contemplating doing what I have now just completed. In the first instance, I would like to acknowledge the encouragement and support of my colleagues in the School of Community Health, and in particular, the Dean of Faculty, Professor David Battersby. My colleagues at CSU supported (or endured) several sizeable blocks of time release as I went off to the field to gather data. The School and Faculty also supported an extended scholarship period at the University of Sydney, where I was able to substantially progress the data analysis.

Sincere thanks and gratitude are extended to my Principal Supervisor, Dr Maureen Fitzgerald, who from day one embarked on both an empowering and intellectually challenging student-supervisor relationship with me. I thank Maureen for the respect she has shown to me as an adult learner, and for the deep understanding of and ability to enable an independent engagement with the research process among her students. Her knowledge as a medical anthropologist and her practical understanding of ethnography provided me with expert guidance through the numerous ethical and methodological issues that arose in the field.

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Finally, thanks are extended to the staff and patients of the three environments that became fieldwork sites for me. I thank the people of Port Edward, Janson and Brennan units for allowing me to be involved in their work, for talking about their work and for sharing their experience and expertise in the highly complex and rewarding field of aged mental health care. I hope that this ethnography captures an element of reality for these research participants, and that the findings of the study go some way to acknowledging their challenges and providing practical avenues for change.
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CHAPTER 1

INTRODUCTION

This thesis is a report of a two-year ethnographic study that explored one part of an aged persons’ mental health program in an urban area of Victoria, Australia. More specifically, this exploration focused on the acute in-patient (residential) treatment unit provided as part of the Port Edward Aged Persons’ Mental Health Program.¹ What follows is a story of the change that has taken place at Port Edward at a time in its history when it was preparing for and adjusting to the process of division and relocation from its original institutional base. The prime reason for engaging in this study was to describe and analyse the ways in which staff and patients’ engagement in adaptive and meaningful occupations were either enabled or constrained and to provide reasoned interpretations for both situations.

As the focus of this exploration is on an institution providing a service for aged persons with acute mental health needs, it is also the study of a health service organisation, and a potential therapeutic environment, or as I will propose, an “occupational milieu.” All social environments are comprised of people doing things, or engaging in occupations. This “doing” or “engagement” has potential to be positive or adaptive to the individual. Some environments may constrain occupation through lack of stimulus to engage, while others promote behaviour that does not maintain or develop a person’s capacity in a positive manner. Ideas related to engagement, capacity and occupation are explored throughout many of the chapters, and in particular, Chapter 3.

This is a study of a place and the people within it. This organisation, like all organisations, is composed of a collection of smaller communities or mini-societies, and an elaborate system of rules, regulations, rewards and punishments that provide a template for action and a backdrop against which members of the organisation go about their day to day lives. Organisations are also situated on historical and political bases. It is proposed that these universal organisational elements are open

¹ The names of people, the institution and its units are pseudonyms
to systematic study and critical analysis and that such analysis can offer us insights into how and why the current set-up functions as it does. An important objective arising from the description and analysis of this particular organisation was to consider ways of enhancing the organisation, to develop ideas for change and further organisational growth. Crucial organisational elements and ideas for change are presented in the final chapters as part of a framework that I have called “Establishing an Occupational Milieu through Organisational Capacity Building”.

The Port Edward Aged Persons’ Mental Health Unit, as an organisation and institutional setting that has recently undergone change driven by state and national mental health reform initiatives, provided the perfect opportunity to explore, in a naturalistic manner, both old and new service delivery models. The process of change enabled me to participate in a natural experiment, to explore the “parent” organisation prior to the change and the two smaller “resultant” organisations. The study represents, therefore, an ethnographic description of three separate institutional settings, a comparison of those three settings and a study of a process that may be likened to deinstitutionalisation. In this case, the organisational changes were based on reforms aimed at transforming a larger institutionally based in-patient mental health unit into two units that were to be more “home-like” and community oriented.

Background and relevance

The purpose behind studying this organisation was based on a number of hierarchically related goals. First, the study represents an attempt to describe my understanding of organisational life in an institution and to show how this institution, like others, is driven by processes reflective of wider cultural systems. Second, the study was an attempt to demonstrate how processes of the organisation impact on the nature of services provided by staff and received by consumers. In doing this, daily life has been described in a way that reflects as closely as possible the real values, daily struggles and viewpoints of the people who make up the organisation. Third, the study provided an opportunity to explore current patterns of
service provision by a range of health professionals, the relationships between different disciplines, and whether there is potential for a change in these patterns and relationships. As a researcher who is also an occupational therapist, the study explores the mechanisms by which valued occupational experiences are enabled by the organisation and its members. In this sense, this study may be thought of as an “occupational ethnography” where the philosophies and theories used by occupational scientists and therapists are used as a framework to explore the organisation of services and the everyday experience of life within the organisation. Occupations are bound within everyday routines and activities, and people are said to be occupationally engaged when they participate in culturally relevant self-care, productivity and leisure activities (Kielhofner, 1995). Theorists from a number of disciplines, including occupational therapy, have recognised the potential of institutional environments, and those who structure them, to facilitate or inhibit occupational engagement (Coppola, 1998; Perrin, 1997; Reilly, 1966). The study describes and analyses occupational behaviour and patterns of engagement within the focal institutions and the meanings that people have around these. Finally, this study was predicated on a need to evaluate services and, in turn, enable service providers to reflect on the outcomes of the recent service changes. The evaluative data provided through this study will enable service providers to plan and organise services in ways that are less restrictive, less disruptive, and more meaningful for the people who use them. The strengths and challenges that become apparent through the evaluation of the organisation have been considered from both occupational, and “capacity building” perspectives. Decisions associated with the adoption of such frameworks are outlined in Chapters 3 and 9.

In order to help me explore these related concerns, my overriding need was to make the focus of my study the organisation. The aged persons’ mental health units in both previous and current form were and are locked wards within larger institutions. Given the closed nature of the settings, a method of study that would give me, as an outsider, as full an access to the workings of the institutional settings as possible was required. The ethnographic method was felt to be the most appropriate given this requirement. In terms of how this thesis is presented, the study adopts a narrative or storied approach (Mattingly, 1998a, 1998b; McCance, McKenna, & Boore, 2001). Such approaches are consistent with the reporting of
ethnographic research in which the aim is to provide an analytic description of everyday life as experienced by human actors (Denzin, 1997; Fitzgerald, 1997). In this case, the actors are both the research participants and the researcher.

The principle methods of data collection were the field research techniques of participant observation and interviewing. Participant observation involves observing while either partially or fully involved in the activities in which a person or people are involved (Fetterman, 1989; Spradley, 1980). Interviews, both structured, formal audio taped conversations, and informal, situational conversations, provided verbatim data. The aim of an ethnographic study is to produce a coherent account or credible story of the observed social environment (Clifford & Marcus, 1986; Emerson, Fretz, & Shaw, 1995; Spradley, 1979). Through engaging in participant observation, peoples’ daily actions can be clearly described though observing them in the environment in which they occur. Understanding those actions is achieved through interacting or conversing with the people themselves. As an understanding of the social and cultural “scene” (Spradley & McCurdy, 1972) or environment began to grow over the course of the study, additional data gathering methods were used to enhance the clarity of the story. In order to describe life within the institutions of concern, and to validate the interpretations that I offer in relation to these, sections of my written fieldnotes are reproduced and verbatim or “word for word” interview data are presented throughout most chapters. The ethnographic field methods adopted to enable this are described in detail in Chapter 4.

Why study an aged persons mental health unit?

As part of the redevelopment of Victoria’s mental health service, a framework for aged persons’ mental health services proposed major reform initiatives, which included a mainstreaming policy and the development of community based services (Department of Health and Community Services, 1995). Specifically, mainstreaming has been stated to develop and strengthen links with general geriatric services and to “support the treatment of clients with a mental illness by trained expert staff in a community-based system” (Department of Health and Community
Further, it seeks to "reduce the relative isolation of mental health services and thereby lessen the stigma which applies to those services and the people using them" (Department of Health and Community Services, 1995, p. 2). The decommissioning of the more institutional parent organisation (Port Edward unit) was a direct response to this policy. The subsequent move to two smaller settings was felt to represent a positive and beneficial response away from segregated institutional management that encourages "patients to learn and behave in a context divorced from the community environment" (Department of Health and Community Services, 1995, p 4). Thus, there was a general belief that many of the perceived negative impacts of segregated institutionalisation, which may have been a feature of the original "parent" institution, could be addressed through the move. Again, one of the goals of this study involved exploring if this move, and all the other changes that would accompany it, was in fact successful in addressing perceived negative impacts. The findings of the study demonstrate clearly that a move, per se, is insufficient to promote the desired change, and that additional, comprehensive and strategically planned organisational changes must be implemented.

Factors that relate to the historic delivery of mental health services and how prepared the generic health workforce may be for new changes have been raised throughout recent Health and Community Services policy documents. In relation to staff, it has been acknowledged, "many service providers, including those in aged care, have not developed the expertise to assess and treat the mental health needs of clients" (Department of Health and Community Services, 1995, p 4). Thus, there seems to be some justification to systematically studying the new organisation of a service, which will be increasingly supported by mainstream (existing) geriatric services. Similarly, staff in existing institutional environments, such as Port Edward Hospital, have been expected to make adjustments in daily practices in addition to being moved physically away from the main psychiatric hospital. This study explored the nature of daily practices in the original parent institution and the two smaller resultant institutions and provides comment on the organisational capacity building required to establish an occupationally engaging environment.

Important background and historical issues that will be useful while working through the findings of the study are presented in Chapter 2. Relevant literature is
presented throughout the chapters, most formally in the background and methodology chapters. I have drawn extensively on relevant literature as a third form of data and, as such, the literature is interwoven throughout the chapters that present and discuss the numerous issues of importance, or the findings. This interweaving of literature throughout the thesis is quite usual in naturalistic approaches and, in particular, ethnographic research (Emerson et al., 1995).

Following the presentation of some key background issues in Chapter 2, I will introduce myself because, as the phenomenologists and post-modern theorists note, the researcher’s identity and social biography (Crepeau, 1997) is important in terms of understanding a particular work or interpretation. I expand on my introduction to Port Edward and the genesis of the study in Chapter 3. Chapter 4 extends discussion of the methodological approaches adopted, and Chapters 6, 7 and 8 present my story of life at Port Edward, Janson and Brennan units. In brief, the study describes how the daily occupational routines, activities and attitudes of the staff have contributed to both the occupational engagement and occupational constraint of the patients within the environments being studied; in this case, three separate units that are part of a single organisation.

Within the original, and largest unit, Port Edward, institutional routines related to eating, and hygiene, in conjunction with a large confusing physical environment, served to contribute to patient disorientation and limited choice in terms of how and when daily occupations occurred. Throughout a number of the chapters, I will highlight the way in which strong disciplinary demarcation of tasks and roles at Port Edward allow staff some control over their social and physical environment, but constrain and restrict opportunities for occupational engagement among patients. Examples of this constraint include the extent to which strongly habituated routines of the Personal Services Assistants (PSAs) limit the experience of a leisurely meal-time and how reluctance among the nursing staff to participate in the running of a group activities program for patients threatens one of the few opportunities for occupational engagement. In my analysis of Port Edward as it existed several months prior to division, I consider changes to staffing ratios, models of practice and how management and leadership issues may have influenced what appears to be a constraining institutional environment.
Following the division and relocation of Port Edward, I continued my fieldwork with the two resultant units: Janson and Brennan. Interestingly, Janson remains institutionally restrictive, while Brennan becomes the “more homelike” and “less restrictive” environment that the division and relocation process had hoped to produce. My interpretations as to why such differences exist focus again on management and leadership, staff routines, relationships and attitudes. As the study progressed it became clear that the ways in which patients’ occupations were enabled or constrained were heavily influenced by the occupational routines of staff themselves, and that these were, in turn, influenced by management and leadership and inter-staff relationships. While many field-note excerpts describe observations of patients, the analytic questions I posed for myself often revolved around the occupations of staff, for example: “How do staff occupations influence what I see occurring here now?”

In the final chapter, I reflect on the findings and implications of the study and provide some recommendations that are aimed at enhancing day-to-day life for both service providers and consumers in this and similar settings. In particular, I expand upon the notion of capacity building and consider how this and related frameworks can inform the establishment of an engaging treatment environment, an “occupational milieu.”

In order for this current portrayal of an aged persons’ mental health service in the process of change to be meaningful, both temporal and social contexts must be understood. A brief journey into the history of mental health service provision and a glimpse of the social and moral climate accompanying the evolution of mental health service provision is needed to situate the recent trend of scaling down institutionally based mental health services within the western world. As part of this, I also discuss the establishment of a number of the key professions, their respective roles and challenges. Finally, I situate this study and its particular methods within past and contemporary studies in the area of mental health service provision.

Throughout this study, the story of a real organisation striving to provide a service in times when change is demanded by policy makers, economists and mental health professionals themselves, the frustrations and hopes of people “on the ground,” both patients and direct care staff, come to the fore. This research is
similar to other ethnographic studies in that it "problemsicizes the ways that individuals and groups constitute and interpret organizations and societies on a daily interactional basis" (Schwartzman, 1993, p.4). It is different to other studies in that many micro-level processes are expressed through the opinions, attitudes, intentions and experiences of the people in these environments, and these expressions, interpreted through my occupational perspective, are unique. The explication and linking of these processes with macro-level structures, makes it possible "to understand the way that everyday routines constitute and reconstitute organizational and societal structures" (Schwartzman, 1993, p. 4). While the findings of this study may not change societal structures, they offer insights into both the need for this organisation and others like it to change, and the ways that this change might be effected.
CHAPTER 2

A BRIEF JOURNEY INTO THE HISTORY OF PSYCHIATRY, AND AGED MENTAL HEALTH AT PORT EDWARD

Organisations provide a definite structure to examine, and because they are made up of people they are composed of readily observable patterns of human activity and relationships (Foote Whyte, 1969). In-patient psychiatric hospitals, in particular, are recognised as being environments built on regimented daily routines where, as Goffman (1973) observed, “all aspects of life are conducted in the same place under the same authority, with phases of the day’s activities highly scheduled” (p. 17). As health service organisations, psychiatric hospitals attempt to provide a therapeutic environment within a bureaucratic institution (Parks, 1985), thus it is inevitable that tensions between espoused missions of cure and treatment, and broader historical, social and political forces exist (Edelson & Lyons, 1985; Goffman, 1973; Parks, 1985; Strauss, Schatzman, Bucher, Ehrlich, & Sabshin, 1964; Townsend, 1998). There is a need, as part of the study of organisations, to consider these less visible forces alongside the more readily observable aspects of daily organisational life. Past studies of change in organisations reinforce the role that historical and social forces play, that new institutions are not created from scratch but are built upon older institutions. In order to develop in a positive manner, new organisations must push back pre-existing institutional forms (Holm, 1988). Consideration of historical developments in the provision of institutionally based psychiatric care is important to enable an understanding of contemporary developments.

Changing contexts in the organisation of mental health services

As this study found, patients’ experiences are inevitably impacted by the kind of changes briefly outlined here, including changes to physical accommodation, models of treatment, social and economic trends, and the ways in which
professionals do their jobs. As a changing organisation, the Port Edward Aged Persons’ Mental Health Service has its own particular evolutionary story. Following a brief summary of broad context changes, the evolution of the aged persons’ mental health service at Port Edward is presented. An understanding of the recent history and the broader organisational context at play when I entered Port Edward unit is essential to understanding the “snapshots” of contemporary institutional life that I have presented in subsequent chapters.

The rise and fall of the asylum: A brief overview of philosophies and practices

In 1800’s Australia, asylums were built on “leafy, open sites” (Farelly, 1996, p. 15) with tranquil outlooks that were felt to be calming and restorative to troubled minds. Many of these sites were built some distance from the main town centers. Australia’s first “lunatic asylum” opened in 1811 at Castle Hill, New South Wales. Governor Macquarie’s stipulations for the promotion of the health and good comfort of the “lunatics” included: “to get a good garden into cultivation as soon as possible . . . in order that they may be furnished with a constant supply of vegetables. . . such of them as are fit for manual labour, are, with the permission of the surgeon, to be employed in cultivating the garden thus ordered, at stated hours everyday; which will be the means of not only amusing them, but likewise prove a wholesome exercise, highly beneficial to their health” (Neil, 1992, p.15).

Current hospital based care for a person with mental illness is no longer provided in large leafy asylums possessing horticultural and other large scale occupational programs, but in smaller and, generally, more geographically accessible locations, close to most consumers’ place of residence. In many respects, services are attempting to become a part of the community, both in terms of their proximity to their stated populations and the locations from which they are offered. The most recent changes in mental health service provision, including the changes explored in this study, are part of an ongoing evolution preceded and accompanied by historical, social and economic swings and turns, which can be most readily traced back to the nineteenth and twentieth centuries.
The philosopher, Michel Foucault observed that madness, once dealt with through confinement and isolation, has been the object of two discourses: one moral, emphasising salvation through work and normal responsibility, and the other, scientific, through treatment by medicine (Barrett, 1996). The care of people with mental illness has, from the Middle Ages, evolved from a primarily custodial type of “barrackment” (Parry-Jones, 1981) towards a comparatively more humane treatment-oriented approach, reflecting a shift from maintaining “order” to providing “care.” Despite frequently cited incidents of barbarity associated with early times, not all treatments of people with mental illness were punitive. In approximately 100 B.C. the Greek physician Asclepiades prescribed exercises and massages in light airy rooms, and the Roman, Soranus (98-138 AD), believed that patients should be treated in pleasant surroundings with activities that could relieve mental anguish (Alexander & Selesnick, 1966). A well elaborated biological theory of insanity is also observed to have been in existence from the time of Hippocrates (Roth & Kroll, 1986). The humoral theory, based on the thought that all illnesses, including mental illness, originate from imbalances in the natural humours (fluids) of the body, is present from Hippocrates right through to the Middle Ages and beyond. Co-existing with the physiologically based humoral theory was the belief that a “supernatural” force was the source of punishment for sins (Roth & Kroll, 1986). Thought to be a form of demonic possession, mental illness was treated by the clergy with exorcism, or torture and restraint, through the Middle Ages (Alexander & Selesnick, 1966). Some humane programs of care existed in these early times, but these appear to have been the exception rather than the rule. In the 1400s in Geel, Belgium, an early form of community care, a type of foster care for the mentally ill, was established (Parry Jones, 1981; Stein, 1997). However, it was not until the late 1700s and early 1800s that a more widespread and revolutionary shift in treatment and beliefs about causation came about.

Phillipe Pinel in France, William Tuke in England and Benjamin Rush in America were regarded as the key reformers and advancers of a “moral” form of treatment in which comparatively humane care coupled with prescribed activity and work was the dominant approach (Paterson, 1997; Stein & Cutler, 1997). The moral treatment movement, which was well in place by the late 1800s, signified a major paradigm shift in the care of people with mental illness. Coercion and restraint in
the discipline of difficult “inmates” was far from abandoned by these apparent reformers (Pinel, 1973; Rush, 1973; Scull, 1981), but their employment were to gradually become less. The patient was, as described by Barrett (1996), “exposed to philanthropic humaneness, a model of patriarchal family authority, a strict regimen of emotional self control and farming work... external restraints replaced by internal restraints” (p. 183). The birth of Australia’s mental health treatment services in 1811 coincide roughly with the moral treatment movement in Britain and the United States.

Prior to the development of psychoanalytic treatment and the widespread use of medications in the late 1950s, in the 1800s the new medical specialty of psychiatry saw doctors adopt physical treatments, such as blood letting, in the belief that mental illness was a symptom of physical disorder. Treatments used at Castle Hill, Australia’s first asylum, included “purgatives, blisters to the temples, and opening an artery to supply a seton, wine and bark (quinine), head shaving, cupping or bleeding”. (Neil, 1992, p. 50) These largely experimental physical treatments existed alongside moral treatment which remained the dominant model of care.

*Early mental health service provision in Australia*

The most significant transformation within mental health reform is stated to have occurred between 1880-1940 (Garton, 1988). As noted earlier, the first asylum was set up in Australia in 1811. The early asylums originally established in New South Wales were not viewed as hospitals and it was not clear whether the asylums were “charitable institutions, houses for moral reform or detention centers for the unwanted” (Garton, 1988, p.18). In 1868 Dr Fred Norton Manning was appointed as superintendent to the Tarbin Creek Asylum. Manning, a strong moral treatment advocate, introduced humane reform as part of the new Lunacy Act (1878). While British doctors were still recommending blistering, purging and leeches, Manning promoted the moral benefits of “good surroundings, hard work and religious instruction” (Garton, 1988, p.39). Routines of labour were encouraged for all acute patients with beer and tobacco being paid to working patients up until 1890. Labour was seen as a symptom of improvement in mental outlook and case notes of this
time frequently detailed the extent to which patients were occupied in some form of work or otherwise (Garton, 1988).

The decline of moral treatment

The psychiatrist Adolf Meyer’s biopsychosocial model of mental illness where “mental disorders were reactions of the personality to biological, psychological and social factors” (Castillo, 1997, p. 8) was a refinement of moral treatment philosophy. Meyer (1922, p. 639) believed that psychiatric disorders were “largely problems of adaptation.” The treatments employed involved the “use of time in helpful and gratifying activity” (Meyer, 1922, p. 639). This approach, which espoused the values of more humane care and “instruction” in the use of time in calming asylums away from society at large, created a societal demand for institutional care. This demand led to a growth in the size of many institutions, however, with a lack of funding to match the expectations of society, overcrowding contributed to an increasingly custodial and decreasingly therapeutic approach to care (National Health Strategy, 1993).

Moral treatment appears to have been as much a social and economic “by-product” of the time as it was an approach to treatment for the insane. The birth of the industrial era and the rise of capitalism created a climate under which the notion of rehabilitation could flourish. There were sound economic reasons to get people back into productive mode. Of English society at the time Scull comments:

Just as the peasantry who found the new industrial workforce were taught the rationale of self interest essential if the market system were to work, the lunatics too were to be made over in the image of bourgeois rationality: defective human mechanisms were to be repaired so they could once more compete with market systems. And finally, just as hard work and discipline were the keys to the success of the urban bourgeois, from whose ranks Tuke came, so his moral treatment propounded these same qualities as the means of reclaiming the insane. (Scull, 1981, p. 115)

Some observers of psychiatric reform believe that the widespread impact of moral treatment was limited by the establishment of psychiatry as a branch of
medicine. Freud's psychoanalytic theory, and associated verbal based therapy, also pre-dated the widespread use of medications, and is also likely to have impacted on the continued viability of moral treatment in rapidly overcrowded asylums. In Australia, as in the rest of the Western world, moral treatment ideals were abandoned due to overcrowding and an inter-war staffing crisis in the 1930s. In New South Wales, this crisis clearly shows itself in greatly increased seclusion and restraint rates in the 1920s and 1930s (Garton, 1988).

Alongside changes driven by societal expectations were further paradigm movements regarding the causes and best treatments for mental illness. The disease "model" viewed a form of brain disease as the major cause of mental illness. This increasingly biomedical approach, which gained momentum in 1950s Britain and America, saw the introduction of medications such as lithium, which was used to treat depressive conditions, and neuroleptics for the treatment of psychotic symptoms.

Three major developments in the recent history of psychiatry have been suggested by Rapoport (1960). The first relates to the humanistic reforms of Meyer, Pinel and Tuke. The second major advance was the rise of moral treatment, as a "total" environment therapy. The therapeutic community or milieu therapy, the third development, is stated to be built on the idea of favourable environmental conditions associated with moral treatment, but included both interpersonal and psychoanalytic ideas. What was the best of the moral treatment era continues according to Rees (as cited in Sharp, 1975) as today's occupational, recreational and social therapy. The idea of the therapeutic community was, from Rees' perspective, nothing new, as these therapies continued to focus on a "total picture" model.

*The modern custodial era: A "crisis" of numbers*

In the 1950s it was not uncommon for most Australian psychiatric hospitals to house in excess of 1000 patients. In terms of staff, most hospitals had very few psychiatrists or medically trained staff, relative to the large number of patients. Nurses formed the majority of staff, though a large number of these were untrained. Other hospital staff included occupational therapists and social workers, however
not all hospitals had these staff. Stoller's (1955) report on mental health facilities in Australia provides a snapshot of the facilities and human resources of the largest hospitals in the country:

Callan Park (New South Wales) (1,845 patients) There were four psychiatrists on the staff and two other medical officers. Full-coma insulin treatment was available for 10 males but no females. E.C.T. was given under mass conditions. There was one social worker and a part time psychologist. There were six male occupational therapists and only one female full trained, although she was periodically assisted by three to six trainees from the O.T. school. A librarian attended for four days a week. Nurse patient ratio was 1:6, but of the female staff only a third were trained, as compared with well over a half of the male nursing staff. The institution was largely custodial and the shortage of medical staff allowed little active treatment. Self-directed patient activities were not encouraged, and community participation was minimal. The figures for restraint and seclusion in this hospital reflected poor general treatment attitude, and marked overcrowding (Stoller, 1955, p. 23).

Mont Park Hospital (Victoria) (1,402 patients) Nursing staff numbered 135 female (25 mental certificates, six general) and 96 male (29 mental, 3 general). This gave a nurse patient ratio of 1:6. The neurosurgical center did major surgery for the Mental Hygiene Department and had performed 30-40 psychosurgery operations. Working patients only numbered 27 percent. There was a female OT building for 60 and a male one for 40 (Stoller, 1955, p. 59).

Claremont Mental Hospital (Western Australia) (1,498 patients) Medical staff consisted of a psychiatrist superintendent, a deputy superintendent and three other medical officers. There was little in the way of psychiatric therapy beyond E.C.T. Nursing staff consisted of 181 males (60 certificated) and 97 females (17 certificated) giving a nurse patient ratio of 1:5.3. There was no social worker. There were no special social rooms for patients' own activities. There was no special library, but a number of books were stored in the receptionist's office and were available for distribution. A small occupational therapy carpentry
pavilion was present in the admission ward. A number of females worked in the main sewing-room at the laundry. Sewing and fancy-work classes were in two female wards. A large OT pavilion for 60-70 patients was in the course of erection. Recreation facilities were quite good, but patient participation was not highly organized (Stoller, 1955, p. 133).

A 64 bed aged persons unit administered from Royal Park Hospital in Victoria is described as follows:

Staffing consisted of a matron and a male and female charge nurses. Two male nurses were on loan from Royal Park Hospital. Patients were mainly seniles and a few alcoholics. Three female and three male staff lived in, plus an ex-patient gardener. The unit fulfilled a custodial role. No occupational therapy, even, was available. (Stoller, 1955, p. 58)

Stoller (1955) reported that the number of operative beds in mental hospitals was 24,170 in 1953. He estimated that the shortfall was approximately 11,000 and anticipated that by 1965 the mental health population would increase by 70 percent. The major form of psychiatric treatment appeared to revolve around full and sub-coma insulin therapy, electro convulsive therapy (E.C.T.), some psychosurgery and some group and individual psychotherapy. The use of the drug Largactil is noted in several of the Australian facilities included in the report. Thus, at the time of Stoller’s (1955) report, physical treatments were the main form of psychiatric therapy. Psychiatrist numbers were limited and untrained nurses formed the largest proportion of staff working in the mental hospitals. Occupational therapy services were provided at many hospitals with some having significant workshop and craft programs.

**Rising anti-institutionalism**

Control of the symptoms of mental illness with medications allowed a number of people who would have previously been institutionalised on a long-term basis to exist outside of psychiatric hospitals. There was also a growing movement against long term asylum care which, as Goffman described in his classic 1960s study of
asylums, could cause "disculturation" or "untraining which could render the person temporarily incapable of managing certain features of life on the outside" (Goffman, 1973, p. 23). The asylum era was also felt to contribute to a marginalisation or "stigmatization" (Goffman, 1968) of mentally ill people from the rest of society, and the geographic location of many of the early asylums is likely to be, in part, a reflection of this. With mentally ill people hidden away from the mainstream community on the edge of towns, fear and prejudices were maintained.

Goffman's (1973) studies focused on what he referred to as "total" institutions, such as prisons and locked psychiatric wards. An unspoken and largely unrecognised objective of the institution, despite public missions of care and protection, was to maintain its own organisational order, thus treatment often ran counter to the workings of the system. In these total institutions, Goffman (1973) notes that staff tended to "feel superior and righteous and inmates in some ways feel inferior, blameworthy and guilty" (p. 18). Patients are described by Goffman as being managed as human objects, with all "inputs and outputs and activities of the person" (p. 74) recorded.

Foucault (1979) also observed the de-humanising qualities of institutional places, describing that the therapeutic and medically useful "space" was born out of disciplinary space, an administrative and political space that "tended to individualize bodies, diseases, symptoms and life and death" (p. 144). Institutions with such constant levels of surveillance (Foucault, 1979) were certain to exacerbate any pre-existing sense of depersonalisation. In exploring the "total" environment, Goffman focused on the staff as well as patients. Of patients he observed how initially, they are "transformed into cooperator, a normal programmed, built in member" and then later "employ unauthorized means to counter what the organization wants" (p. 74). Staff, also capable of becoming institutionalised, made what Goffman called "secondary adjustments" (p. 184), engaging in practices that ran counter to the rules and regulations of the organisation. Despite recognition of the aims of psychiatric hospitals to provide patients with a supposedly therapeutic environment that released them from the day-to-day concerns of their normal existence, Goffman (1973) stated that it would be "difficult to find environments that do not introduce more profound insecurities - and what responsibilities are lifted, are removed at a very considerable and permanent price." (p. 331)
Increasingly, institutions became viewed as over-controlling, restrictive of choice, and generally harmful. This apparent rising anti-institutionalism (Johnson, 1998) preceded a movement throughout the western world towards "de-institutionalisation" which, along with concepts relating to "normalisation" and "least restrictiveness" (Wolfensburger, 1970), gathered strength. Deinstitutionalisation involved a "discharge of existing patients into the community and a policy of reducing admissions and treating people outside specialised psychiatric institutions" (National Health Strategy, 1993, p. 20). In Australia, psychiatric hospital bed numbers declined from approximately 30,000 in the early 1960s to approximately 7000 by the early 1990s (National Health Strategy, 1993). Despite a general social perception that de-institutionalisation has been successful in improving the quality of life for previously institutionalised mentally ill people, many concerns and criticisms were and are voiced. Among the continuing concerns is the perception that resources (money and skilled staff) present in the former institutions have not followed people out into the community (Australian Broadcasting Corporation, 1994; Mechan, 1995).

Deinstitutionalisation was also felt to have contributed to a proliferation of community and non-government agencies disconnected, or at best only loosely connected, to each other, which, for the person with a chronic and long standing condition, would prove to be impossible to negotiate. Still other critics note that a number of those people formerly living in large hospitals have not been deinstitutionalised, rather they have merely moved into other smaller institutions. This proliferation of "transinstitutionalisation," particularly among older persons with mental illness, is, according to some observers, evidenced in an increase in nursing home admissions following hospital closures (Mott, 1997; Swan, 1987; Willis & Morrow, 1995). Along a similar line, increasing re-admission rates associated with short hospital stays, a "revolving door syndrome," is stated to be another effect of larger institutional closures (Sandler & Jackoet, 1985). In Australia, de-institutionalisation has not resulted in a total loss of hospital beds, rather, former specialist psychiatric in-patient services are being delivered from regular health service sites. This process of treating mentally ill people outside of specialist psychiatric hospitals has been referred to as "mainstreaming" (Commonwealth Department of Health and Family Services, 1997; Manderschied,
1997; Department of Health and Community Services. 1995; National Health Strategy, 1993). Mainstreaming is aimed at providing inpatient care "closer to where people live, in less stigmatized environments" (National Health Strategy, 1993). Mental health strategy reports have cautioned, however, that mainstreaming cannot guarantee immunity from the long-standing effects of institutionalisation:

A challenge facing those States with large institution based workforces is to ensure that movement of staff into new community services is accompanied by programs to facilitate development of the skills required for effective community practice. These do not come automatically with changes of work location; experience elsewhere has taught that the culture of institutions can survive a hospital closure. (Commonwealth Department of Health and Family Services, 1997, p. 122)

In the state of Victoria, area based health services currently rely on a case management system that attempts to provide a "whole of life" (National Health Strategy, 1993) service previously offered in psychiatric institutions. These comprehensive services offered by health professionals allied to psychiatry, such as social workers, occupational therapists and psychiatric nurses, aim to prevent the more chronic mentally ill person from "falling between the cracks" of service provision. These "case managers" have access to back-up hospital beds in smaller "acute" units when people need to return for "longer term inpatient treatment and rehabilitation, or specialized secure treatment environments" (National Health Strategy, 1993, p. 23). Thus, there appears to be a developing community treatment system that maintains some institutional support, albeit on a smaller and more short-term basis. Of the growth of the non-government sector and community based services, which are being increasingly identified as taking on the rehabilitation and personal recovery aspect of care, the National Mental Health Strategy evaluation recommendations include the statement that:

Personal recovery and rehabilitation services cannot exist in isolation of treatment services. The challenge in achieving a balance of illness and rehabilitation approaches requires coordination of services rather than segmentation. Where the illness is of a long term nature, or recurrently episodic, services are needed to assist the person to restore their lives as much as possible, and find ways to adapt to living with a chronic illness. The skills required to assist
consumers in these ways are underemphasized in favour of models promoting the treatment of acute symptoms. A better balance of approaches is required to improve long-term consumer outcomes. (Commonwealth Department of Health and Family Services, 1997, p. 27)

It appears that the best of services and expertise previously provided in institutional settings should continue to be provided in new and existing facilities in order to guard against what might result in a total deletion of programs that are not "somatic" or medication related. Thus, in-patient programs, the acute units, should not become merely medical and symptomatic in focus and multiple approaches should be adopted in both the community and these more institutional settings.

Practice and professionalism in mental health service provision:

Ideologies and their influence on treatment.

Like all organisations, the functioning of psychiatric institutions and the social organisation within them reflects the divergent economic and political interests between members (Frost, Moore, Louis, Lundberg, & Martin, 1991). A study by Strauss, Schatzman, Bucher, Ehrlich and Sabshin (1964) that explored the ways in which professional forces impact on the practice of psychiatry in institutions proposed that the social structure of the hospital is derived from "the number and kinds of professionals who work there, the treatment ideologies and professional identities of these professionals" (p. 351-352). In order to understand what is happening in hospitals it is important, therefore, to consider them from the standpoint of being places where professionals have fought for an identity and continue to pursue their own purposes (Strauss et al., 1964). Of the interplay between professions, their ideologies and practice, Strauss et al. found that professional ideologies and identities impact on: distinctions between types of patients and the goals formulated in relation to them, whether all staff will carry out the same type of activity with patients, what position the member will take with regards to a custody/management versus treatment rhetoric, the moral position of members regarding types of treatment, such as electroconvulsive therapy versus
psychotherapeutics, negotiations and relationships with non-professional staff, and, ultimately, the ability to work together in the organization (Strauss et al., 1964).

As with virtually all branches of health care, the medical profession has dominated both thought and practice in working with people with mental illness. At this time, the disease-focused view of psychiatry continues to predominate among medically trained psychiatrists and the use of medication for the control of symptoms still has prime legitimacy, however other views and approaches are tolerated. Changes to DSM-IV have seen the introduction of other factors that may need to be considered in diagnosis and treatment, such as culture (Castillo, 1997), and mental disorders are stated to be a “manifestation of a behavioral, psychological, or biological dysfunction of the individual” (American Psychiatric Association, 1994, p. xxi-xxii). Despite changes in emphasis and an apparent incorporation of other factors, it is usually psychiatrists who are at the head of the decision making chain regarding the treatment of people with mental illness within in-patient or acute unit settings. It was the increasing popularity of institutional care and the opportunities this provided that saw psychiatry gain such a firm footing, while the introduction of medication as part of the disease-oriented view strengthened the place of psychiatry in the care of people with mental illness (Castillo, 1997).

Professions allied to psychiatry

The rise of the asylum and the moral treatment movement saw the birth of a number of professions allied to medicine and psychiatry who today remain an integral part of many in-patient or acute units, including among others, psychiatric nursing and occupational therapy. In England, psychiatric nursing originated when asylum attendants received training. Initial training in 1891 focused on first aid and handling difficult and aggressive patients (Nolan, 1993). One historical account of psychiatric nursing in Britain asserts that the medical profession “capitalised on training to improve its own public image by claiming that the increasingly detailed practice of psychiatry now demanded skilled assistants” (Nolan, 1993, p. 155).
The occupational therapy profession had its origins in the use of "occupation aides" who helped in the work and activities programs as part of the moral treatment movement of British and American psychiatry. While the overcrowding of many asylums in Britain and America meant that patients were gradually required to work more for economic rather than treatment purposes (Paterson, 1997), there was some renewed interest in the considered use of occupation for therapeutic purposes in the early 1900s. Of the moral treatment champions, Adolf Meyer, who emigrated from Switzerland to America in 1892, was possibly the strongest advocate for the use of occupation in an effort to assist patients to adapt to themselves and their environment. Meyer is stated to have advocated an approach to mental health that "did not emphasise drugs, custodial care, incarceration or psychosurgery" (Stein & Cutler, 1997, p. 46). It was Mrs. Meyer, a social worker, whom Meyer states may have been (in 1902) one of the first, "if not the first, to introduce a new systematized type of activity into the wards of a state institution" (Meyer, 1922, p. 639). Regarding the use of occupation he stated "our role consists in giving opportunities rather than prescriptions. There must be opportunities to work, opportunities to do and to plan and create and to learn to use material" (Meyer, 1922, p. 641)

In the United States, occupational therapy was used as a formal program in psychiatry in the Bloomingdale Asylum in New York during the early 1900s (Stein & Cutler, 1997), with the profession being established there in 1914. In the Bloomingdale department, Louis Haas used crafts with patients in order to provide a realistic work environment that would promote satisfaction in having achieved something. In England, occupational therapy, based on moral treatment philosophy, was also practiced in the early 1900s with an English training program being established in 1930. In Australia it appears that the treatment orientation in the early 1950s was custodial and occupational, however the extent to which occupational therapy engagement was becoming more individualised is not known. In his account of the development of the Mental Hygiene Service in Victoria, Cunningham Dax (1961) refers to the employment of occupational activities and occupational work by occupational therapists in occupational centers, which changed in focus from large craft classes (occupational work) to industrial activities.

Both occupational therapy and psychiatric nursing had their origins in the asylums and experienced growth during the moral treatment era. Both professions
were also influenced by increasingly inter-personal and psychodynamic approaches to treatment. Influenced by Freud's psychoanalytic theories in the 1900s, and a perceived need to increase their scientific base, occupational therapists in psychiatric institutions adopted a dynamic approach that saw them gradually abandon their occupational focus on engagement in work and leisure activities in favour of activities therapy used with patients to help them in the expression of unconscious intra-psychic matter. A number of scholars in the field noted that the profession was losing its original occupational focus and, in 1966, Mary Reilly (1966) referred to the need for occupational therapists working in psychiatric institutions to continue to build and nurture a milieu, an environment, that "acknowledges competency, arouses curiosity and demands behavior across the full spectrum of a human's abilities" (Reilly, 1966, p. 63). Reilly also provided interesting views on the various roles of the professions in relation to the patient-practitioner relationship:

We acknowledge that there are special conditions for communication with psychiatric patients which must be learned and practiced. The special conditions, we believe, are not the same for the psychiatrist, the nurse and the occupational therapist. We agree that thinking and feelings may be broadcast through interpersonal transactions and these transactions are primary areas of concern for the psychiatrist and the nurse. It is our conviction that patients also broadcast their thinking and feelings through what they do. This area of performance is of primary concern to the occupational therapist. We submit that these concerns are similar but not the same thing. (Reilly, 1966, p. 66)

In Britain, concern regarding the role of psychiatric nursing centered on a growing fear that nurses would become mere medicine dispensers and doctors' assistants, and that jobs would be under threat from occupational therapists and social workers whose numbers were increasing in the 1950s. In the United States, the work of Hildegard Peplau, who was strongly influenced by the work of Harry Stack Sullivan, provided psychiatric nursing with the "interpersonal relationships" model on which to base its practice and scholarly inquiry (Chambers, 1998, p. 204). This model proposed "listening, reflecting, reviewing, problem solving, remaining self aware and using self as a therapeutic agent" (Chambers, 1998, p. 204).
Psychiatric social work, as a specialty of medical social work, is stated to have originated in America at the Boston Psychopathic Hospital in approximately 1906 (Timms, 1964). The first school was set up there in 1916 following an interest in mental hospital after care. In Britain, social work on behalf of the mentally ill appears well established outside of mental institutions by the 1920s, and was preceded by the foundation in 1877 of the “After-Care Association for the Female and Friendless Convalescent on Leaving Asylums for the Insane” (Timms, 1964, p. 14). In Britain, general social work had its origins in charitable organisations and extended into medical social work from the work of almoners who were largely concerned with payment and the abuse of free services in hospitals. First appointed in 1895, they were required to undergo a general social science diploma. Psychiatric social work was not established as a recognised discipline with its own course until approximately 1930. Thus, unlike psychiatry, occupational therapy and psychiatric nursing, social work did not appear to have its genesis in the asylums of the moral treatment era, but within the community. In Britain and the United States, specialist training courses to prepare social workers for psychiatric practice were in existence by 1930, however, in Australia, social work was a generic training program, enabling graduates to practice in any area. In calling for a specialist psychiatric social work course to be introduced in Australia, Stoller (1948) stressed that the functions of the social worker would be:

1) Lucidation of the facts about the social situation of the patient, 2) advising the psychiatrist as to the Social Agencies which may be available to deal with the problems of the patient and then making those practical arrangements which are necessary, such as admission to special homes or hospitals, 3) interpreting the patient's illness to the family and also, helping the patient attain that attitude of mind which is handicapping his satisfactory adjustment to his social milieu, naturally in cooperation with the psychiatrist. (p. 15)

Current challenges for the allied health professions: Nursing and occupational therapy

Both psychiatric nursing and occupational therapy within psychiatry face significant challenges relating to staff numbers and quality of practice. Current crises within psychiatric nursing in Australia include those directly and indirectly
associated with two key occurrences: deinstitutionalisation and the cessation of separate undergraduate education for psychiatric nurses. In relation to deinstitutionalisation, the concern that psychiatric nurses have been discredited by the findings of critical researchers interested in studying institutions and their negative impacts has been raised (Willis & Morrow, 1995). A perceived change in the client profile where those now admitted to the "new era" ward are felt to be the most disturbed, and frail and chronic of individuals are creating a burden on wards that are being increasingly staffed by either inexperienced nurses and/or enrolled nurses (Meehan, 1995; Willis & Morrow, 1995). Enrolled nurses undertake formal training for the equivalent of a full year as opposed to the three or four years taken by registered nurses or psychiatric nurses. Related issues include the observation that clients bored in the new post-institutional hospital ward develop maladaptive behaviours causing an increase in stress for nursing and medical staff. The extent to which nurses can and/or do spend time interacting with their patients beyond "routinised" care giving tasks (Bray, 1999; Lepola, 1997; Meehan, 1995; Tichen, 1998) and their ability to develop and maintain the type of interpersonal therapeutic approach originally espoused by Peplau (1952) have been areas of concern.

Historically in Australia psychiatric nursing was a separate field of nursing with its own educational program. More recently psychiatric nursing education has become integrated with general nurse education. This has raised concerns regarding several related issues (e.g., Happell, 1997). The first queries whether changes in the content of integrated curricula are sufficient to support the skilled practice of psychiatric nursing by comprehensively educated nurses. The second relates to the extent to which the changes will have a positive impact on nurses’ desire to enter what appears to be a relatively unpopular area among undergraduate nursing students. Thus, the issue of recruitment into the area of mental health has, for nurses, been perceived as a significant area of concern.

A current crisis relating to the practice of occupational therapy in mental health in Australia can be seen to stem from two main issues. These are: recruitment and retention within the profession generally, and deinstitutionalisation (Stephenson & Vanclay, 1989; Weir, 1991). As a profession, occupational therapy has, throughout its history, periodically experienced shortfalls in a number of specialty areas and geographic locations. Within the field of mental health, the
process of deinstitutionalisation has superimposed an additional challenge to a profession that has continually struggled to obtain a critical "mass" within various health and welfare settings. The closure of large psychiatric institutions and large occupational therapy departments from the late 1980s saw with it the demise of a relatively strong career structure, which provided the opportunity to develop clinical expertise with the supportive supervision from more senior colleagues. Although opportunities to practise within community mental health teams have grown, roles within these settings have taken on a more generic and interdisciplinary focus, thus occupational therapists have experienced having to compete with other disciplines for such positions and, if successful, have had to adjust to practice as the sole occupational therapist. This has been seen as a positive challenge for the profession (Weir, 1991) on the one hand, and, on the other, it has been seen as a threat, where limited numbers and visibility, would weaken the professional image (Stephenson & Vanclay, 1989).

Another layer of this problem that has attracted recent discussion at a national and international level relates to reduced opportunities for mental health fieldwork for undergraduate occupational therapy students (Ciolek, 1998; Hayward, McNamara, & Carmody, 1998; Vuksic & Dean, 1998). Given that undergraduate students were traditionally placed in large occupational therapy departments in psychiatric institutions, a loss of such supportive learning environments has contributed to a greatly decreased opportunity to experience the role of the profession within in-patient settings. Thus, deinstitutionalisation and recruitment problems within the occupational therapy profession, has created a crisis in which the visibility of the profession within in-patient mental health has declined significantly.

Challenges for Psychiatry

Despite the leadership position that psychiatry has come to enjoy in the field of mental health, a number of new challenges exist which threaten this position, particularly in the field of aged mental health. As will be discussed in Chapter 8, an "approach to resourcing that considers the needs of older persons with acute
psychiatric disorders as inferior to those of people with similar illnesses aged under 65” has meant that comprehensive service provision, addressing both diagnostic and rehabilitation provision is difficult (Ames & Stafrace, 1999). The threat of a reduction in the involvement of psychiatrists in management and an increase in the role of less costly “allied health or non-clinical staff represents an obstacle to the constructive involvement of psychiatrists in the change process” (Ames & Stafrace, 1999, p. 783).

Broad evolutions: A summary

The establishment of and growth of institutionalised forms of care for people with a mental illness is associated with custodial management provided (initially) by attendants turned “psychiatric” nurses. Social and economically informed changes saw the establishment of “engagement” style treatment for psychiatric patients removed from normal life. Within highly organised institutions, nurses helped to supervise engagement in structured occupations, and provided a springboard for the establishment of occupational therapy as a profession. Prior to and throughout these movements some medical practitioners provided direction for custodial and then moral treatment, while others continued to experiment with, and provide, somatic cures. The discovery and widespread use of pharmacotherapies, in conjunction with gradually changing societal views about large scale institutional management has firmly established the role of medicine both within the new “community” system of treatment and new versions of institutional treatment. For medicine, role legitimacy and effective power has strengthened, while nurses, occupational therapists and social workers grapple with their roles relative to that of each other and medicine. The widespread use of medication and changes to the availability and desirability of in-patient institutional treatment has altered the “core business” and de-stablised the role legitimacy of some professions.
Making sense of an evolving organisation: Port Edward Aged Persons’ Mental Health Service.

As previously outlined, this study is ultimately concerned with analysing a defined aspect of the “industry”, a particular service, catering for a particular client group within a defined period, 1998-2000. This particular service is an inpatient unit called Port Edward. The evolutions of the “industry” prior to 1998 and the evolution of this particular service are more than just background reading. An analysis of the origins and evolution of aged persons’ mental health services in this particular setting will reveal that while evolution occurs, old forms and past challenges reappear. Change is not new to the aged persons’ mental health service. The most recent move (the division and relocation) is just one of numerous changes in the history of the service. The most important of these includes physical, attitudinal, administrative and personnel changes.

The story of the in-patient aged persons’ mental health service begins with Charlotte ward, the very first ward to cater for large numbers of older people on the original site. Charlotte ward was one of a number of wards set within the grounds of a very large old psychiatric asylum, called Orana Villa. Orana Villa Psychiatric Hospital, which dates back to the early 1900s consisted of wards that catered for adolescents and adults, some of which were in the process of, or had already moved to, new locations by the late 1990s. One ex-staff member of Charlotte ward described the institutional nature of that ward:

That was a very institutionalised unit with dormitory style accommodation, a large lounge room, one large dining room, and was a locked facility, and it was very clearly a locked facility. When people came into the unit, they had to be let in and when people required to go out of the unit, they had to be let out. A little different from the restricted environment, it was solely a closed environment. At that time the majority of the population was of people carrying the diagnosis of dementia and everybody was housed in basically the one dormitory area at night time . . . with only partitions, low partitions which really didn’t provide any privacy . . . there were bed screens around the individual beds but there was no privacy for conversations as such. We also had communal bathroom areas and we only had two shower areas. There were some single rooms in that environment but they had historically been seclusion rooms because prior to the ward becoming a psycho-geriatric unit it actually had
been the locked female admission ward for many, many years. It was a big rambling ward very much on the institutional lines.

Another informant reported that while the old Charlotte ward was an aged care ward, older patients who had "functional" problems such as depression or schizophrenia were admitted to general wards with much younger adults. The patients of Charlotte ward were typically those who had behavioural problems as well as physical and cognitive impairments:

You had 33 patients, probably 15 of which would have been chronically physically dependent.

... Probably most of them suffering from severe dementia and needing a lot of physical hands on work during the day and night.

The move in 1986 heralded a new era in aged persons' mental health services. The Port Edward Aged Persons' Mental Health Unit existed on the Orana Villa site for 13 years before the relocation discussed in this study. As a new unit, Port Edward was seen as an innovative service within both Orana Villa Psychiatric Hospital and the mental health field in Victoria. The move formalised the segregation of adult and aged psychiatry. The unit was now a specialist aged persons' mental health facility to which all patients over the aged of 65 would be admitted. This resulted in the birth of a new psychiatric specialisation. Statements by a former Port Edward senior staff member indicate that the move from Charlotte Ward resulted in both changes in attitudes towards aged persons' mental health and the reputation of the unit.

Port Edward was actually accredited 3 times, twice under the umbrella of Orana Villa and then under the umbrella of the Portside Health Care Network, so the unit had been accredited 3 times ... it did mean that we had attained a standard. ... when we moved into Port Edward and things started to settle down there was a great shift in how people viewed psycho-geriatrics. It was no longer the punishment area, it was an area now that staff were requesting to come to work in, it was very much seen as a teaching area, we had started developing great links with the universities, we were now having medical students coming through the unit ... and the unit was seen as having nursing staff who had great expertise and great skill in psycho-geriatrics ... and there was recognition of that skill, it was not a dead-end job anymore, that you did not only feed, shower and change people.
The new unit appears to have gained not only respect, but more nurses and other staff. With the move came the introduction of on-site allied health input, such as occupational therapy, social work and psychology. These professionals had previously been located and managed within discipline specific departments away from the actual wards. They were now to be managed by a unit manager, a nurse with ultimate authority over the day to day running of all aspects of the unit. The nurse unit manager, previously the head nurse, engaged in daily clinical practice, was now viewed as a non-clinical leader, and additional support for nursing research and education and clinical leadership was provided in the form of a Clinical Nurse Specialist (CNS). The Port Edward unit also introduced a specialist Dementia Management Program (DMP), which was unique in Victoria at the time. Under new leadership from the former CNS who later went on to become the nurse unit manager, this special program operated as a segregated wing of the unit, opening in response to an increased admission of patients with dementia. The opening of the new wing, which required its own dedicated staffing of 2 nurses, brought the number of admissions to Port Edward up to 36. A staff member recounts the precursors to the DMP being set up:

We had noticed from observation that there was basically a very, very big mix of patients with dementia and patients with affective disorders, and they were getting very frustrated with the wandering intrusiveness and the basic interference of the patients who suffered from dementia and no amount of explanation to them about their behaviour would suffice. They basically wanted to see us doing something about it . . . we actually produced something that was never done before, we actually had . . . an acute dementia unit which I don’t think exists still in Victoria.

With the change of government in the early 1990s and the introduction of new streamlined and, reputedly, more integrated health care “networks” across the urban area, Port Edward unit ceased to operate under the administration of Orana Villa Psychiatric Hospital and major changes to the management structure and staffing began. A nearby aged care service, Portside Hospital, took over the management of Port Edward unit. Allied health disciplines, such as occupational therapy and social work, ceased to operate within their own independent teams and were incorporated into the new Portside managed unit. Physical space was made for the new allied
health staff in disused bedroom suites and a small office space needed to be built in
the foyer of the unit to accommodate independent record keeping and extra
secretarial staff who took over the functions previously carried out by Orana Villa
Hospital administration. Plans for major physical changes were again underway
with news that the Port Edward unit would eventually be divided into two units and
be moved to other sites. Similar to other large psychiatric hospitals in Victoria,
Orana Villa was to be gradually de-commissioned in line with mental health policy
initiatives to reduce the number and size of “stand alone” psychiatric hospitals, or
hospitals that were not attached to general health services. A senior staff member
described some of the changes occurring at this time:

Back in 1995, a tender went out for services and the Portside Hospital actually won the tender
for aged psychiatry . . . so it went to the Portside Hospital. There were some major changes
the Unit went through . . . there were staff cuts all over the place, because the unit had to
become independent financially. It was actually supported a lot by Orana Villa itself.

The DMP also closed at this time, although the closure is stated to have been
related to multiple issues, rather than simply a service “cut” associated with the
administrative take-over:

Why we shut it down is 1. We couldn’t get staff to work down there. 2. We needed to
prepare for the move, and we weren’t going to be able to have dementia management in that
kind of form when we moved, because we wouldn’t have had the staffing levels.

Staffing levels and the way in which nurses would work underwent a
significant change at the time of the restructure. There was a phasing out of 12 hour,
2 day on/ 2 day off shifts and the introduction of 8 hour shifts. A reduction in
nursing staff was effected through the closure of the DMP and discontinuation of
funding for the CNS position. This heralded the start of what appeared to many
staff to be a shift in concern from the support and development of staff, to a concern
with budget balancing. One staff member relayed the realities of the balancing act
as follows:
You come into that balancing of quality and money, because all the arguments had been put up for the 8 hour rosters, that there was better communication between staff, that you could get in a better skill mix of staff, that there was better continuity and all that sort of thing. At the end of the day the 8 hour roster cost more so we had to look at reducing our staffing levels, so the clinical nurse specialist was one of the roles that went.

With the administrative move completed in 1996, all that remained to complete the mainstreaming and de-commissioning process was to divide and physically relocate the old Port Edward unit. Plans for one of the new units, Janson, were completed and plans for the second unit, Brennan, were to begin some time later. Many staff had made choices in terms of which unit they would like to move to months prior to the expected move date of early October 1998. Significant personnel changes were to precede the physical move, however. A new program manager was appointed in 1997 to manage all of the aged persons' mental health services as part of Portside Health Care Network. The program manager also took on responsibility for the restructuring and relocation of the inpatient units. With the current unit manager, a level 5 registered psychiatric nurse, set to lead the Janson team, advertising for a new unit manager for Brennan was required. Prior to advertising of the position, the unit manager resigned, necessitating the advertisement of positions for two new unit managers. Both positions were advertised as level 3 registered psychiatric nurse posts. Of this change a senior staff member stated: "We just couldn't afford to have someone of that ranking, or calibre, or whatever you like to call it, running an 18-bed unit."

Practical plans for the move began in earnest once both new unit managers were in position in the soon to be closed Port Edward unit. One of these changes included running the Port Edward unit as two separate teams to get staff used to the idea of being in their respective teams. It was expected that the move would occur in two phases. The date planned for the first part of the relocation was set for October 1998. Half of the service, representing one half of the geographic catchment area of Portside Health Care Network, was to move into its new location some 15 kms away and the other half was to move early in 1999, as soon as the new buildings for that service were completed. There was some delay in the move to Janson, which finally relocated in March 1999, some 5 months later than expected. When Brennan unit moved in April, 1999, all aged persons' mental health services
ceased on the Orana Villa site. Short-term plans for the original Orana Villa Psychiatric Hospital site, which sits in a prime inner urban residential location, include possible conversion to housing for a major international sporting event.

The reorganised Portside Aged Persons’ Mental Health Program now exists as an organisation composed of acute, community and residential services. Janson Aged Persons’ Mental Health Unit operates at a large community health service site, as does its community partner, Janson Aged Persons’ (community) Assessment and Treatment Team (APATT). Brennan Aged Persons’ Mental Health Unit operates as a ward in a busy general hospital alongside its community partner, Brennan Aged Persons’ Assessment and Treatment Team (APATT). The general health facilities that Janson and Brennan operate from are some 10 kms apart. In addition to the inpatient and community based assessment services, the program is responsible for a collection of specialist residential hostels and nursing homes within the Portside Healthcare network that cater for the area’s aged persons who have mental health needs. While participants in this research refer to other services as part of the overall Portside Aged Persons’ Mental Health Program, the study focuses on the inpatient aspects of the program prior to and after physical relocation in 1999, specifically, Port Edward Unit and the resultant Janson and Brennan units.

In addition to providing background information about the development of mental health service provision and the Port Edward Aged Persons’ Mental Health Service, there is a need to situate myself as researcher within this study. Many of the descriptions and analyses that I present are impacted by perspectives that I have brought into the study. Two personal contexts are described in the chapter that follows. The first context describes the events surrounding my entry into the study, while the second presents the philosophical and theoretical underpinnings that have guided me in my journey prior to and throughout this study. These are presented in the next chapter. In the process of presenting these perspectives the chapter also outlines the theoretical foundations and questions upon which this study was originally based.
CHAPTER 3

GENESIS OF THE PROJECT AND GETTING MY FOOT IN THE DOOR

Much negotiation and preparation preceded my physical entry into Port Edward Unit. The fact that the study was situated in an aged persons' mental health unit was an event of chance and luck. If it were not for an existing relationship that I had with an insider at Port Edward, I may still be negotiating entry into another institutional setting. My contact, a friend and professional colleague who worked within Port Edward, was aware of my desire to explore institutional environments. It was at her suggestion that I contacted the program manager of Port Edward, whom she knew was hoping to secure a research student to study the imminent closure and relocation of the Port Edward acute unit. In my initial meeting with Port Edward's Program Manager in May 1998, mutual needs were discussed. The program manager outlined the need for an evaluative study of the outcomes of closure, division and relocation of the current service, and I outlined my interests in institutional environments and the nature of their capacity to promote positive change or otherwise. I also outlined the suitability of an ethnographic approach to the study of the current and future units, and that such a study was likely to focus on the people within the unit (both staff and patients) as opposed to merely focusing on the physical environment. I was fortunate that the program manager had an understanding of qualitative research and the ethnographic approach, so there was no opposition to "what" or "how." The next stage of the project was concerned with "when." In this case, "getting my foot in the door" would not be possible until I could satisfy the institutional ethics committee as to my intentions.

Negotiating the ethics process in order to conduct research in Port Edward involved submitting applications to, and attending, two separate but related committees concerned with research conducted within all mental health settings throughout the health care network. The first of these was the scientific committee, which scrutinised the proposed research with regards to its scientific worth and methodological rigour. This panel consisted of mental health professionals with medical and other backgrounds. At this meeting my supervisor and I were called on
to defend the methodological approach and we were given some ethics-related advice to help in the next stage of the process. With several weeks to make changes suggested by the scientific committee, we were admitted to the next scheduled meeting consisting of a full panel of the Institutional Ethics Committee (IEC) for the second bout of scrutiny. This committee meeting went remarkably smoothly, with a mostly supportive panel that made practical suggestions with regards to how to approach the issue of informed consent. The agreed requirements included that written consent would be required for all interviews, and that a thorough explanation in language appropriate to the staff member or patient was required. Approval was provided (without the need for written consent from individuals) to engage in observation and/or participant observation. This approval was given on the condition that I made it widely and clearly known that I was a researcher. When assisting staff in their work with patients, it was staff that made decisions about whether they would allow me to be involved with patient work. In these situations either the staff member or myself informed the patient that I was observing and helping as part of my research. Informal observations in the public spaces of each unit (i.e., sitting and talking with patients in the lounge or corridor or garden) also involved an identification of my status as a researcher.

Several weeks later I received a written confirmation of the changes discussed at the meeting and was ready to submit revised participant information and informed consent documentation. Official ethical approval was received by mail on Friday, 21 August 1998, and fieldwork commenced at Port Edward on Monday, 24 August 1998. The period of time between submission for ethics approval and actual approval was approximately 3 months.

Occupational philosophy and theoretical perspectives: Providing shape to the scope and conduct of the study

Like all ethnographic studies in which researchers are aiming to embed themselves into a setting in which they are unfamiliar, becoming a part of the research is both desirable and methodologically appropriate (Fetterman, 1989; Foote
Whyte, 1991; Spradley, 1980). In particular, the process of engaging in participant observation necessitates that the ethnographer keep detailed field notes, which Emerson et al. (1995) explain are “written accounts that filter members' experiences and concerns through the person and perspectives of the ethnographer” (Emerson et al., 1995, p. 13). In the analysis phase, the ethnographer also reflects on field experiences. Therefore, not only is the filtered experience attended to with the researcher’s own meanings, theoretical and personal orientations in mind, but, additionally, these first order interpretations, when revisited in analysis, become further overlaid with reflections and/or new insights gained from literature and other sources. As such, ethnographic descriptions are “theory informed re-presentations” (Fitzgerald, 1997, p. 51). Such representations, personally filtered, also bring a heuristic flavour to the research. Like phenomenology, heuristic approaches to inquiry involve an exploration and explication of the personal experiences, meanings and orientations that the researcher brings to the focus of inquiry (Moustakas, 1997). The importance of explicating the researcher’s social biography in order to establish themselves as a credible or well calibrated “research instrument” is discussed by Crepeau (1997) who states “our social biography is part of this calibration process because disclosing who we are and how we came to do a particular study helps the reader identify how our history and biases may have shaped every step of the process” (p. 106).

This study was conceptualised and conducted, in the main, alongside my role as an occupational therapy educator, during 1998 – 2001. In my academic role and in this study, I have been drawn to exploring the personal and professional philosophies and theories that practitioners bring to their work. This exploration has included reflection on my own practice and that of other health care providers with whom occupational therapists interact. My experiences, assumptions, and reflections-on-practice have followed me into this study. A number of theorists have referred to the important role of reflection (Schon, 1983; Webb, 1995) and “thinking” that surrounds the complexities of practice. This practice oriented thinking is often referred to as clinical reasoning (Elstein, Schulman, & Sprafka, 1978; Mattingly & Fleming, 1994), and its study is associated with, and oriented toward, the development of sound professional practice.
As an occupational therapist, I have sought to understand the philosophies that inform the practice profession of occupational therapy, and in doing so, have uncovered a range of perspectives regarding the “client”, the therapeutic “environment”, the use of “self” in therapy, and the view of “health” articulated by the profession. The range of perspectives held by occupational therapists, appears as varied as clients’ presenting problems, the context of treatment and the personal philosophy of the therapist (Feaver & Creek, 1993; Kortman, 1995). As an example, a therapist working in a psychiatric setting where a strong psychodynamic approach is followed may view that a client’s problems originate from intrapsychic conflict. They may engage the client in activities that aim to shift or express intrapsychic matter, through art, craft or dance activities (Barris, Kielhofner, & Watts, 1988a). The way in which therapists’ theoretical perspectives impacted on their work in child and adolescent psychiatry, became the focus of my Masters research (Fortune, 1995). Unlike my Masters study however, I wanted this current study to explore beyond the client and their diagnosis to focus on the service context. I wanted to explore how the treatment environment was implicated in the therapeutic actions of staff. This led me to generate a number of questions. For example, how does context impact on what is philosophically valued by occupational therapists? What values and philosophies do occupational therapists hold and which of these will I adopt to help guide me in this study?

Literature on occupational therapy theory and philosophy pointed me to what could be viewed as two divergent but often intertwined foci for the profession. Rogers (1982) aptly describes what could be termed a “subskill” focus, whereby therapists are primarily concerned with “subskill training for factors such as eye-hand coordination, strength and endurance and self expression and control” (Rogers, 1982, p. 714). This form of therapy appears to focus on the performance components required to develop competence in a necessary area of performance. With this focus, some therapists may specialise in the application of techniques to develop isolated skills with varied concern for the broader context of how and if those skills might be used. Other therapists might engage in skill training as a means to an end, so that a client may perform in a range of tasks related to their role as a mother, or a worker (Chapparo & Ranka, 1997; Kielhofner, 1995). This concern with linking the use of therapeutic applications to the daily life of the client
and their valued roles, is also reflected in the development of numerous conceptual models that aim to integrate professional philosophy with practice concerns (Creek & Feaver, 1993; Kielhofner, 1995).

The second major focus of concern, which has seen a renewed interest in the last 10 years, is that of the use of “occupation” (Kielhofner, 1995; Meyer, 1922; Reilly, 1962; Wilcock, 1998; Yerxa et al., 1989). The concept of occupation and the adoption of an occupational perspective to guide this study struck a particular chord, as it seemed that an occupational perspective might include a broad enough focus to incorporate my questions about the treatment environment. I came back to my research question and asked myself, “How did the environment impact on occupations and could the occupations of service providers impact on the occupations of service users, and what were those occupations?”

Conceptualisations of occupation that have been articulated by a number of theorists from outside and within the practice profession of occupational therapy (Meyer, 1922; Reilly, 1962, 1966,), and more recently, academics within the discipline of occupational science (Primeau, 1996; Yerxa et al., 1989), have defined that our occupations are far more than paid work. Being occupationally “engaged” however, involves more than doing just “anything.” Occupational “engagement” appears to be as much a state of “being” as it is “doing” and the element of choice and subjectively perceived meaning and pleasure are thought to be key elements in positive occupational engagement (Zemke & Clark, 1996). A definition offered by Jackson (1996) is that occupations are “culturally and personally meaningful activities in which individuals partake on a daily basis or at various times throughout their lives” (p. 341).

In as much as paid work has the potential to provide benefits that go beyond economic reward, such as opportunities for social interaction, development and/or maintenance of physical and intellectual capacities (Farnworth, 1994; Jackson, 1996) so too can non-paid occupations. A number of theorists have highlighted links between occupation, health and well-being (Kielhofner, 1983; Wilcock, 1998). Ann Wilcock (1998), in particular, posits a theory in relation to this link:

Occupation is the fundamental mechanism by which people realize aspirations, satisfy needs, and cope with the environment and this need provides a mechanism; to utilize this mechanism
effectively humans need to develop or maintain natural and social environments in which there is sufficient challenge to exercise individual capacities and community potential. (Wilcock, 1998, p. 110)

The above quote, which conveys a view of occupation as both means and ends to health, continued to resonate with my questions about the environment. While the implication that occupation is a positive, adaptive mechanism is evident in Wilcock’s quote, a number of authors have recognised that engagement in certain occupations that appear to be chosen and meaningful, are not necessarily health promoting or adaptive (e.g., Farnworth (1998) who discusses the relationship between time spent in passive, non productive occupations and offending). For the purposes of this study, I have adopted an emphasis on the positive and adaptive nature of occupational engagement, as highlighted by a number of other occupationally oriented theorists including Wilcock (1998) and Law, Steinwender and Leclair (1998).

Other links with doing and well-being and the context of occupations, have been borrowed from theorists in other fields, in particular the work of psychologist Mihaly Csiksentmihalyi. The experience of “flow” discussed by Csiksentmihalyi (1991) that articulates how humans perceive optimum absorption in “doing” through challenges that neither over-stress nor under-stimulate, is useful in explaining the subjective states that meaningful occupations produce. Humans have a need to be occupationally engaged, to experience “flow” and to use whatever capacities they have at their disposal, and the environment would appear to be a major determinant of those capacities. The ingenious escape plans hatched by war time prisoners, and the stories of self-enforced “doing,” the desperate attempts to engage mind and will by recent political prisoners, provide some evidence of the need to remain engaged. Viktor Frankl’s observation in Man’s Search for Meaning (1959) that mortality rates were highest among prisoners who were unable to find a purpose in Nazi concentration camps, also provides other supportive insights into humans’ need for occupation.

Given that humans are social beings, occupations that are socially prescribed are also believed to contribute to well-being, an important factor in humans’ perceptions of health. Again, Wilcock articulates the role of occupation:
Social well-being occurs when the range of each individual's occupations and roles enables maintenance and development of satisfying and stimulating social relationships between family members, with associates and within the community in which they live and that the occupation is balanced between social time and time for reflection. (Wilcock, 1998, p. 104)

The early moral treatment pioneers saw a link between mental health and occupation and these ideas continue to serve as an ideological guide for modern day theorists and practitioners in occupational therapy. The notion that occupations are connected to health through the sense of well-being they provide is believed to be sufficient justification to warrant a professional role with individuals who are at risk of experiencing occupational deprivation, or who are within environments that may contribute to occupational deprivation and/or boredom (Farnworth, 1998; Whiteford, 1997, 2000). The notion of deprivation related to occupational engagement is discussed by Kielhofner (1983) who states: “When social systems or other conditions deprive the individual of satisfying engagement in occupation, there is a clear threat to the mental and physical integrity of the person” (p. 36). The idea that our environments could have such a profound impact on occupations, and in turn, that occupational engagement or deprivation could have the degree of impact on physical or mental health that has been highlighted throughout the literature in these few paragraphs, further strengthened my decision to explore the “context” of treatment provision in its broadest sense.

The ability to exercise choice and perceive personal responsibility is espoused as an important feature of occupational engagement (Kielhofner, 1995), and these two factors are believed to have powerful benefits in terms of well-being among older people (Jackson, 1996; Kaufman, 1986; Langer & Rodin, 1976). In a study designed to ascertain the effects of choice and personal responsibility among nursing home residents, Langer and Rodin (1976) found that 93% of the older people encouraged to make decisions became more active and felt happier, had increased mental alertness and increased involvement in many different activities. Conclusions made by Langer and Rodin (1976) and others (Forrester Jones, 1997; Reilly, 1966) suggest that the environment, as a participative “milieu,” has a strong impact on health. In particular, Langer and Rodin (1976, p. 169) state, “feelings of helplessness and hopelessness, both enhanced by the environment and by intrinsic
changes that occur with increasing old age, may contribute to psychological withdrawal, physical disease and death." In her study among staff and persons with dementia, Hasselkus (1998) found that occupation enabled "persons with dementia to continue to relate to their worlds" (p. 432), and cites the work of Kitwood & Bredin (1992) who believe the social environment is a major influence on well-being. Such findings highlight the importance of environments that enable "doing" or "engaging" and how such environments can determine health and well-being or otherwise.

The idea of a participative environment or "milieu" in which occupational engagement is an organising factor, led me to literature regarding environmental, ecological and social therapy. I encountered a number of related notions, and uncovered a certain elasticity around the ideas. A useful distinction is made by Cumming (1969) who suggests that the therapeutic community is characterised by the presence of programs that use group techniques to assist the patient to understand and control their own emotional situation, while milieu therapy strategies are more closely aligned to the idea of moral treatment, aiming to develop diffuse and specific skills, both social and instrumental competence. Rapoport & Rapoport (1960) discussed a number of the features of the therapeutic community, including the importance of communication, the ability of the patient to be involved in the affairs of the hospital (democratisation) and reality confrontation. The "therapeutic milieu" discussed by Gunderson (1978) stresses the importance of features that promote containment, structure, support, involvement and validation. Gunderson's model (1978) has been adapted by Taft, Delaney, Seman & Stansell (1993) and applied to dementia care settings. In this framework, Taft et al. (1993) point to the responsibilities that staff have to provide a social environment that "creates a culture of caring that supports, involves and validates individuals with dementia" (Taft et al., 1993, p. 38). The idea of involvement and support, or engagement, as an organising framework for an environment would appear to be highly relevant to this study, and as such the term "milieu" is adopted and associated with occupational engagement. In combining the concept of occupation with that of the milieu, I am adapting the idea of the supportive psychiatric environment, and formalising a concept hinted at by Reilly (1966), when she talked about the building of an occupational therapy program in which "occupational therapy is a milieu, or a
culture” (p. 62). The milieu, Reilly states, must “acknowledge competency, arouse curiosity... deepens appreciations and demands behaviour across the full spectrum of a human’s abilities” (p. 63). Adopting this notion of an “occupational milieu” in this study has contributed to a sensitisation to certain features that may or may not be present in the units, and as is revealed in later chapters, my fieldwork and participant interviews assist me to elucidate what prevents these features being established.

My exploration of the literature on occupational therapy and occupation has led to the emergence of a useful concept for use within this study. Occupational therapy, as viewed from an occupational perspective, was emerging not as a specific set of techniques but as a philosophy promoting that well-being and health can be a product of enabling people to engage in occupations that will be perceived by them as meaningful. Jackson’s (1996) study of meaning and occupation among a group of elderly members of a “health care advocates” group found that “one powerful method by which members negotiated the loss of activity imposed by disability was to weave present motif of activities with threads of meaning from the past... to search out specific opportunities that allowed them to continue to express personal themes of meaning in daily or weekly occupations” (p. 349). Thus, occupational therapy, from an occupational perspective may be any process or action that enables people to engage in meaningful experiences. It became clear that enabling people to “engage” may be effected through contributing to policy, designing a building, working one to one with a person or with a group of people. From this realisation, it also became clear that professionals from other disciplines, and those who plan and manage the day-to-day work of staff in hospital wards had the capacity to enable occupation in others, both staff and patients.

Institutions, therapeutic processes, mechanisms and models: Personal views on how occupation could and should be enabled

Focusing on the institutions in this study enables me to describe the extent to which peoples’ everyday occupational experiences are dependent on the broader
historical, physical, social and political processes related to the institution. Theorists from a number of disciplines, including occupational therapy, have recognised the potential of institutional environments, and those who structure them, to facilitate or inhibit engagement in everyday activities that may be experienced as meaningful (e.g., Reilly 1966; Townsend, 1996).

My own experiences with the service that is the focus of this study began as a student occupational therapist in Charlotte Ward in 1985. My only remaining memories of the place are the overall sight and smell of the ward, its dull décor and the large number of older people sitting around staring, apparently unengaged. In this sense, the ward was not an adaptive occupational milieu. It did not appear to be demanding much behavior that provided meaning or joy to the patients. As a more senior student in another large psychiatric institution, I recall positive experiences of being involved in lively programs, with both older and younger adults. I recall running a variety of groups, with carefully selected patients. More often than not, these groups occurred away from the ward in specially designated occupational therapy spaces. As a student, my focus was on being able to devise group objectives that would provide a template for what would happen within the group, and then try to run the group as closely as possible with those objectives in mind. For the young adults, the objectives usually related to providing skills that could be utilised for living independently, such as budgeting, meal preparation and job hunting. Other groups focused on increasing self-esteem and communicating assertively with others, all skills that were believed to be of value in being able to live outside of the institution. On reflection, the focus was very much on the individual within the group and the skills that they would attain, the sort of focus described by Rogers (1982) earlier in this chapter. There appeared to be little focus beyond the individual, within the time that they might be in a group or booked for an individual assessment appointment. What happened outside of group or assessment times, while patients were in their wards was not a focus. Occupational therapy did not appear to be part of the overall ward environment, rather, it was a separate concern, something patients could be sent to or referred to if they were felt to be suitable. Whether patients engaged in meaningful occupations beyond these sessions was not really contemplated. It seemed that therapists could control treatment within their
own environment and, for me, I could avoid going into the main wards, which I found daunting, chaotic, noisy and impersonal.

At this early stage of my career, it had never dawned on me that occupational therapy might focus on the ward environment and how supportive of skills and positive experiences the ward and its staff might be. In retrospect, I saw the large hospitals as very valuable, despite being personally daunted by the wards. Their value seemed to lie in providing a captive audience for large amounts of people who could receive occupational therapy in the occupational therapy department. Without occupational therapy to go to, patients would wander around the main ward or the grounds, unoccupied, unhappy and missing out on valuable learning opportunities. In retrospect, this appears to be a narrow view of the occupational therapy role.

At the time of entering Port Edward, my past experiences had contributed to a belief that institutions like Port Edward had potential to be positive and supportive environments, despite the numerous negative impacts that were widely documented with regard to in-patient mental health facilities (Foucault, 1973; Goffman, 1979). My awakening to and growing appreciation of the health promoting and illness preventing potential of occupational engagement in even the most hostile and depriving environments gave me faith that I should explore this occupational environment and uncover the potentials. My more developed views enabled me to now enquire about the potential for a role beyond the skill training of individuals. In addition, my own involvement in organisations, some of them large institutions, had allowed me to reflect on the impact of numerous factors usually beyond the “good intentions” (Townsend, 1998) of staff and despite suitable “facilities.” What were the organisational factors that might impact on occupation and the establishment of an occupational milieu? In subsequent chapters, my exploration around this and related questions will elaborate on the ways in which the organisation as a whole, and the changes occurring to the organisation, have impacted on the occupations of the service providers and users within it. Again, aspects of my social biography influence the major findings associated with the organisation.

In the final analysis phase of this study, I experienced a career change that took me from occupational therapy education, into policy analysis associated with workforce development for the drug and alcohol field. The major framework informing this work was that of capacity building (NSW Health Department, 2001;
Paul, 1995). As I moved toward the final stages of analysis and began contemplating my recommendations associated with the development of an adaptive occupational milieu, the capacity building framework provided great clarity. The elements of, and strategies associated with capacity building also appealed to my occupational sensibilities. This framework, to be described further in Chapter 9, appeared compatible with my view that occupational engagement could be achieved by remaining focused on the occupational environment, rather than peoples’ individual skill of lack thereof.

Having described historic and personal contexts associated with this study, it is now necessary to further situate this work within an appropriate body of research and to describe and provide reasoned justifications regarding the methods that I have adopted in the conduct of the study. The questions that have guided me in my decision making around the conduct of this study are also implicated in my decision to adopt an occupational perspective. For example, if the study of occupation is related to uncovering themes of meaning that relate to ‘doing” and “being” then how might I best find out about these things? What approach to research could tell me about the occupations of service providers and users and capture some of their experiences and ideas surrounding a major change in their service environment, and how would I fit into this picture? Given the aims of this research, and an apparent limited focus on more experientially oriented research within the field, I chose a naturalistic approach. This approach is described in Chapter 4.
CHAPTER 4

APPROACHES TO THE STUDY OF LIFE IN A PSYCHIATRIC UNIT

Despite the rhetoric of change in approaches relating to research and evaluation of health services generally, the predominant approach to studies focusing on mental health service provision in acute or inpatient settings has relied on a primarily positivistic epistemological orientation. Such approaches are adopted in the belief that a phenomenon and its attributes are known and can be objectively observed (dePoy & Gitlin, 1998). Based on hypothetico-deductive thinking, the researcher posits a possible reality based on available theory and collects data which, it is hoped, will enable confirmation of what is already expected to be true, or quantify aspects of behaviour that are expected to occur (dePoy & Gitlin, 1998). The hypotheses upon which such studies are conducted are deduced primarily with reference to general theories, a priori knowledge. The observation that positivistic thinking retains such a stronghold over inquiry in health and human service organisations can be seen in the continued proliferation of published research findings derived from quantitative data. The methods used in these studies reveal reliance on measurement tools designed to gauge the attributes of a person or setting and quantify these. The dominance of positivism as expressed in research designs that seek to control, reduce and measure is also revealed in the design and wording of applications for ethical approval of studies (Sieber, 1982; Wax & Cassell, 1979). My own personal experiences of negotiating scientific and ethical appraisal committees on behalf of this study indicated both a bias in favour of positivistic research and a misunderstanding of naturalistic or ethnographic research.

Naturalistic research aims to discover phenomena grounded in a particular setting or context, and is often focussed on ascertaining the meaning associated with phenomena, from the perspectives of people within the setting (dePoy & Gitlin, 1998; Fetterman, 1989; Fitzgerald, 1997; Lincoln & Guba, 1985, 2000). Naturalistic studies are not typically characterised by the measurement of pre-determined variables that aim to confirm or disconfirm a hypothesis, rather the researcher enters the field in order to learn about contextually relevant issues from the setting and the
people involved. Data collection methods range from unobtrusive research actions that appear "normal" and "natural," such as participant observations and informal conversations, through to less natural methods, such as document review, formal interviewing and the use of questionnaires and surveys. Because naturalistic studies aim to reproduce and offer interpretations of everyday life from the perspectives of those who experience it, narrative and textual forms of data become the primary focus of analysis. These data may be in the form of inscriptions or writings, an account of what the researcher sees, experiences and learns while participating in the daily rounds of life amongst those within a setting being studied (Emerson et al., 1995). Alternatively, or in addition, data may be in the form of stories told by informants who have a particular perspective to offer regarding a phenomenon. Further, quantitative representations of aspects of everyday life are not a primary aim, and given that naturalistically derived findings are contextually embedded, the aim to generalise particular findings beyond the setting or people studied is not paramount. Naturalistic researchers do, however, aim to demonstrate the ways in which particular findings may reflect broader social and cultural phenomena (Denzin & Lincoln, 2000; dePoy & Gitlin, 1998; Hamada, 1999).

Despite the comparatively local and subjective nature of naturalistic research, which has led to criticism of its usefulness in a climate that favours the objective and more obviously generalisable, the theories upon which many apparently objective, quantitative studies are based have their origin in naturalistically derived findings (dePoy & Gitlin, 1998). Of particular relevance is Goffman's (1973) study that highlighted the problems of institutional life. Since the publication of this, and similar, works, many service reforms driven by de-institutionalisation and mainstreaming policies have provided researchers with numerous opportunities to study change outcomes. Some of these have been naturalistic and specifically ethnographic in approach (Edgerton, 1967, 1993; Estroff, 1981; Forrester Jones 1997; Johnson 1998), however innumerable others have been conducted from an experimental and quantitative approach. Thus, naturalistic inquiry, while providing a springboard for numerous studies in the positivistic tradition, does not appear to have promoted a comparative amount of naturalistic inquiries. This may relate to the idea that the primary use of naturalistic inquiry is to prepare or pave the way for...
"real science" (Hammersley, 1998), or positivistic experimental-type research, in which the aim is to collect quantitative data.

Many of the articles reviewed during the course of my own study highlight issues regarding the status and understanding of naturalistic, qualitative approaches within the field of institutionally based mental health service provision. A selection of these articles exemplify three key themes: first, the use of positivistic quantitative methods in studies perhaps better suited to and/or in need of enhancement with the addition of naturalistic qualitative methods; second, the use of the term naturalistic to describe research that is overwhelmingly positivistic and quantitative in method; and, finally, the use of rhetorical statements that downplay the relevance or importance of a study or its findings on the grounds of its naturalistic approach.

Regarding the use of positivistic quantitative approaches, it is my contention that many studies have attempted to numerically "capture" aspects of the institution and organisational "culture" without necessarily demonstrating that the often multidimensional constructs that they seek to measure are contextually relevant. Using batteries of behavioural, belief and/or affective scales, researchers have made statistically based inferences about aspects of a ward environment and the impact of these on patients and staff. In an example focusing on nursing practice in psychiatric wards, Morrison (1998) used five separate scales in an effort to measure and present the "culture" of a ward with respect to levels of aggression. In assessing the environmental quality of long stay wards for the confused elderly, Bowie, Mountain and Clayden (1992) focused on the development of a range of empirical scales that would aid in the measurement of quality of care. They explicitly state that assessing "quality" of care necessitates "objective measurement." In this example, five scales are used to assess quality through quantitative means. In a later study, Mountain and Bowie (1995) again focus on the quality of long-term care, this time for people with dementia. In this study, six scales were used to primarily quantify "quality." One of the tools, a "Ward Restrictiveness Scale," aims to collect data regarding ward routine and care practices via a 24-item semi-structured interview protocol. Although more qualitative data is likely to be collected through such a tool, actual narrative data collected as part of the interview was not analysed or presented on its own terms. One of the problems of quantifying quality is that unless qualitative descriptions and analyses are conducted in the first
instance, the relevance of a particular measure, in terms of the concepts or constructs of concern, cannot be judged.

In a study by Benjamin and Spector (1992) that sought to assess the impact of client independence and personal responsibility on three long-stay psycho-geriatric wards, one of which was a non-nursing unit, a battery of measurement tools were again relied on in order to ascertain patient outcome. In this study, patient variables, such as cognitive performance, physical disability, and social disturbance, are correlated with measurements of staff demographics, staff perceptions of policy and program, staff perceptions of physical and architectural features and staff perceptions of resident and staff relationships. The results indicated positive outcomes for patients on the non-nursing unit. Although this may imply that a lack of trained nursing staff was not detrimental to patient outcomes, the authors discuss that it is the greater promotion of choice and involvement on the units that is of relevance, a feature presumably lacking in the nurse-staffed units. The authors conclude that the enthusiasm of the (non-nursing) staff members “must be recognised as possibly having some positive effect on resident outcomes” (Benjamin & Spector, 1992, p. 750). I would argue that the incorporation of a more thorough description and analysis of the approach of nursing and non-nursing staff within each context would have greatly enhanced the utility of such findings. A continued reliance on apparently more objective approaches to data collection and analysis seems to undervalue the potential richness of context embedded practice. This article also provides a clear illustration of how positivistic quantitative studies can indicate the need for naturalistic studies.

The view that naturalistic forms of inquiry aimed at description, analysis and representation of daily life in experientially and narratively rich forms have less scientific legitimacy than more narrowly defined numeric representations is highlighted in a study by Bowie and Mountain (1993). In this naturalistic observational study in which the authors’ accounts of life on a long stay ward are recorded they state: “the accounts in the diary are in no way scientific” (Bowie and Mountain, 1993, p. 1001). They conclude that many of the features of life on the ward remain unchanged from those described by Goffman (1973), however an analysis of the micro-relationships in the actual setting, which might foster a more localised in-depth understanding is not forthcoming. This opportunity may be
overlooked because of the authors' own conceptions of what constitutes real science.

The term "naturalistic," as used to describe two relocation studies highlights confusion regarding naturalistic research or, at least, the use of terminology in research. One study of long-stay hospital asylum closure by Shergill, Stone and Livingstone (1997) aimed to describe social and physical changes in the subsequently resettled environments along with changes in patients' cognition and behaviour, changes to patients' (primarily with dementia) use of medical services after moving from a hospital ward to either a psychiatric nursing home or another hospital bed. In this study, the use of the term "naturalistic" is used to refer to the natural move (de-institutionalisation) that occurred quite independently of the researchers' intervention. The means of gauging the change in the elderly patients post-relocation were not, however, naturalistic, according to the definitions with which I work or that proposed by Guba and Lincoln (1981) and Lincoln and Guba (1985; 2000), two of the key writers on this approach. The methodology relied on an interview based scale with patients (the Mini Mental State Examination), a behavioural scale (Crichton Royal Behavioural Scale) conducted by the nurse in charge of each setting, data on the comparative frequency of visitors and medical consultations in the new environments, and the use of environmental rating scales. Detailed descriptive information about the old or new environments, either observational or interview based was not forthcoming, and as a consequence a naturalistic or qualitative "feel" for the old or new environments, either socially or physically, was not discernable. This study concluded that the new environments afforded adequate care for the patients with no significant pre and post move changes to cognition, behaviour, frequency of medical consultations or patient visitors. Environment scale data however, indicted increased ward restrictedness, and fewer recreation and social activities. An Australian study, which focused on the closure and relocation of a large typically institutionally organised aged persons' mental health unit to a purpose built psycho-geriatric nursing home, utilised primarily quantitative data collected from subjects (patients and staff) via a battery of measurement tools and structured interviews with staff pre and post relocation (Lydall-Smith, Stafarse, & Eccleston, 1998). The overall project was comprised of four studies. Study I measured resident functioning before and after relocation.
Study 2 measured aspects of the physical environment pre and post relocation. Study 3 explored staff satisfaction after relocation through structured interviews and psychometric measures. The findings are reported in primarily quantitative terms. Potentially rich qualitative data are reported in terms of, for example, more privacy, less activity, more staff turnover. Study 4 utilised questionnaires to determine the views of relatives and friends regarding their satisfaction with the relocation and its effects. For studies 3 and 4, the issues of quality are expressed mostly in quantitative terms. While the term naturalistic is used to describe the study, it appears to refer only to the fact that the relocation was not caused or controlled by the researchers. The choice of tools is selected prior to entry into the field and their use is not determined by decisions of relevance once in the field. Thus, while the site and the move are natural, the decisions about how, where, when and what data to collect is not related to immediate context dependent micro-concerns.

The notion of “naturalistic” from the perspective of these studies does not capture the localised narrative, non-numeric accounts of daily behaviour using more context dependent methods. Such narrative based accounts are more in accordance with my own view of naturalistic study, which is more in line with those of scientists who adopt a naturalistic, qualitative approach to inquiry (Fine, Weis, Weseen & Wong, 2000; Lincoln & Guba, 1985, 2000).

The point that I aim to make in outlining the above studies is that the majority of them sought to measure pre-determined variables in natural and changing settings using structured and non-naturalistic methods. Although I do not deny that these represent valid and necessary ways of knowing, it appears that the drive to achieve objectivity through omitting descriptive and subjective data regarding the state of the natural environment renders these studies somewhat incomplete. My own study took an alternative approach. The approach that I adopted did not attempt to achieve distance and objectivity rather, as Crepeau (1997) states, “because many qualitative methodologies are based on entering the lived experience of others, distance and objectivity are to be avoided at all costs” (p. 106). My approach to the study of an institutional organisation within the process of change represents an attempt to fill a void within the recent body of literature relating to institutional and relocation studies within the field of aged persons’ mental health. As a naturalistic inquiry, it provides a contextually rich and localised account of a natural setting.
drawing from data collection methods that are driven by events that occur in that setting.

The conduct of naturalistic studies that aim to generate contextualised data using less intrusive and unstructured methods have a long tradition derived largely from anthropology. Such methods have gained increasing philosophical acceptance in the current postmodern climate. This is not to imply that naturalistic inquiry is a postmodern form of research, but that the general postmodern distrust of all theories and methods that claim to represent “one” truth has meant that standard methods of “knowing” have been subjected to scrutiny, in turn facilitating the adoption of alternate ways of knowing (Richardson, 1994). Many professions with traditionally positivistic orientations have come to see the value of adopting naturalistic approaches (Lincoln & Guba, 2000) in an effort to “ground” their numeric data and provide a more complete “picture” of the phenomena they are studying from the perspectives of those who go about their daily lives within these contexts. Australia’s National Health and Medical Research Council (NH&MRC) has also recognised the importance of qualitative approaches and has set guidelines for Institutional Ethics Committees to assist them toward an informed and fair appraisal of research protocols adopting qualitative approaches to research and evaluation (National Health and Medical Research Council, 1995). That acceptance of multiple ways of knowing is growing is also evidenced in research texts for health professions, where approaches to research are now being presented in less dichotomised ways, thus approaches to problems in the health and human service field are best explored using a “triangulated” or “mixed methods” approach (dePoy & Gitlin, 1998; Lincoln & Guba, 2000; Minichiello, Alexander, & Jones, 1999; Morse & Field, 1995). Rather than accepting that quantitative approaches alone are the most appropriate, balanced critique of research has increasingly focused on appraising the appropriateness of multiple forms of data collection and the best approach given the research question or concern. The legitimacy of the “post-positivist” paradigm (Denzin & Lincoln, 2000; Lincoln & Guba, 2000) that this research draws from is stated to be “well established and at least equal to the legitimacy received of conventional paradigms” (Lincoln & Guba, 2000, p. 164).

Naturalistic approaches, such as ethnography, have attracted postmodernist criticism for claiming “realism” (Hammersley, 1992, 1998) and/or that the
ethnographic account is "relative" (Denzin, 1997; Hammersley, 1992, 1998). Critics have queried the usefulness of producing one person's account of the world, questioning whether such relativistic accounts are any more useful than reading a travel novel or magazine article (Clifford, 1990; Hammersley, 1992). In response, Hammersley (1992) has advocated that ethnographers adopt a more "subtle" rather than "naive" realism. He reinforces the point that ethnography should aim to represent reality rather than claim to reproduce it. Such an orientation also needs to acknowledge, "representation must always be from some point of view which makes some features of the phenomena represented relevant and others irrelevant" (Hammersley, 1992, p. 51). Similarly, Denzin (1997) suggests that the ethnographer can only produce a text that represents multiple, situated understandings, where each episode of understanding is used to "shape the phenomenon being studied" (p. 8). A postmodern orientation to research should, therefore, focus on the richness that different approaches bring to an inquiry. In addition, the postmodern researcher should engage in a process of reflexivity through which they aim to acknowledge and present the personal, historic and political biases that they bring to the study. Such approaches to research claim no ultimate "presence" (Fox, 1993) or ownership of "the truth."

An ethnographic study of in-patient aged persons' mental health services

As highlighted earlier, this study is non-positivistic in orientation and adopts a naturalistic and, specifically, ethnographic approach to the study of a health service organisation in the process of change. This approach was felt to be the most logical given my desire to experience for myself the "ordinary routines and conditions" (Emerson et al., 1995) that are part of daily life within Port Edward, Janson and Brennan aged persons' mental health units. As discussed in Chapter 3, the philosophical and theoretical perspectives that I bring to the study draw from humanistic beliefs in the value of occupational engagement or, more specifically, the relationship between opportunities to engage in doing and being at a meaningful level, and states of health well-being and personal control. In adopting an ethnographic approach I aim to develop a deep appreciation of the occupations of
staff and patients and the meanings and values associated with these occupations. Given that this study also involves a search for the occupational milieu, the place where occupations happen, this study may be considered an "occupational ethnography". Thus, my own perspectives, my theoretical framework and professional background as an occupational therapist merge to create an occupationally focussed ethnography.

In this occupational ethnography, I have aimed my focus at the "micro" relationships within the organisation. I have adopted the view that the occupational actions and states observed and experienced within the organisation are the product of daily interactions, negotiations and contestations between the "social actors" as they go about the occupations demanded of them within the contexts being studied. In terms of a theoretical orientation, this view draws from two arguably (Burrell & Morgan, 1993; Denzin, 1970) compatible strands of phenomenology, namely, situational ethnomethodology and symbolic interactionism. As Burrell and Morgan (1993) offer,

The situational ethnomethodologists, like the phenomenological symbolic interactionists, are more concerned to study the way in which social reality reflects a precarious balance of intersubjectively shared meanings which are continually negotiated, sustained and changed through the everyday interaction of individual human beings. Social reality is for them either reaffirmed or created afresh in every social encounter. (p. 253).

According to Denzin (1970), the similarities between the two traditions include that both "demand consideration of how interacting selves cooperate in the construction of a routine" (p. 295). In addition to cooperation and negotiation, conflict oriented interactions also drive behaviour (Fitzgerald, 2000). A number of "contestations" of conflicting "discourses" (Fox, 1993) are identified throughout Chapter 6, including how these serve to maintain sub-optimal organisational functioning and constrain occupational engagement. The constraints and opportunities are considered to be the product of localised daily struggles between service providers and between them and patients. Macro level forces, which also contribute to more localised constraints and opportunities, are also considered and discussed. The primary goal, however, is to describe daily life and provide an interpretation, a representation filtered through my own occupational perspective.
My focus is on the occupational in that it aims to identify the constraints and opportunities, which impact on the ability to spend time, to “do” and “be” in meaningfully perceived ways within the unit for both staff and patients.

While this study is an occupationally focussed ethnography, it adopts a “conventional” approach to ethnography. Doing ethnography has been described by Geertz (1973) as “an elaborate venture in thick description” (p. 39) through which meaningful structures may be identified and interpreted. Ethnography, according to Spradley (1980, p. 8), is “the study of both tacit and explicit cultural knowledge.” Thus, making “cultural inferences” (Spradley, 1979) is an important task of the ethnographer. Cultural inferences “are made via a) what people say b) how people act and c) from artifacts people use” (Spradley, 1979, p. 8). As outlined earlier, this ethnographic study was focused on an in-patient service in the process of change. The primary means by which I gained exposure to what people said, how they acted, and the artifacts they used was through participant observation or, fieldwork, which was carried out within all three units. As an outsider, I aimed to become acutely aware of those things that “normal” participants have “usually blocked out to avoid over stimulation” (Spradley, 1980, p. 55).

*Doing fieldwork*

Fieldwork was conducted in the original Port Edward Unit over a period commencing in August 1998 and ending on 5 March 1999. A break from fieldwork occurred during the time Port Edward divided and relocated to two new sites. Fieldwork re-commenced in Janson and Brennan units in July 1999 and lasted until October 1999. The total fieldwork period spanned approximately 13 months and represented roughly 300 hours of observation. Each unit functioned over the full 24-hour period of a day and the main structure that organised staff time was the three separate nursing shifts. In order to gain a fuller appreciation of the reality of life on each unit, my fieldwork attendances aimed to cover periods that incorporated the three separate nursing “shifts.” These were: day shift 7am-3.30pm, evening shift 2pm-10pm and night shift 10pm-7.30am. The majority of my fieldwork attendances occurred during the hours that most patients were awake and active, between 7.30am and 9.30 pm. The fieldwork “shifts” typically bridged two separate nursing shifts, usually day and evening. In the longest of these, I would commence at
7.30am and finish at 3pm. In other fieldwork “shifts” I managed to span three nursing shift changeovers by starting at 6am and finishing at 2.30pm. On many occasions, however, I would stagger my attendances to capture several hours before one nursing shift and several after. An average fieldwork shift spent on the units was approximately 5 hours.

Ethnographers “participate, observe and ask questions to discover the cultural meaning known to insiders” (Spradley, 1980, p. 86). The ethnographer’s story has been described by Denzin (1997, p. xiv) as a “vehicle for readers to discover a moral truth about themselves.” My task was to uncover and incorporate the multiple truths operating within the social scenes I encountered. Engaging in participant observation necessitated that I adopt numerous roles and engage in a multitude of occupations central to the daily life of insiders: nurses, occupational therapists, personal services assistants and patients within each unit. After a brief period of observation, that included accompanying nurses during routine tasks, I began to offer to take on many of these tasks, becoming an extra pair of hands, a “floating nurse”. I hoped that this would help me establish an identity among the staff as someone who, rather than being a burden, could be quite useful.

Participant observation with respect to occupational therapy was initially oriented towards the observation of group activities run by the therapists and then moved towards actively recruiting patients for attendance at groups, participating in the group as a member and sometimes running the group as a co-leader. As a researcher and allied health professional with a background in occupational therapy, my identification with the struggles of the occupational therapy members required considerable and ongoing monitoring. On one hand, I needed to ensure that I did not, because of my relatively greater understanding of their professional ethos, gain a reputation among people from the other disciplines as a “spy” or advocate for the occupational therapy members. On the other hand, I needed to guard against becoming over-critical of the group because of some of my own alternative views of the best approach to occupational therapy practice. My desire to understand the nursing perspective, a comparatively foreign professional culture, and the largest single professional group within the units at any one time, compounded the delicate nature of this balancing act. Given that I had entered the field with what I believed to be a relatively well-developed personal philosophy of institutionally based
occupational therapy, which was as much idealistic as practical, the tension between the need to participate, observe and experience and not influence was significant. I needed to promote my identity as a student who was there to learn about the unit, not just occupational therapy.

As a result, I observed and assisted personal service assistants (PSAs) in the preparation and clearing of meals and observed and discussed the daily cleaning routines of the personal assistants during informal conversations. I attended nursing and allied health handover meetings, psychiatrist led clinical ward rounds and many other ward based meetings as an observer. When I was not engaged in the above, I spent my time sitting, talking and walking with patients and, as I did so, observed many other things. I listened to conversations between patients. I heard and observed many interactions between people while simply “being” in the unit. These included interactions between staff, between staff and patients, patients and their friends and family, informal and more formal interactions between medical officers and patients, consultant psychiatrists and patients, social workers and patients, all made within public areas of the unit. The ethical implications of this situation necessitated a constant system of introducing myself as a researcher to new staff, patients and their families as they were encountered. This was in addition to a more formal introduction of my study and myself to the staff at a public meeting. A plain language statement/information letter designed for staff and patients and approved by the hospital ethics committee was widely distributed to staff and given to patients who had the capacity to read and understand it. This outlined my intended actions as part of participant observation.

Ethnographic field research “involves the study of groups and people as they go about their everyday lives” (Emerson et al., 1995), thus, the aim of engaging in numerous participant observer activities was to expose myself to as many of the daily and nightly realities of life on the units as possible. The experiences that I had while engaged in participant observation allowed me to formulate context relevant questions regarding when, what, how and why the various members of the unit acted as they did. My original research query, which was broad, unrefined and based on a perceived relationship between the function of an organisation and the extent to which it supported or constrained occupational behaviour among members, was redefined and given more focus as my understanding grew. The choice of what
tasks to engage in and observe was determined by three main considerations: first, the need to seek an answer to new and changing questions; second, what staff and patients were doing at any given time; and, finally, the willingness of staff and patients to allow or tolerate my presence.

Within each unit, I managed to secure a space where I could write. Throughout each fieldwork shift, I wrote down what I observed and learned in the course of participant observation. Regularly scheduled breaks from the ward to write were a crucial aspect of the fieldwork, due to my decision not to take any notes while on the ward. This decision was based on the possibility that some patients might react with heightened paranoia if I was seen to be writing things down. I also believed that if I was to blend in and be seen as an insider I needed to do what others did. Apart from medical officers who sometimes wrote as they talked with patients, staff did not engage in writing outside of the staff “station.” In his ethnography of custodial care, Salisbury (1962) also highlights this pragmatic and symbolic need to withdraw from the ward for writing, in his case, to avoid being miscast as a doctor.

Fieldnotes: Ethnographic data

Writing fieldnotes occupied a significant proportion of each day I spent in the field. According to Emerson et al., (1995, p. 13) fieldnotes are:

\[\ldots\text{written accounts that filter members experiences and concerns through the person and perspectives of the ethnographer. Fieldnotes provide a distinctive resource for preserving experience close to the moment of occurrence and hence for deepening reflection upon and understanding of those experiences.}\]

My written accounts fell into two distinctive types of fieldnotes. First, I made “scratch notes” or “jottings” (Emerson et al., 1995; Sanjek, 1990) during short withdrawals to my writing place approximately every hour. During the construction of these scratch notes I recorded brief, noteworthy occurrences that had captured my attention within the past hour. I did not elaborate or reflect deeply about what I wrote at this point, as my main aim was to “fix” the observation or experience in memory for later analysis. Sometimes my withdrawal to write was triggered by a
brief interaction or nearby conversation that I wanted to preserve "verbatim" before I forgot it. The second type of fieldnote was a more reflective and analytic reconstruction based on the scratch notes of the day. In these full fieldnotes (Emerson et al. 1995), which I wrote at home once I had left the field, I would recreate the scene in detail and include my own reflections on the significance of the experiences, which were generally not contemplated at the time of the actual experience. The process of generating accounts of field experiences was both analytic and interpretive. As a result, full fieldnote writing was a lengthy process. For example, a 6-hour fieldwork shift could generate 500-1000 words of scratch notes; however, a full fieldnote writing session would transform the original scratch notes into a 3-5,000 word account. Of the process of transforming scratch notes into full fieldnotes Emerson et al. (1995, p. 51) state: "In turning jottings and headnotes into full notes, the fieldworker is already engaged in a sort of preliminary analysis whereby she orders experience, both creating and discovering patterns of interaction."

In total 125,515 words of fieldnotes were generated over the 13 month period. The breakdown of these for each unit was: 60,000 words for Port Edward unit, 34,203 words for Janson unit and 31,411 words for Brennan unit.

The secondary method of data gathering in the study was through formal interviewing. Interviews served to provide what Fettersman (1989, p. 30) has termed an "insider's perception of reality," a perspective that is crucial to the accurate description of situations and behaviours. During these interviews, I was also able to explore how people talked about what they did. Twenty interviews were completed over a 15-month period; two of these occurring during the break in fieldwork and two were conducted several months after fieldwork had been completed. Eight staff interviews and 4 patient interviews were conducted prior to relocation and a further 8 staff interviews were conducted after relocation. Some interviews adopted a semi-structured format while others were unstructured. In the semi-structured interviews, I prepared 5 or 6 questions to guide the interview. These set questions were drawn directly from my ongoing list of setting-specific questions generated from fieldwork observations. The interview situation allowed me to obtain a more full explanation of specific field related interests from the perspectives of individual staff and patients. I allowed informants to view these questions and answer them in their own
way. All interviews conducted with patients were unstructured as were a number of the staff interviews. In these unstructured interviews, I would start with a very broad question such as: "Can you tell me about your role as a nurse here?" or, "Can you talk about how you find being on the unit?" Then, as the situation allowed, I asked more focused questions about issues of interest. Toward the end of my time in Janson and Brennan units, I would use the interviews to "check out" some of my interpretations with informants. As an example, I would pose an "informal theory" to my informant to gauge how plausible they believed it to be. My subsequent interpretations and analysis were then modified according to these responses.

All informants were asked to provide written consent, which indicated that they understood the purpose of the interview, the subsequent uses of the data and that they could withdraw from the study at any time. Prior to the interview, all staff and patients were given a verbal explanation of the study and the plain language, information letter. In the case of patient interviews, a decision was made to not interview any patients who were legally classified as "involuntary" under Section 12 of the 1986 Victorian Mental Health Act. While this classification was in no way related to how mentally capable a patient was of granting informed consent, it did require that I obtain written consent from a legal guardian, in addition to that of the patient. For example, people who experienced significant cognitive impairment because of dementia may have been admitted to the unit on a voluntary basis, while other patients who may have subsequently improved from a brief psychotic or depressive episode may have been admitted as involuntary patients. For convenience, I decided to omit these patients from the potential pool of formal interview informants. Seven patients were approached during the course of the study with a view to them being informants in an interview situation. Each patient was given at least a day to re-consider their initial commitment to be involved and were encouraged to take an information sheet to share with a family member or friend. Of these seven, four agreed to be interviewed and three declined after having time to reconsider. Signed consent documentation was stored in a lockable file within the office of my associate research supervisor, who is employed by the health care network.

Formal interviews were audio-taped and transcribed verbatim. Approximately 40 hours of formal interview data were transcribed. Of these, the shortest interview
was 20 minutes and the longest was 3.5 hours. My original intention had been to interview all staff both before and after relocation, however, I perceived that a number of staff, while being accepting of my presence on the unit, and happy to engage in informal conversations, were not so happy to be formally interviewed. This realisation came most notably because of several situations where I perceived that staff who were previously very happy to converse with me became less welcoming and enthusiastic in my presence after I asked them to participate in a formal interview. Rather than risk losing their acceptance through creating undue pressure or expectation that I would “hassle” them when I was in the unit, I rethought this aspect of the methodology. My relaxation in the presence of these staff after this decision had been made and a realisation that I was already obtaining very detailed accounts of behaviours and beliefs in less formal situations appeared to also have a relaxing effect on the staff concerned. The richness of data contained within the fieldnotes, which included much informal conversational data, assisted to confirm that this change in emphasis was methodologically and ethically appropriate. In reflecting on methodological decisions made during fieldwork for his classic study of street corner life in urban America, William Foote Whyte observes that he had discovered the answer to questions that he would not even have had the sense to ask if he had conducted interviews. In an excerpt from *Street Corner Society*, Whyte’s key informant, Doc, explains to the researcher: “You ask those questions and people will clam up on you. If people accept you, you can just hang around and you’ll learn the answers in the long run, without even having to ask the questions” (Foote Whyte, 1991, p. 185).

Tertiary data collection activities which served to supplement participant observation and formal interviewing included: the use of written questionnaires, reviewing official documentation, and doing “spot checks” (Johnson & Johnson, 1990) or random behavioural observations of patients. Two written questionnaires were constructed in a broad based attempt to reach as many staff members as possible and give them the opportunity to put across an anonymous viewpoint as to their current perceptions of life on the unit. The questionnaire also served the purpose of giving staff information about the study, how it was progressing and what I was hoping to do. One questionnaire was distributed in December 1998, while the service still operated as Port Edward unit, and the second was distributed
to all staff of the two new units in September 1999. The first questionnaire and attached information letter was addressed to each staff member personally and placed in their mail folder. The letter directed staff who wished to participate to seal their completed questionnaires in the envelope addressed to me and return it to my mailbox. The second questionnaire was distributed to staff electronically via their e-mail accounts. This second method had potential to offer less anonymity in that staff could return their e-mail response directly to my e-mail address, in which case, I would see their identifying information. I drew attention to this aspect of the questionnaire and suggested staff could print off their responses and place them in sealed envelopes I had left in an area of the staff station of both units. Each questionnaire required an open-ended written response and gave the option to add “any other comments.”

Pre-move questions:

1. What do you feel are, or have been, the positive aspects of life on the unit for you as a staff member and/or patients?
2. What main challenges/constraints impact on your ability to carry out your role/daily work on this unit?
3. What survival tips would you give a new staff member?
4. If I was a new staff member, what would I need to know to really understand why things are they way they are?
5. What are your views on any of the past, current and impending changes to this service?

Post move questions:

1. From your perspective, what new and positive achievements have been realised as a consequence of the move from Port Edward Unit?
2. From your perspective, what challenges, either new or existing, are present in your current environment? Please discuss why and in what ways these challenges continue.
Both questionnaires yielded very low response rates. For the first questionnaire, only 3 were returned, for the second questionnaire, only four were returned. Despite this low response rate, each questionnaire provided very useful and, in several cases, very detailed information. Written response data is represented in a number of the staff response vignettes.

Document review focused primarily on the multitude of paper "forms" that were part of the everyday documentation required of staff in the units. These included written assessment protocols, admission and discharge paperwork, legal documents such as "authority to restrain" or "hold in seclusion" forms. A small number of patient records were viewed in an effort to understand the type of information that was recorded on these forms and some of the typical jargon used. The patients who had provided written consent to be interviewed, also gave permission for me to view their files; however, the personal details of individual patients were not of concern and not recorded. Previously collected data that was part of an action research project conducted by an outside consumer-focused group on behalf of Port Edward unit was also reviewed. These data were composed of patient feedback as to their perceptions of the positive and negative aspects of ward life, and staff feedback in relation to the patient identified issues. Fortnightly staff meeting "minutes" were reviewed, as was a book, which allowed staff to record their current concerns. This book was frequently used as "gripe" book, a site for a running dialogue where staff could communicate with each other in a non-direct and anonymous manner about challenging and problematic situations.

Once the study had moved with the service into Brennan and Janson units, I began to start noticing what I perceived to be a difference in what patients did in each unit when they were not engaged in any specified activity or ward routine, such as during meals. I decided to begin random observation checks in each of the units at a different time each day. During these, I recorded what the patient was doing, where, and with whom. Through this, I hoped to introduce a more systematic and methodical overview of my more casual observations which, on the face of it, suggested to me that in one unit patients tended to behave predominantly in one way and on the other unit they behaved differently. In support of "random" observations, Johnson and Johnson (1990) note that:
Misleading impressions and overlooked patterns can be very difficult to discern by fieldworkers who, after all, can claim to have “seen” the behaviour with their own eyes. And the misinformation, in the absence of methodological checks, will persist to confound future efforts at analysis (p. 172).

By default the spot checks also provided valuable information as to the interactions, or lack thereof, between patients and staff and helped generate questions that focussed on what occupations staff were engaged in when not directly providing care to patients. The result is that a variety of data collection methods were adapted to enable me to formulate interpretations of life in the aged persons’ mental health units. While naturalistic methods, such as participant observation and formal interviewing, were the predominant modes, other methods that aimed to elicit a general, rather than specific, impression of viewpoints and behaviours were also adopted. These other methods, namely written questionnaires and behavioural spot checks, were adopted in response to a contextually dependent perception of required methodology, thus the need for these methods was felt to have evolved naturally, rather than being pre-planned.

Rigour, trustworthiness and credibility

It is an epistemological and conceptual error to judge qualitative research by the same criteria as quantitative research (Krefting, 1991; Yerxa, 1991). This is a study that seeks to discover, describe and understand, rather than confirm, verify and quantify. This aside, all research must be judged by some form of meaningful criteria. In considering the trustworthiness (Krefting, 1991; Lincoln & Guba, 1985) of this research, the notion of “truth value” is established when, for example, the reader is satisfied that the descriptions of a cultural scene are sufficiently credible that the reader might feel as though they have been transported to the very location. Sufficient depth of description is required so the reader can judge for him or herself how well this particular scenario might fit with their own, or one with which they feel familiar. In this study, I have reproduced verbatim accounts of participants’ viewpoints and reasonings. To assist the reader to make up their own mind, some of these accounts are quite lengthy. Immersion in the field for lengthy periods is one
way that ethnographers can ensure credibility. The longer I spent in each unit, and
the closer I worked with staff, the more difficult it became for staff to differentiate
between me the researcher and me the extra pair of hands, despite my frequent
reminders. Time and familiarity simply made staff forget who I was, enabling me a
closer insight into how things really were as staff “dropped their guard.”

Other yardsticks of rigor, trustworthiness and credibility, included the use of
multiple data collection methods from multiple sources, referred to as triangulation
(Denzin & Lincoln, 2000; dePoy & Gitlin, 1998; Krefting, 1991; Lincoln & Guba,
1985). In terms of receiving feedback from participants as to the credibility of my
descriptions and interpretations, each interview informant was provided with their
interview transcript. The explicit request for feedback as to the accuracy of the
researcher’s interpretation is often referred to as member checking (Krefting, 1991).
While the transcripts provided to each informant did not contain extensive
interpretations, many of the interpretations made in the construction of this thesis
were actively explored during interviews and further tested out during peer
debriefing (Krefting, 1991) where I would discuss my findings, experiences and
interpretations. These peer-debriefing opportunities occurred with other
postgraduate students as part of organised colloquia, with ex-employees of the units,
and other personnel with a close understanding of the unit itself. These
opportunities provided an important “check” through which I was able to reject,
alter or clarify my interpretations.

In the chapters that follow, I present data obtained through a variety of
methods, and from multiple sources, to support my interpretations of life within Port
Edward, Janson and Brennan aged persons’ mental health units. The methods and
sources are chosen to add as much meaning to the descriptions and analyses as
possible. As I begin my journey into each unit, the “temporary” home of patients
and “workplace” of numerous staff, I focus on orientation and landmarks, and how
each place seems to work in a superficial sense. This environmental mapping has
been described by Spradley (1980) as doing a “grand tour.” Getting into the “scene,”
experiencing and describing it was a vital first step if I was to understand and
interpret what was going on.
CHAPTER 5

Introducing the occupational environment

"Grand tour" observations aim to describe the major "things" encountered in a cultural scene, including space, activity, objects, acts, events, time, goals and the feelings of the "tourist" (Spradley, 1980). Starting with Port Edward, I recount my first day of fieldwork in each unit. In Port Edward my acclimatisation to the inpatient environment begins, and it is at Port Edward, that I meet many of the staff, and some of the patients, whom I later follow to Janson and Brennan units.

Port Edward Unit: New people, new place, and home of the "sundeck"

My first day of "official" fieldwork started at 9.00 am with a formal introduction to a primarily non-nursing audience as part of the fortnightly staff meeting. The meeting was chaired by one of four consultant psychiatrists for the unit. I was nervous prior to the meeting, as this would be my opportunity to formally explain and launch my study to all the staff of the unit. After several general items are discussed, I was introduced by the consultant and, at his invitation, began my explanation of the study. As I spoke, I handed out my carefully worded information sheets to everyone present and tried to explain the study in the two minutes allocated. "I am a research student and have come to study the unit as a whole, in an anthropological sense, both its social and physical elements. "I'm also an occupational therapist, so I have some understanding of mental health and hospitals." I went on to explain participant observation: "this means that staff will see me on the wards, sitting and talking with patients, perhaps going to meetings, helping staff wherever I can, attempting to get to understand how the unit functions.... and I hope to interview staff and patients and that the information and consent forms provide a more detailed explanation for those who would like to be involved in interviews." In my nervousness, I could not recall later if my explanation attracted any questions. People seemed unaffected, but they took and
glanced at the information sheet. After I had finished speaking the consultant concluded my introduction by stating: "And Tracy's study has been approved by the scientific and ethics committee." I found it difficult to focus on the rest of the meeting's business, noting only the largely silent nature of the meeting and the respectful command over the staff group that this consultant had.

Two more orienting activities provided structure for my first "stint" in Port Edward. The first of these activities was morning tea with the allied health team, the occupational therapists and social workers, and the second was an official "tour" of the unit with one of the unit managers. I used both of these "engagements" to ask questions about who was in the meeting and find out as much as I could about staff and patients.

The participants: Staff and patients of Port Edward unit

My retrospective reconstruction of the staff meeting during morning tea with the allied health group, and my tour of the unit, revealed that the morning staff meeting was usually only ever attended by managers, medical and allied health staff. Besides the consultant psychiatrist, program manager, part time "senior" or grade 3 occupational therapist and two new graduate, or grade 1 occupational therapists, the meeting was also composed of two social workers, a senior and a new graduate. Another social worker, of grade 2 level, was absent. Two unit managers, both with nursing backgrounds, were present, one already appointed to head Janson unit and the other to head Brennan unit. During my tour with one of the unit managers, it was explained that "in a couple of weeks the ward staff will be moving into the new unit team structures, nursing those patients who fall with in each unit's respective catchment area. I will lead Brennan unit. Everyone knows where they are going."

Also at the morning staff meeting were three medical officers doing their rotations through psychiatry, a psychologist who provided part time cover for the inpatient unit, one of two administrative assistants, and one nurse, a level 2, registered psychiatric nurse (RPN) who was the associate charge nurse (ACN) for the day shift. This nurse was responsible for running the unit "clinically" and reported to the unit manager. During my ward tour the unit manager, Gary, revealed that one of the problems of the morning meeting was that "ward staff" or nurses and personal
services assistants (PSAs) were not able to be present, as they were busy with the morning breakfast routine at this time. Thus, I learn that four nurses were absent, as were three PSAs, and that these two groups formed a larger group referred to as “ward staff.” At this point I wondered if my introduction at the staff meeting had been all in vain, as I had a strong feeling that it was the ward staff who I most needed to “sell” my research to.

As I wandered through the unit with Gary, I met most of the ward staff and encountered patients sitting in the various chairs in the unit or wandering throughout the corridors (see Figure 1). From the unit foyer (see Figure 2), which houses the meeting room, administrative offices and the staff station, the locked part of the unit is visible through a set of “one-way” glass doors.

Figure 1. Long Corridor, Port Edward

Staff and other outsiders can see in, but patients cannot see out. As I hover in the foyer, while my “guide” speaks with one of the medical officers, several patients come up to the glass door, try to open it, rattle the handle, and wander off again. Immediately visible through the door is a row of six or seven chairs (see Figure 3) that line one of four long corridor walls running the perimeter of a square central outdoor garden courtyard. The chairs, which look out onto the garden, are all occupied, with some of the patients dozing in them. I am given a set of keys just before the unit manager uses his own set to unlock the door and enter the “ward” part of the unit. We head towards the chairs. The unit manager says hello to those patients who are awake. I use this opportunity to introduce myself and explain, “I am a research student and I am here to learn about the unit.” From what seems like this “sundeck” of fully occupied chairs, there is a clear view through windows to the garden courtyard (see Figure 4). In the garden are three other patients, one sitting alone on a garden bench, another sitting on a chair having a cigarette, while another patient walks slowly up and down the length of the garden, taking continuous puffs on his cigarette. I take in as much as I can as we wander and pause. As we encounter nurses, Gary introduces me and explains to
some of the nurses why I am here. During one introduction, I am left to explain the

Figure 2. Foyer, Port Edward

study for myself. No elaborations are asked for and I perceive no significant interest, but I figure that I will get other chances to elaborate as I get to know staff. Gradually I meet all three personal services assistants or PSAs. When we wander into the large dining room, kitchen and servery area, I meet one PSA who is permanently assigned to the kitchen, and is in charge of food ordering, preparation and dishwashing. Two other PSAs are encountered in other areas of the unit, one is cleaning one of the 6 or 7 communal bathrooms accessed from the corridors, and the other is mopping the floor in one of two large lounge areas. In one of the lounges, I meet more patients, who sit and stare in the vicinity of a blaring television. Three or four of the patients are sleeping, so I figure I will meet these patients later on. When I ask Gary about patient numbers, I am told that while the unit capacity is 36, there are never more than 31, as the original figure included a special 5-6 bed purpose built dementia care ward which is now closed. This statement is followed up with “it’s a bit of a bone of contention with some staff and I tell you that only because you will hear about it, staff will talk about it.” Gary continues on to explain that some of the staff have the perception that the ward is more difficult to manage since the dementia care unit closed. I try to remember this as we leave the lounge area to go and look at the now closed dementia unit or DMP, which I am told stands for Dementia Management Program. In the old DMP, one of the medical officers is writing in a file. I am introduced, and the unit manager explains that the doctors sometimes use the space as a quiet place to write notes. I imagine the potential of the small unit – it is composed of a large lounge with a breakfast bench separating the main space from a kitchenette. Four double
bedrooms lead directly off one wall of the lounge; one an observation room with a small glass panel. There is a separate bathroom and toilet. Even though it is empty, the unit has a cozy, self-contained feel to it, but it seems a long way from the hub of the main foyer and front desk.

When we come out of the DMP and back into one of 3 accommodation wings, I feel disoriented and lost until we come back out into one of the corridors, which forms a perimeter around the central courtyard. Through the courtyard, I can see that we are diagonally opposite the locked door where we first entered. For a moment I think about it from a patient’s perspective – all the accommodation wings come out into the courtyard corridor. This could be very confusing. We wander back down towards the lounge and dining room entrances and Gary unlocks a plain door (no glass) and we are immediately confronted by stairs. “This is the staff room,” he explains, as we climb up. There is a fridge, sink, microwave, and hot water unit in a kitchen area and a large round table littered with newspapers and magazines. A sliding glass door leads to a balcony where there are a line of chairs and a smoker’s bin. Gary explains that it is mostly ward staff and some of the registrars (trainee psychiatrists) who come up here as the O.T.s and social workers have set up their own tearoom near their office on the ward. We leave the upstairs staff room via a different set of stairs, which lead to the outside of the unit, just outside the main foyer. We go inside and the unit manager tells me that he has organised an hour at 2 pm for ward staff to come and hear about my study, as this is a time that I was more likely to get a good turnout. As it is lunchtime, I leave the
unit and enter the nearby pre-fabricated building that houses the community team. I have lunch with the senior occupational therapist and fill in time until the meeting at 2 o’clock.

At the 2.00 pm meeting, only 4 people show up. These include 2 nurses and both of the administrative assistants. One of the nurses is an RPN, or registered psychiatric nurse, who has completed a 3 or 4 year course, and the other is a state enrolled nurse, or SEN, who has studied for one year. I explain the study and hand out the information sheets. One of the administrative assistants complains about her workload and that she hopes to leave before the move. I don’t follow this up with any questions, but remember it, for another time. The nurses ask questions about my experience as an occupational therapist. I tell them I went to university with the senior occupational therapist. This information seems to be accepted favorably, almost as if this connection stands as some form of recommendation, a stamp of approval.

After I leave the meeting, I return to the “sundeck,” and take a seat. I take in the atmosphere and chat to patients. Already my presence has changed the usual occupations in this particular part of the unit. Any conversation appears to be seized on as an “event” and heads swivel to the source. The chairs are not positioned for easy conversation between patients, rather they are positioned for sitting and looking straight ahead. In the months that follow, I learn that the “sundeck” is the place that patients go when there is nothing else happening. Consequently, the “sundeck” seating is usually fully occupied except for the dead of night and at meal times. This position becomes a trusted vantage point for the months ahead, where I can quietly watch the comings and goings of staff and patients and informally converse with the patients who sit there, when I am not working with one of the nurses on his or her “rounds,” helping out in the kitchen, attending one of the groups run by the occupational therapists, or sitting in on one of the unit meetings or clinical ward rounds. Six months later, after Port Edward Unit had divided and relocated into Janson and Brennan units, I found similar congregation points in both places, but none that gave such a good view of the “action,” both inside and out, as the “sundeck” at Port Edward unit.
Re-establishing connections: Familiar faces in new places

Janson: Home of the "proxy card"

My introduction to the first of the new units, Janson, began 3 months after its move from Port Edward unit. After receiving directions from main reception at the Janson Health Centre, that the entrance to the Janson aged persons’ mental health unit could not be accessed from the main health facility entrance, I get back in my car and drive half a kilometer around a few streets to the rear of the Health Centre. I see the sign for Janson Aged Persons’ Mental Health Unit. As I approach the automatic glass doors, 3 adults, whom I assume are clients of the adjacent adult mental health unit look towards me, one person is seated on a chair, another sits on the concrete path and the third stands smoking. As I enter what appears to be a shared foyer for both units, I approach the main reception area, which is a partitioned glass booth. One booth is adult reception and the other is for the aged persons’ unit. A man sitting in the aged persons’ booth identifies himself as "only the computer technician," so I wander off to my right, towards two heavy fire doors and ring the bell as the sign near the locked door indicates. I wait for up to a minute and then I ring again. The next time a nurse comes and lets me in. She asks who I’m after and I tell her I have an appointment with Paul, the current acting unit manager, who I know well as one of the ACNs from Port Edward. The nurse leaves me. I remember seeing her on a few shifts at Port Edward, but she doesn’t acknowledge me. Paul doesn’t come for another 5 minutes, but when he does he is welcoming and tells me that we will go on a tour of the unit and then he will take me to the main administration department to get a "proxy card" and a key. I remember the plans and discussions about these cards, which could be waved at the door to make them open.

In Paul’s office, which is immediately inside the unit on the left of the big heavy doors, I outline that my main focus will be to continue working with staff, helping out where I can in order to learn about the new environment. Paul tells me that he thinks that staff tend to see me as helpful, and that he is very pleased to have me back. We begin our tour. Directly out in front of the Unit Manager’s office, to the left of the entrance, is a small open lounge area with a two-seater settee and
some single chairs with nice flowery patterns on them. I notice the old piano and the telephone - a Telstra coin phone from Port Edward. Paul first orients me to the doors I had just come through. "These are fire doors and so they must stay locked at all times, but there is a bell for people to ring."

Facing into the unit again, the staff station is the next room, just beside the Unit Manager's office. It is locked and can be accessed by either the proxy card or the key. Paul flashes his card and with a little buzz, the door unlocks. This room has some of the tell tale features of the old unit — the whiteboard that has the patients' names and bed number listed on it, is prominently mounted on the end wall. Paul directs my attention to the personal pagers lined up on the wall. It looks very high tech, and conjures up images of a police surveillance set-up. I seek out other familiar things. I ask him where are the patients' cigarettes kept. Then I see the "fags" lined up against another board, some with patients names boldly printed on them in pen or black texta. The familiar "two pages to a day" diary is on the desk, and there are two computer terminals in this room. These are new additions. Paul attempts to introduce me to a man who turns out to be one of the rotating psychiatric registrars. He barely sustains eye contact for long enough to hear out Paul's explanation of my research, but goes through most of the motions of appearing interested. From the office, at least part of three wings (see Figure 5) can be seen, these fan out to the left and right from the half circle design of the staff station, which is essentially a large glass booth from hip height up.

![Figure 5. View toward small lounge and bedroom wing: Janson.](image)

Directly in front of the central part of the office is the back wall of the kitchen, which cannot be seen into. Neither can the dining area, or the 4th wing, which sits on the other side of the kitchen. As we go out of the office door, Paul introduces me to a new nurse, Jenny. Like the registrar, she seems somewhat pre-occupied and not overly interested in hearing about my research, but sparks up a little when I mention finally that I am also an
occupational therapist. I ponder this, and remember that like the Unit Manager, who was appointed just under a year ago, the occupational therapist had recently resigned and left. Outside the kitchen area (see Figure 6), I meet and greet another nurse and one of the agency PSAs who worked casually in Port Edward.

**Figure 6. Kitchen/Dining Area: Janson**

She greets me with surprise, and grabs and hugs me like a long lost friend. We then walk towards what Paul describes as the “high dependency” (HD) wing, which he says “was originally designed as a special dementia unit but is not being used as one because it would require at least two nurses to open, and there is no money for this, so it is just used as part of the general ward.” This wing has its own observation/seclusion room, which has a window into it from the corridor of the wing and the nurses’ station. Standing in the center of the lounge of this wing, which is carpeted and has a small coffee table and comfy chairs, I envision the lounge area as an intimate and inviting small group area. It has its own small kitchenette, accessed through a hip height stable-door, which is locked (see Figure 7). The hotplate area has a lockable lid over it.

**Figure 7. High Dependency Unit: Janson**

The kitchen looks as though it has never been used. Paul shows me into another room, which has a special electrically operated “Parker” bath in it, but says “no one has had a bath yet as no one knows how to use it.” The HD wing has 5 or 6 bedrooms, which have linoleum floors. They seem as sterile as the rooms at Port Edward. The old, familiar sharp-edged bedside drawer sets are beside each bed. I am shown to the
only one of the rooms is occupied, which appears as unoccupied as the other rooms. This room has its own ensuite bathroom, although most of the other rooms do not.

We leave the high dependency wing and return to the kitchen preparation area. The room is closed, with no hatch or servery to allow people to see what is happening inside. Meals are warmed up and "plated" in the kitchen and then brought out to the tables and served to patients. It seems isolated and private, a closed shop. Paul then takes me into what he calls the activities room, which is a small room, with its own separate toilet, which is almost as big as the activities room itself. There are no table or chairs and the room appears unused with the contents of the cupboards not neatly organised. I wonder what purpose this very small room could have beyond being a storeroom and extra toilet? Next door to this is the client kitchen, which Paul explains is currently used as a staff kitchen/tearoom while there are no cooking groups happening, although the area is being used by the occupational therapist for the adult team for her cooking and meal preparation groups. I ponder for a moment the close proximity of the adult and aged persons units and the need to share group activity space with adult clients. The notion of mainstreaming the new units with other aged care services appears somewhat compromised by these two very basic observations. I don't say anything other than "hmm."

We then go down to look in some of the bedrooms off the central wing. These bedrooms are carpeted and have plain curtains, which blend in with the walls, the patterned comfy chairs provide the only color in these otherwise neutral and impersonal rooms. The rooms in one wing have ensuites, while those in another wing have shared bathroom facilities. In one of the rooms, Paul points out the old laminated drawers from Port Edward, and explains how one patient has already gouged holes in the wall by repeatedly ramming the sharp edges of the drawers into it in frustration. Back out in the corridor, Paul shows me into the "surgery" where the drugs are kept. I am introduced to another new staff member, a graduate nurse doing his eight months psychiatric training. This nurse is warm and welcoming and seems genuinely interested in my study.

Next, we go into the room that has the washing machine in it. Paul explains that patients can do their own washing in here if they want to but there is no line outside and they need to dry their clothes in the dryer. At this point its seems the

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tour is over and it is time to go and sign for my proxy card and key. We walk through the lounge area of the main wing first. This small lounge area has four double settees, configured in a square, which orient towards the TV video set. The settees are brightly patterned and this little lounge “nook” has a warm feel to it. The Bert Newton morning show is on the TV, but none of the patients appear to be watching. Two patients are dozing and two others watch the comings and goings of others in the immediate area. We continue into the lounge of the high dependency unit and go out a door down the back of this wing into a long series of winding corridors, requiring frequent “flashes” of the proxy card to get through the series of doors on the way. Soon we appear in a long covered walkway, into the main part of the health service. Paul points out the other wards as we walk up a corridor, which is at least 100 metres long. The first sign of life that we come to is a café, buzzing with visitors and staff. I spark up with excitement as we walk past and I ask Paul, "So is this somewhere one could come with a patient?" He answers, "its not really for patients." My heart sinks a bit when I realise that one of the redeeming features of my tour so far, one of the homely and community oriented settings, is not for patients. Off this cafe wing are the administration offices where we go and sign for my key and proxy card. We return to the café and go down another corridor. “This is the APATT team office space,” says Paul. We go into what is a shared office space with a small reception area, and I meet some of the case managers that I had got to know from the prefabricated building next to Port Edward unit. I reflect now on the distance of the community team from the inpatient team, physically in the same facility, but virtually, and perhaps metaphorically, miles apart. In other doors off this corridor are the aged care occupational therapy and physiotherapy areas, which includes a hydrotherapy center. This whole treatment/therapy area buzzes with staff and patients and the isolation of the aged persons’ mental health unit becomes increasingly apparent as we descend further towards the back of the health center on our way back.

When we get back into the unit, Paul shows me into the “ECT” suite, which he says, has never been used. I later learn that one of the reasons for this is that it is difficult to get an anaesthetist to work there, so all the patients who need to have ECT are transferred to Brennan unit, some 10 kilometres away. We go into another locked room. “This is the staff room for the adults and aged staff.” It has a
distinctly unused feel to it and given its distance from the actual unit I can now see why nursing staff have adopted the clients' kitchen as their own. The final door I go through is to another shared office space, without partitions between desks. Paul states that this is the allied health office space, which is shared between the adults and aged team. I wonder if there is any space for me to sit in here. I ask about some writing space as we leave and Paul shows me into a small office with a phone and desk. There is no window, and the room resembles a cell. "You can use this room if you need to, it is the consultant psychiatrist's, but neither of the consultants has claimed this area." Any wonder, I figure to myself. With my tour now definitely over, I wander into the patients dining area, which is positioned opposite the small lounge area. I recognise the round tables from Port Edward even though they are covered with new flower patterned plastic tablecloths. Two of the tables have one patient sitting alone at them. One of the patients watches other people coming and going, and the other sits with his/her head hanging, dozing. As I wander, one of the nurses walks up to me and says in a jovial manner "so we are still going to be your laboratory rats?" I laugh and say, "yes." Back in the office, one of the nurses is playing concentration on the computer and another is writing her file notes. From here, I can see patients seated in the lounge chairs, and other patients wandering in the various spaces of the corridors that are visible.

I decide to take a quick self-guided tour of the outside garden area before leaving for the day. I go up to the main door out to the garden, which runs off the lounge area.

**Figure 8. Outdoor, smoking area: Janson.**

The door is locked, so I reach for my keys. As I do, two patients ask me if I can get them a cigarette. I re-lock the door and head back to the station to rummage through the boxes to find the names of both of these patients. With the fags in hand, I go out with the patients and lock the door behind me. I sit on one of three chairs, which line a
narrow pavement (See Figure 8). The garden is not inviting and there are butts littered everywhere. Both patients are eager to come back in with me when they have finished, despite the pleasant sun. Feeling thoroughly back in the swing of things, I return to the office, flick through the pages of the diary, and plan my next few visits. I say goodbye generally to the three people in the office. One nurse half lifts her head and says a functional “bye.”

_Brennan: Home of the “love boat”_

On my first day at Brennan, the smaller and second of the two units to move, I access the unit by walking through the main general hospital entrance and walk up to the first reception desk I encounter. At this general reception area for the entire hospital, I am instructed to follow the blue line on the floor, continue past the café and I would see the signs for general aged care services, and that there was a temporary sign for the aged persons’ mental health unit. En route, I walk past typical hospital lifts and see signs listing the services on the various floors of the hospital. Numerous patients wander around, some in their bedclothes, others with family or friends. I walk past a charity shop and then past a combined news agency/café, which is busy and inviting, with people browsing at magazines, or selecting cards for their loved ones. Past this point I hit a long and more empty part of the corridor and notice a sign that indicates a geriatric ward. I continue past this until I see the temporary sign above what is the entrance to the aged persons’ mental health unit. I enter the unit from the main hospital corridor through two open doors. In this corridor I encounter the familiar face of one of the administrative/reception assistants from Port Edward. She is sitting in a small glass booth behind a glass screen, which is open. She gives me a smile of acknowledgement, which makes me feel at home. I offer to catch up with her later and continue on to find the unit manager, Gary, with whom I have an appointment. As I walk beyond the reception area, I can see that the actual ward part of the unit is beyond two locked doors. What comes before these doors are two more offices on the right hand side of the corridor, one of which I guess is Gary’s office, and on the left, a whole series of closed doors. The door closest to the locked unit doors is the staff tea room/kitchenette. Next is a glass door that leads into the staff station. As I loiter and
wait for Gary, I can see through the staff station into the locked part of the unit, where the patients are.

After a minute or so Gary comes and without any mucking around offers: “so do you want to do the tour now?” I say yes, and he leads. He takes me around fairly enthusiastically and so I feel quite welcome. We go back up to the entrance of the unit and, as Gary opens the very first door inside the unit, which is a dirty linen/cleaners storage room, he says “you should take note of this area as a design feature.” I eventually understand what he means when he says, “having the linen room here means that they don’t have to come into the unit and that’s an important design feature.” Next we go to the first door on the opposite side of the corridor, which is a room of partitioned desks for allied health and some of the medical staff. Gary tells me that I can have one of the three empty desk spaces and a key to the lockable set of drawers. We then go to the next room on the left, which Gary states is called the “activities room.” “This is where Liz (the occupational therapist) works with patients.” I take in the features of the room, a good space with an area that has a large table for groups or other craft occupations, which then extends off into a kitchen space. The kitchen area is long and narrow but has a lot of bench space, and I notice that part of it is at a lower height for wheelchair users. There is also a lockable full-length cupboard which Gary says is good for Liz to be able to have things locked away, implying that things have been known to go missing from the ingredients cupboard in the past. The entire kitchen and group area looks out onto a courtyard, which has outdoor chairs and a portable barbeque. Gary refers to this as “a supervised outdoor area for Liz to use for groups, and we are thinking of getting monthly staff and patient barbeques going out here.” Gary is genuinely enthusiastic about the potential of his unit.

We then head back out the door we came in, past Gary’s office, past an “examination” room, which has an examination plinth, eye chart, and other telltale medical paraphernalia. Gary states that it is another space that can be used by any of the staff. Directly opposite this is the staff station. We go in. Delia, one of the RPNs from Port Edward is in there, as is one of the consultant psychiatrists. At this point I remember that as Brennan has only three nurses rostered on for day and evening shifts, the other nurses must be busy on the “floor.” We don’t disturb either of the office occupants, and Gary and I talk quietly as we look out into the unit from
the office vantage point. From the centre of the station, I can see into three different wings of the unit. Gary explains that the centre one is called the "pink" wing. Off to the left of this is the high dependency wing, and then from the right of the centre is the "green" wing. Gary explains that these colour codes simply refer to a slightly different colour of decorations on the curtains. They are informal terms rather than actual distinctions. The office is very small, about a third of the size of the Janson office, but gives a very good view into all areas of the unit. Straight ahead, in the central section, I see the two PSAs, Gina and Roy, in what appears to be a large open kitchen servery area. It looks more like an open hotel bar than a kitchenette. The servery is right in the centre of two lounge areas, one that flanks the "pink" wing and the other flanking the "green" wing. Modern café style tables are positioned around both sides of the bar (see Figure 9).

![Figure 9. Dining tables flanking the kitchen: Brennan](image)

The area seems very inviting. I wave to Gina. Before we leave the office, Gary explains the features of the staff station, specifically the eight or so personal beepers hanging on the wall, those that are not hanging on their cradles are presumably attached to nurses. Gary explains that the beepers are activated in an emergency and a sensor on the ceiling keeps track of the user so that others can come for assistance. Two "buzzes" means that nurses from the adult psych unit will come running into the ward as back up. I am suitably impressed with the high tech nature of this, but the notion of homeliness doesn’t spring to mind.

Finally, we go out into the main ward and I move towards the servery area to say hello to Gina and Roy. I tell Gina, "you look very at home here" gesturing to her position behind the bar-like servery. "It’s called the love boat," (see Figure 10) says Gina. I imagine the TV show and the central place of the bar and its function in bringing people together. Gary joins us and he and I continue on into the high
dependency wing. Like Janson, this HD wing can be locked off from the main part of the ward and is visible from the staff office. Walking into its central lounge, there are comfy chairs positioned around a TV and music system. The lounge area has a simultaneously homely, but sterile feel to it.

Figure 10. The love boat” with view to staff station: Brennan

There are no patients in the area, and it is quiet and very clean, almost too perfect and tidy. Directly in front of the seated area is a view to a small, contained courtyard with its own door. Unlike Janson, this wing does not have its own kitchen. We go into the first room off the lounge, which is the observation/“at risk” room. This has a heavy reinforced door that has a small glass observation panel, and there is also a window between this room and the staff station. The room has nothing but a low bed with special “suicide proof” bedclothes. There are four more single rooms, all empty, as everyone is accommodated in the wings of the main unit.

We head back out to the dining area. Inside the long oblong shaped servery, two hip height stable doors access the preparation area. A movable boiling water unit is on the bench inside the servery, which Gary explains, is put away at night behind a roll down grate when the area is not used. This very open plan kitchen is in full view of the office. There is a public toilet at the back of the servery area and access out into a large open courtyard area, which although it has been sculpted and pebbled, seems a bit empty.

Lavender bushes and olive trees are establishing themselves along with other small plants. A clear path invites the walker around the garden and back to the lounge entrance (see Figure 11), however, there are no patients out walking and only one patient sits smoking on one of the chairs placed in a row just outside the door.
(see Figure 12). We go into one of the rooms off the pink wing. Unlike the high dependency (HD) wing, each person has his or her own ensuite bathroom/toilet. Each room has its own chest of drawers that is lockable. Gary explains that keys are given out selectively to those who can cope with them. The rooms are warm and colourful, thanks to the curtains. Unlike the rooms in the HD wing, these rooms are carpeted.

In the ensuites (see Figure 13), my attention is drawn to a sensor fitting, which Gary explains will set a light off in the staff station at night, letting nurses know that a patient is out of bed and has moved into the toilet. I pause briefly to think about how useful these additions would have been in the old Port Edward unit, which was such a large, rambling environment in comparison. I wonder how necessary all the beepers and buzzers are in such small spaces. We go into the laundry room. Gary tells me that patients can be let in by a staff member to wash their own clothes and can also access an area of the courtyard, which has a washing line.

After we finish the tour, I am issued with some keys. I decide to set myself up in the allied health office area and chat briefly with Liz, the occupational therapist, while I settle in. I feel at home in this office space, but I am also drawn to go out into the main unit before I leave for the day. I decide to spend 15 more minutes in the unit and head for the staff station. I introduce myself to an unfamiliar nurse, who informs me she is “agency” and that it’s her first time here. The phone rings while we chat. I answer the call automatically and transfer it to the required destination. The nurse, Claire, thanks me, as she wasn’t yet sure how to transfer
calls. I spend 5 minutes showing her how to do it. I feel like an old hand. One of the RPNs, Delia, comes in and to my surprise is very chatty with me. Delia never really ever engaged with me in Port Edward, and so her actions make me feel at home.

Next, I go and sit on one of the four settees in the main TV area. There are seven women sitting around the television on the various couches watching a cartoon show. Two men wander around and two others are sitting at the café tables, just watching. I introduce myself to one man, Bill. Bill's confusion becomes quickly apparent, when he confuses the servery with a bar and offers to buy me a beer. I go back into the staff station where Delia comments about the confused state that Bill seems to be in. Apparently she had heard most of the conversation, as the door to the office was open. I consider this to be good from a design point of view.

I tell Delia I will see her around on one of my next "shifts" and leave, fairly excited about coming back into the unit to get "stuck into" my fieldwork.

Analysing everyday life

Learning the ropes and establishing myself as a new and useful player in each environment was crucial to gaining access beyond the superficialities of the environment. The "grand tours" were now over. Having become familiar with each "unit" environment and some of the staff within each unit, a more meaningful and analytic exploration of some of my experiences is now possible. My descriptions
aim to provide enough detail for others to glimpse at life in each environment, and my analyses are an attempt to put forward reasonable interpretations as to how and why aspects of institutional life, whether these aspects are values, attitudes or behaviours, are either constraining or enabling to people within the units.
CHAPTER 6

REPRESENTATIONS: OCCUPATIONAL ROLE PERFORMANCE IN AGED PERSONS’S MENTAL HEALTH UNITS

In this, and subsequent chapters, I present a “more or less coherent representation, carried by word and story, of an authorially claimed reality” (Van Maanen, 1998, p. xi). To further quote Van Maanen, through these chapters I aimed to “create historically situated tales that include both highly focused portraits of what people in particular places at certain times are doing and a reasoned interpretation for why such conduct is common or not” (1998, p.xi). I do this because it is through this process that I am able to demonstrate the ways in which peoples’ occupations are reflective of the broader context, and in turn, how those occupations enable and constrain others.

Through spending time in each unit as a participant observer, I was afforded an insight into the occupations of staff as they performed the daily tasks and roles associated with providing a service to aged persons with mental illness. Within Port Edward, many of the tasks that I engaged in as a participant observer and staff helper occurred within the structure of predictable routines, a hallmark of large institutions (Goffman, 1973; Johnson, 1998; Parks, 1985). Spending time within Janson and Brennan units allowed me to experience and consider the ways in which staff occupations can change when the occupational environment changes and, on the other hand, how habitual ways of thinking about and performing in daily occupations can remain within the context of major physical change. As part of my exploration into staff occupations, I also learned about the values and beliefs that individuals hold regarding their own and others’ occupations and how these beliefs impact on the overall environment of the acute inpatient unit. Given the 24-hour involvement that nursing staff have over the occupational environment, a detailed exploration into this group of staff is provided as a starting point. Explorations of other staff occupations are in the chapters that follow. The story starts at the parent unit, Port Edward.
Doing the rounds: Ward staff taking control of patient care

My introduction to the realities of nursing routines began in Port Edward. From the start of fieldwork, I threw myself into the morning ward staff “rounds,” which began each day at 7.30 following a half-hour nursing “handover.” Often making a point to arrive at 7.00 am, I would listen carefully to the brief “rundown” on each patient’s behaviour during the night, noting which nurse the patient was allocated to for the day by the amount of questions or notes taken by a particular nurse. Sometimes I would approach a particular nurse and ask if I could accompany him or her during “getting up” routines and, at other times, I would wander around the corridors and offer help where I thought it might be welcomed. On my first morning, I spent several hours with Pat, a registered psychiatric nurse. I carefully observed Pat’s manner and was struck by the ability she had to ‘be with’ patients at the same time as completing routine tasks. Pat’s experience and skill stood out in both the old and new unit and was exemplified by recognising a patient’s preferences and working with their capacity, rather than ignoring it. Pat’s approach was an important learning experience and her approach served as a valuable benchmark for considering the approach and skill of other staff.

We go into Elsa’s room first. Pat walks toward the bed and says hello, but as Elsa is still asleep Pat says, “I think we will leave her for a bit.” Next, we go into Olga’s room, just next door. “I’ve got a bit of pain in my legs,” says Olga. Pat says, “I will get you something for that.” I hover outside Olga’s room until she gets back. She has a small plastic cup with different coloured pills in it and another with water and, in the other hand, a jug of water. She carefully sits on the side of the bed and gently places tablets and then a drink from the cup in Olga’s mouth. She then says to me: “We will come back to Olga,” but Olga replies: “I’d like to get up now.” So Pat helps Olga up carefully peeling back the bedclothes, helping her to swing her legs over the side.

Olga was thought to have Parkinson’s Disease, and Pat explained that she was not completely clear as to why she was in the unit. Despite this, Pat devoted professional care and attention to Olga, and, until I got to know Pat and other nurses much better, I was not aware that this was a bone of contention for some staff. As the weeks went on and I got to learn about more about patients and their conditions,
I realised that there were in fact two distinct "types" of patient. First, there were those patients who had a definitive psychiatric diagnosis, such as depression, bipolar affective disorder, mania, or schizophrenia. In many ways these patients were portrayed as being "real" psychiatric patients. The second "type" of patient had what was variously called an "organic" or "degenerative" condition attributable to definite and sometimes permanent neurological changes, such as dementia or Parkinson's disease. It was clear that a number of nurses were not in favour of admitting patients with "organic" conditions, particularly when they had significant physical mobility problems that seemed to outweigh any behavioural problem that they may have. Nurses revealed their opinions about this in various ways. A raised eyebrow or rolling eyes would sometimes accompany an explanation of the patient's condition, or a frank statement such as: "He's an inappropriate admission as far as I'm concerned" or "We're getting far too many of these types." In the first few days of a patient's stay on a ward, nurses and other staff aimed to assess the "functional ability" of patients, their capacity to care for themselves, and their ability to engage in social and occupational activities. For some patients, significant direction, both verbal and physical, might be required in daily self care tasks. While many patients were acutely unwell, engaging in group and other everyday activities was understandably limited. Evidence of recovery for clients with a psychiatric diagnosis was seen in, and could be accelerated by the right balance of medication and engagement in the life of the ward. Evidence of "recovery" appeared somewhat more elusive for people with dementia, where significant cognitive impairment and the presence of challenging behaviours called for a "management" rather than "treatment" approach. The opinions and approach of staff to management and treatment for patients with varying abilities and diagnoses are discussed throughout this and the following chapter.

At Port Edward, each nurse was allocated 5 patients to work with during his or her eight-hour shift. As part of an adapted primary care model of nursing (Marquis & Huston, 2000) each nurse had total responsibility for the daily care needs of his or her patients. Nurses could also be "associate" nurses for a number of other patients, taking on their care when the patient's primary nurse was absent. Primary care nursing, an approach developed in response to problems surrounding a team nursing approach (Marquis & Huston, 2000) was based around the provision of 24-hour care
by registered nurses, who had responsibility for admitting the patient, establishing the care plan and coordinating with others in the health team. One of the registered psychiatric nurses at Port Edward unit described the responsibilities from her perspective.

When you are a RPN, you have got to do the medications ... You have got to do the bloods, you have got to look after clinically the things that are going on in the ward with all the patients really ... beyond your patients, and liaise with the medical staff ... [Patients have to be] looked after physically, their ADLs and things ... their basic cleanliness, fluid, food, toilet, so you have got to look after ... multiple physical things, plus assess and look after their mental state.

Three different types or “divisions” of nurses provide nursing care at Port Edward, Janson and Brennan. The divisions, recognised by the Victorian Nursing Council include, Division One, in which nurses (RNs) have been educated for at least 3 years in preparation for general practice in any environment, including psychiatry. These nurses were also referred to as “comp trained” or comprehensively trained nurses by a number of staff in this study. Data from literature (e.g., Happell, 1997) and participants within this study reveal that there is a view that despite their comprehensive training, RNs’ ability to practice effectively, or at least as effectively as an RPN within psychiatry, is debateable. Division Three or Registered Psychiatric Nurses (RPNs) have undertaken at least three years of formal preparation to specialise within the field of psychiatry and can only practice within psychiatry. Division Two nurses, “state enrolled nurses” (SENs), undergo one year of formal educational preparation. State Enrolled Nurses (SENs) must be supervised by RNs and RPNs, and there are a number of duties they cannot perform. Given that the numbering system used to describe the divisions is confusing and does not suggest any relative hierarchy, I will refer to the different types of nurses as either SENs, RNs or RPNs. When referring to nurses, or who is “on” for the shift, apart from using nurses names, it is these terms are also adopted.

In as much as the primary care model revolves around the allocation of patients to RNs or RPNs, the differentiated mix of nursing personnel at Port Edward necessitated the need for an adapted primary care model. In practice, this meant
that RNs and RPNs were required to carry out the tasks that SENs were not qualified to do, such as giving injections and other medication.

Included in the informal classification of "ward staff," along with RPNs, RNs and SENs, were the personal services assistants or PSAs. These multi-skilled general staff took prime responsibility for tasks that supported direct nursing care, such as monitoring food supplies, meal preparation, cleaning, and linen/bed changing. In Port Edward, the role of the PSA beyond kitchen and cleaning duties appeared to be minimal, despite a hope and expectation from one of the unit managers that they would become more involved in patient care:

They are supposed to be multi-skilled, so they are supposed to be able to do the kitchen and do the cleaning, but they also have client involvement. I have worked in places where we have had some of the PSAs as part of the case management... being a contact person. But that, I think, would be a bit too scary for people in this place... I don't think they are anywhere near ready for that one.

The field note records that detail the many times spent with Pat, a very experienced RPN, highlight an occupational tension with regards to the performance of nursing tasks and roles within the institution. While Pat seemed able to balance numerous client related tasks with a considerable degree of regard for each patient's needs, for example, leaving sleeping patients to rest, the pull of routine, institutional "events," such as meal times and medication dispensation, meant a constant rush against the clock. At Port Edward, patients who did not make it into the dining room between 8.30 and 9.00 am ran the risk of missing out on breakfast. Unless their primary nurse was prepared to make the patient's breakfast and sit with the patient after the personal services assistant (PSA) had cleared up, both nurse and patient would have to hurry to beat the institutional clock. At Port Edward, the incentive to meet institutional time lines rather than adapt practice to patient time lines was considerable. One aspect of this was most evident in Port Edward and Janson unit, where the task oriented nature of the PSAs had served to "set" all other occupational events. The incongruence between the sequential task oriented approach of PSAs in relation to meal times, combined with an adapted primary nursing model in units staffed by SENs who are unable to undertake "total" patient care, appears to have resulted in the retention of a "task" approach to nursing for all
but the most patient-focused RNs or RPNs. A number of Port Edward nursing and non-nursing staff, while understanding some of the structural reasons for the timing of various routines, had concerns as to the rigid nature of events such as morning rising and meal times. For these concerned staff, the prospect of changing the stronghold of those routines seemed remote.

I have talked to the PSAs about changing the meal times when we go to the new units and it is like "no." I talked to the nursing staff about, you know, well would there be a benefit to changing meal times and it is like "no it is fine the way it is." So there are some things that will stay very rigid for the time being . . . it is like . . . no visitors during meal times, we don't want the relatives in the dining room at all. Like, when I came here, they actually asked relatives to leave.

One informant from Port Edward reflected on the reasons for the routine rigidity and contrasted this to the more client-centred approach adopted in the smaller dementia management wing (DMP). The manner in which institutionally imposed routines can impact on clients' occupational choice and, consequently, their behaviour towards others, was also hinted at through the informant's reasoning:

I think it's the nursing ratio. I don't know why though . . . maybe it's the environment, who knows . . . when we had the dementia management program running, people could get up when they wanted. . . there would be a morning newspaper group at about 10 and . . . breakfast with them and maybe read a bit of the paper round the table and some of them were just getting up out of bed, you know. It catered to individual needs perfectly . . . There was one bloke who never got out of bed before 10 in the morning when he was with us and, umm, when his management plan went with him to a nursing home it was on it . . . this man is a behaviour problem . . . but he has got not one problem if you leave him till 10 o'clock in the morning and then he's fine for the rest of the day.

In both the above instance, and the one below, the ability of staff to be flexible with patients is related to the staff–patient ratio within a given environment. The DMP, unlike the open ward, was a small manageable environment where things seemed to happen around patients, rather than around staff:
In the DMP, it didn’t matter what time you got up because the nurse and O.T. would help the patient make some toast for themselves . . . the kitchen’s always there. Whereas [now] the kitchen’s open and shut . . . and the PSAs then have to be cleaning the ward . . . That has an impact because they’ve got a routine that they’ve gotta . . . It’s not possible to have a piece of toast at 11, you know . . . I could get it for the patient . . . but there’s no way that the PSAs would be able to get it.

Despite the change toward a primary nursing care model from a more task oriented team approach in which team members would focus on tasks rather than patients, it was clear from some nurses’ perspectives that this shift had not occurred effectively. Meaningful occupational routines took second place to staff notions of being properly cared for in a physical sense. The problem with task oriented routines and the imposition of cultural values that may be at odds with that of some patients is revealed through this nurse’s reflections:

I think we are too task orientated here. I think we are obsessed with the scrubbing and showering thing . . . I think we need to take more note of what people have been doing at home, and if older people have only been showering once a week at home then who are we to say they need to be scrubbed every day in hospital. We tend to drag them off to the showers and make them live the way that we expect them to live. That is very unfair.

Interestingly, when interview informants were asked to comment on those qualities that indicated advanced or exemplary nursing practice, how rigid the nurse was in relation to routine task performance appeared as a key quality. One staff member believed that exemplary nurses were not rigid, rather they were “willing to let people get up when they want to get up” because they were “able to organise themselves a bit more around the patient rather than organising the patients around them.” Caregivers need to adopt controlling approaches to care with patients whose behaviours may be described as unpredictable is discussed by numerous authors, including Hasselkus (1997), Lyman (1993), and Moody (1988). In Parks’ (1985) ethnography, which focused on the social relationships among staff and patients in a state mental institution in New Zealand, the stronghold of nursing rituals were interpreted as being crucial to the retention of power and authority within the institutional setting. In specific, Park noted that “getting up” was a ritual that
conveyed to the young men on the ward their "patient" role and their subordinate status within the hospital hierarchy.

A number of contemporary nursing scholars have viewed nursing practices from Focauldian perspectives (Gastaldo & Holmes, 1999; McCormick, 1997) and have observed that nursing power in hospitals has emerged from nurses ability to keep order and, in specific, maintain control of the patient and the environment. While not explicitly interpreted as a need for power, issues of staff control over the human and non-human environment and its relationship to the habitual task performance by staff arose in this study, particularly within Port Edward and Janson units. A number of staff explained that they felt that a move to the new units would decrease the strongly habitual and somewhat custodial approach to patient care because staff would have more control over the environment, which would be smaller both in terms of its physical dimensions and patient numbers. Coupled with design and technological features that would provide greater surveillance, patients could have access to dining and kitchen areas, which would otherwise be out of bounds or locked as they were within Port Edward. Because of Port Edward's size and layout, control had to be taken in an overt sense due to the lack of control that the physical environment posed.

Several informants hoped the new units would afford the type of control that was possible in the now closed DMP. One staff member said, "the fact that you had more control meant that you didn't need so much control . . . We're just on top of everything all the time, you knew what was going on." Foucauldian notions of "panopticism" (Foucault, 1979; Gastaldo & Holmes, 1999) shed some light on the above informant's perspective. More thorough and far-reaching surveillance of patients allows the overt "gaze" and/or oppressive presence of attendants to go unnoticed.

To varying degrees in each of the three units, there was a "chunking" of nursing time around the provision of food and drink. Similar to an airline passenger with little to do during a long flight, the anticipation of meal times for patients who were oriented to time and place became a source of comfortable familiarity, evidence that they had become habituated to the patterns of the institution. The evening supper trolley even seemed strangely reminiscent of the airline meals trolley, something to look forward to.
Supper was wheeled out on a trolley at about 8pm; there was warm milk, cocoa and sandwiches. Rose pushed the trolley and, while serving, asked each person: “Would you like a hot drink and a sandwich?” Those in the lounge, who were able, came up and got theirs and then Rose would move out to other areas of the ward pushing the trolley.

For nurses and patients alike, adherence to mealtimes created comfort and a sense of control, while changes could create discomfort. In attempting to address why humans repeat themselves so much through habituated patterns of doing, Young (1988) suggests “habit, by allowing predictable events or features of an event to be managed with hardly any effort, enables people to concentrate most of their attention on the unpredictable” (p. 83). From this perspective, the survival advantage of habit becomes evident when applied to the context of an aged persons’ mental health unit where coping with a changed and changing environment requires an adaptability that, without habit and structure, would be even more difficult to attain. Many of the patients within the three units had either temporary or permanent and declining cognitive functions, and habitual patterns, as Young suggests, may have been advantageous.

Some of what is stored in memory can be activated in the present in another way, not by being recalled but by being entrenched in a habit, and the habit (or habitual memory, one might call it, to mark the fact that habit is a harnessing of memory) is not ordinarily subjected to recall (Young, 1988, p. 86).

Routine is also recognised as being very helpful to nurses (Jones, 1975; McCourt Perring, 1993), enabling the ward to run smoothly, minimising “disturbed behaviour, provides automatic checks that necessary procedures have been carried out for all patients and... above all, routine makes it possible to satisfy ones superiors” (Jones, 1975, p. 121). Habit and routine therefore have potential to be helpful in the chaotic ward environment, but the question of when habit ceases to be helpful and becomes constraining requires consideration. The following field note excerpt from Port Edward highlights the controlling nature of spaces, place and time in the institution.
Pat asks me if I can take Olga up to the dining room so she can go and check on her other patients. “No worries,” I tell her. I feel myself hurrying Olga just a bit, because I know it is past 8.30. I want her to get a seat close to the door so I don’t have to walk her too far. The door is not open when we get there. I decide to open the door just to get Olga seated, but as there are at least 5 other patients outside queuing to come in, a few slip in as I manoeuvre Olga in. In my mind, I am aware that they should not be in here and I tell some of them this. One patient, Leslie, has already complained as to why the door is not opened. I say, “I don’t know where the nurses are but there needs to be nurses here before you can come in. I’m not a nurse.” Some of them slip in.

In the above excerpt, it appears that I have taken on board the “rules” of the nursing team. While recognising that my actions are constraining, my fear of upsetting or angering the other nurses and risking any sanctions of my freedom to work alongside the nurses outweighs my desire to let them all meander in. Fortunately, a nurse saves me.

Pat comes by and beckons the patients who are not hers back out – repeating just what I had said. It is getting towards 8.40 and still no other staff... Pat goes out to see where they are and then just turns around and opens the door, unable to wait for the others with such a large crowd gathering outside... at least she is here. One of the graduate nurse students comes with the drugs trolley a few minutes later. Now it’s breakfast time.

When nursing staff transgressed set task oriented routines complaints would arise in nursing meetings or a staff communication book. This field note taken from a nursing meeting recounts Rose’s concern about being left alone in the dining room.

It seems that two of the SEns are not happy. Firstly, Rose is concerned with the fact that there were not enough staff coming into the dining room on time and that those who did make it, were getting left with up to 10 patients by themselves and this was not fair. The unit manager agreed that all people needed to be on deck. Rose finished with: “It’s not good enough for people to come sauntering in 10 –15 minutes later.”
Patient safety was a reason frequently cited by nursing staff against allowing or prolonging access to dining areas where potentially dangerous items, such as knives, hotplates and hot water supplies existed. The need to have patients out of these areas when nurses and PSAs were engaged in other activities and, therefore, unable to “supervise” impacted on patients’ freedom to sit and linger over a post-breakfast cup of tea, or to engage in an extended conversation with fellow diners. Discourses surrounding safety and risk management in relation to the care of people with dementia are discussed by Hasselkus (1997), and of nursing practice generally, Hazelton (1999) observed, “traditionally more open forms of coercive behaviour are now replaced with more subtle manipulative control practices” (p. 226). Benign manipulations, such as bribing patients with cigarettes or “white lies” are discussed by Hasselkus (1997, p. 645) as being important staff techniques for “keeping client behaviours within acceptable limits” so that minor challenges don’t escalate into crisis situations. The use of such techniques are discussed by Moody (1992) as being acceptable in those situations where staff have at heart a genuine desire to maintain a persons sense of dignity, rather than cut corners or take the easy option.

At Port Edward and Janson, the rushed nature of familiar occupations, such as enjoying a meal or “having a cuppa,” reduced these occasions to obligatory, perfunctory activities that had to be “done” by staff and “had” by patients. Patients’ engagement in such potentially meaningful social occupations did not appear to be recognised as a source of valuable assessment data beyond a concern for changes in dietary intake. Participant observation experiences at both Port Edward and Janson reflect how nursing and personal service assistant approaches thwarted potentially positive occupational experiences for patients. At Port Edward, unsafe floor covering in the lockable kitchen/dining area and the subsequent need to move kitchen and dining operations to a new, more open space, challenged staff control over the environment. A senior staff member shared her hopes surrounding what she felt would be a similar situation in the new units.

I am hoping the dynamics will change in the dining room when we move, because it won’t be locked off all the time any more, that will be a thoroughfare and the tables will need to be set just before meal times. So that is actually going to, hopefully, impact a bit and make a bit of a change.
My fieldnotes reflect a qualitative change after the dining room is relocated to an open (unlockable) area of Port Edward.

Morning tea is called. I go in and sit with one of the patients and we chat. Gina pushes the trolley around and picks up the cups, the patients are free to remain in the space for as long as they like, it is an open area. It feels better, more relaxed and the atmosphere a touch more “jolly.” Also, patients don’t have to wait at the door to be let in, they come in, in their own good time and thus one barrier and one set of keys are discarded.

At Janson unit, a more patient-centred attitude and homelike atmosphere during mealtimes appeared to remain elusive despite the fact that the dining area was an open thoroughfare.

There are almost 10 people seated in the dining area, which surrounds the kitchen. The tables are set, and, in the kitchen, the tea and cereal trolleys are full and ready to go. Eliza, one of the patients, asks if she can get a cuppa. “I like to have a cuppa before my breakfast, but here it always comes later, after the toast.” I shake my head and say, “sounds like a good idea.” I go into the kitchen and ask the PSA (one of the SENs is also within earshot) before I help myself to the teapot, but she says: “They can wait!” . . and the SEN echos – “It’s not time yet.” I look at my watch and it is 8.28. I wonder if I am in a boarding school canteen? I offer again that I don’t mind serving the one patient who is asking. “If you serve one now they’ll all want some,” says the PSA. What a contrast to Brennan, I think. When the trolleys finally go out, 2 minutes later, I help with serving out the odd cuppa and bowl of cereal. Breakfast is rushed as usual, and there is no happy banter – people are just having things done to them or for them. The dining tables are all but empty by 9 am.

The above field-note entry portrays how embedded staff practices based on control can be. Rather than engage in negotiated interaction, staff rely instead on controlling patients through strictly observing normal time lines. Staff and patients alike remain institutionalised. Maintenance of a controlling approach to care, or a “tradition of toughness,” as discussed by Morrison (1998) and Johnson and Morrison (1993), has been linked to increased violence, prolonged hospitalisation and increased use of resources.
Of all the units, Brennan was, to a greater degree than Port Edward and Janson, able to over-ride the institutional mealtime regime.

I feel like a waiter in a swanky restaurant, part of a nice team in a decent café. The bank nurse, Imelda, and Gina deliver the meal trays to the waiting diners. Janet, one of the SENs, settles down with the new patient who has a “soft” meal. Frances, the associate charge nurse for the shift, weaves in and out, unobtrusively helping the odd patient here and there to take some dinnertime medication. I go off to find a few patients who I know aren’t here yet. I find Paola in the HD wing. She readily gets up and takes my hand. The only free seat for Paola happens to be with 2 other Italian patients – 2 men. One of them, Gabby, usually sits by himself and doeses and has little or no contact with other patients. Gina, who is also Italian, comes by swiftly with Paola’s meal. I watch them, all the Italians – staff and patients sitting and chatting at the one table. Patients are up and down, getting themselves top ups for their tea from the trolley, which is parked inside the servery. There seems to be no issue — no rush, nice and leisurely – homelike, no need to herd them back out like children. Marge, one of the patients who is waiting for discharge, helps clear up the dishes and puts trays back on the trolley. Meanwhile, back on the other side of the servery, the Italian quarter, Paola has begun singing in Italian – I go over to watch and listen. I see Marge’s head move in time, and all the patients and staff applaud when Paola finishes. Lovely, I think to myself, lovely. Marge comes up to me and shares: “She’s good isn’t she.”

Client behaviours such as those described above are discussed by Hasselkus who states that “clients being friendly... socialising with others, singing with gusto and talking a lot” are “indicators of wellbeing.” Indicators of wellbeing associated with social contacts, participation in activities and expressions of warmth, are also discussed by other authors including Kitwood & Bredin (1992) and Zgola (1990). The key to this triumph, a subtle but powerful indication of the achievement of a less restrictive and more home-like environment, lies in an apparent change in the practice and attitudes of both PSAs and nurses around what were strictly scheduled care giving occupations. For the PSAs at Brennan, a greater involvement with patients was also realised, thus the rigidity of task completion relaxed and, with it, the overall social environment seemed more relaxed. Janet, an SEN, commented on the notion of order, reinforcing the idea that greater control over the physical environment in Brennan allowed staff to exert less overt control.
We still kind of have set [meal] times here . . . but . . . [the patients] meander in as they please. I think that was necessary to have at Port Edward . . . those set times and then everyone knew, staff . . . as well as patients knew what time the meal was and to be there 'cos you have got to have some kind of order. At Port Edward, it was necessary and, um, yeah, here is . . . I suppose a bit flexible, yeah . . . flows . . . I suppose physically it is a lot better now.

*Feeding and dressing: Is that all there is?*

My priority as a fieldworker was to become habituated into the major routines of each environment, such as getting up and retiring, meal times, nursing handover and other meetings. This seemed the clearest and most visible way in which I could be of assistance to nurses and learn about their occupations. My next priority was to experience and understand the tasks and roles that nurses engaged in outside of these routines. What happened between breakfast and lunch? Where did the nurses go, what did they do? With the set routines completed, I reasoned that this otherwise free time might be taken up with the business of the unit, assessment and treatment of patients. What did this amount to in nursing terms? At Port Edward, I quickly discovered other set routines quite separate from the nursing specific ones. Consultant psychiatrists chaired clinical meetings that revolved around assessment, treatment and discharge planning between 9.30 and 11 am on Monday, Tuesday and Wednesdays. Each patient's primary or associate nurse would be present for the duration of the discussion of his or her patients. As part of his or her role, the associate charge nurse for the shift (ACN), a senior RPN, would record pertinent nursing action details that arose from the meeting for all of the patients, thus they would remain for the full duration of the meeting, as did one of the two occupational therapists, social workers and community team members. Nurses might also have escort duties, such as taking a patient to another health facility or department of the hospital. For RNs, RPNs and SENs qualified for such duties, the collection of "bloods" for testing might also occur outside of the set nursing routines.

Other routine "events" occurring daily included the "group program." These structured opportunities for occupational engagement were organised and run by the occupational therapists who worked on each unit. Immediately after breakfast, an orientation "type" group was run for all patients in the unit. Nurses did not attend
this group. After this was morning tea. Most of the nurses would again appear for this activity. Lunch and afternoon tea were also separated by another occupational therapy run group or outing. I attended many of these groups and outings during my time at the three units and it was clear that nurses did not attend these groups. With the exception of going on an outing, where the nurse might drive the bus or provide an extra pair of hands for the occupational therapist, it seemed that nurses had no input into the group program. I wondered what nurses did while most of the patients were attending the groups.

In order to learn about nursing occupations during these periods, I needed to be selective regarding my attendance at occupational therapy groups. Not every patient went to every group, and I had learned from my time spent helping Pat, and other nurses, that not every patient made it to breakfast on time. I figured nurses might be following up the patients who were still in bed or still having their breakfast. As part of learning about occupational therapy in Port Edward, most mornings I would help recruit patients for the orientation group, perhaps walking with one or two patients from the dining room straight into the adjacent lounge where the group would run straight after breakfast. Nurses would also take patients into the group, but they would never stay. As I had figured, some nurses stayed behind in the dining room with their patients. Through not going to the morning group, and staying behind in the kitchen, I discovered the “morning cuppa” ritual, an unofficially scheduled break where nurses would reward themselves for the effort of having got through the “getting up” and breakfast routine. I recall my inaugural “cuppa” with the morning nurses, the invitation being extended a week after my fieldwork began.

Most of the patients have gone, many to the group and some to sit in the courtyard. Carol asks if I want a cup of tea. Wow, I think to myself, I’m being perceived as one of the gang. Carol quietly calls out to one of the others: “What are ya having?” I get a large coffee bought to me at my table, where I was sitting with one of the morning latecomers. Carol and James sit at another table with two other patients who have finished, but want to stay. Pat has now returned from checking on her still sleeping patients and joins them at their table. Carol says over her shoulder to Joseph, the associate charge nurse for the shift, “we are helping Tracy with her research.” I interpret this as an excuse to sit and drink tea. I ask Carol, “so is this break 1 or 2?” “Neither, this is an illegal break, but we have your research as an excuse.”
There is a nice atmosphere, the nurses relax and the patients sitting with us don't seem like patients, they are part of our leisurely cuppa group. The patients, like me, are allowed to be with them, on a different, normal level. I feel accepted.

While the above fieldnote entry speaks more of my own increasing acceptance as a team member, it also demonstrates what Salisbury (1962) observed in his ethnography focusing on the social relationships in a state mental institution in America. Salisbury stated: “if any lesson is to be learned from my experiences in such a role, it is that patients enjoy the experience of having normal relationships, such as they might have outside of the hospital, in which there is no element of philanthropy, curing or authority” (Salisbury, 1962, p. 15). The unscheduled tea break provided an opportunity for normal relationships among nurses and between nurses and patients.

Being in each unit without a fixed schedule of commitments served to draw me into a multitude of “miscellaneous” patient related tasks. Of these, the three major tasks, which could take up almost an entire shift, revolved around: reorienting or accounting for temporarily “lost” patients, obtaining and lighting cigarettes for patients who smoked, and taking people to the toilet. Nurses also spent a significant amount of time engaged in such tasks. At Port Edward, the number of patients who could not find their way to their own room, a toilet or the dining room was significant. The confusing layout with long corridors and a multitude of identical doors proved stressful for nurses and patients with and without cognitive impairments such as dementia. Similarly, the impersonal nature of the bedrooms at Port Edward meant that patients might even spend significant amounts of time in a room, perhaps thought to be their own, only to be shouted out by the actual occupant, or, be feared lost, sparking a panicked search as happened one morning.

I overhear one of the nurses saying that Pat is out looking for Claudia. She has been missing and they are out searching. I see Pat. She says that she has looked everywhere and cannot find her. I decide I better help. She unlocks the old DMP wing. “I looked in here,” she says. But we look again. There are several rooms in the DMP foyer. One of the rooms has a sign on it “Sally’s room.” I didn’t even think there were any patients down here. It is locked, so I unlock it with the universal key. I call out as I try to open it. We hear a voice and Pat says, “I bet it’s her.” As I look in, I see Claudia in Sally’s bed. I feel great relief for Pat, who says:
"Okay, I just need to go back and raise the alarm that she is here... I can’t believe what time wasting that was... in this place you could look for ages and just get to one room and then the person goes into the room you just looked in." I offer to escort Claudia back to her own bed.

At both Janson and Brennan units, the visibility of patients in the smaller area all but eliminated the need to search for patients. Only patients with dementia wandered in search of their room or other places. In the new units, which both provided single rooms, patients could personalise their rooms with photos and other items. Whether this was officially encouraged or because the seemingly greater security of a single room and the newness of the environment enabled this is unknown. I recounted only one incident during fieldwork in the new units where a search was required.

It is just past 6.00 am and I take a wander around to check the activity levels of patients. I notice that Paola’s door is wide open and she is not in there. I go to the staff station and ask the ACN. “She’s in bed,” says the associate charge nurse. I shake my head. Then she click, “Oh, she’s in with Francesca,” she says with a smile. “She is actually in bed with her,” she says. We go and peek through the crack in the door. The two women are top and tail in the bed. “I think they know each other, and it’s the first time she has been in bed for a decent amount of time in the past few days. We need to move another bed in there.”

For safety and security reasons, most of the patients were not able to keep their own lighters or cigarettes, fires had been purposely and accidentally lit and cigarettes had a habit of being stolen. Smokers’ supplies were kept in the staff station and had patient’s names emblazoned on them. Therefore, all staff, but mostly nurses, responded to constant requests for cigarettes. This was interpreted as an infringement of basic rights by a number of patients and was a bothersome task for staff, who were required to locate the patient’s own brand, then go outside with the patient to light the cigarette for them. I made myself useful in this task and quickly learned that cigarettes also had other uses, as this vignette about a confused and agitated patient, Mary, demonstrates:
Mary has already lashed out at me, she seems convinced that others and I are one of the prostitutes that her long deceased husband had visited in the past. Belinda, comes up and says, “I’ll get you a cigarette Mary.” Mary is appeased. In the meantime, another nurse, Carol, on a smoke errand for another patient, comes back in through the same door and offers Mary a cigarette. Another 30 minutes passes and Mary is now in the dining room, she has thrown the tail end of a cup of tea at one of the nurse students, who has refused to get her a cigarette. We all ignore her demands. “Get me a cigarette please, will you get me a cigarette please.” I decide to get up, and say to her: “Would you like a cigarette?” “Yes, yes I would.” I ask her: “Can you walk with me up to the office then?” To this she says, “No, I won’t, you can stick it up yer bum!” Another patient calls out: “Can you get one for me?”

At Janson and Brennan units, the cigarette monitoring tasks continued, however because of design problems with respect to the enclosed outdoor areas, there were many instances where staff were required to not only light patients’ cigarettes, but also stay outside with them until they had finished. Both new units had outdoor areas bounded by fences that could be climbed by any fit or determined patient. Because of this, outdoor areas might remain locked during the entire stay of patients who were believed to be “absconding” risks. Staff were required to lock and unlock doors for any patient who wanted to go outside. For smokers, this was a further infringement and visible step backward in terms of promoting those qualities highlighted as part of mental health policyinitiatives, specifically, the provision of a least restrictive environment (Manderschied & Pirkis, 1997; Department of Health and Community Services, 1995). At a symbolic level, I had the perception of myself as a “jailer,” a privileged key holder. In essence, while certain gains had been made through the move to smaller units in relation to the control of patient movement throughout space, the need to control doors to areas that might reasonably be expected to be secure was somewhat contradictory.

The most demanding aspect of direct patient care involved assisting patients with personal hygiene. With patient showering and toileting initially completed as part of the getting up routine, toileting for those patients requiring assistance was a task that nurses took sole responsibility for throughout the day and night. Approximately an hour before finishing their shift at 7.30, night shift nurses changed the clothes and sheets of any wet or soiled patient. Each night shift was likely to have at least several patients needing to be changed during the night. In all respects, nightshift care reverted to task oriented nursing, the only workable
approach given the presence of only 3 nurses at Port Edward, and 2 nurses at Janson and Brennan. In Janson and Brennan, both nurses usually attended to the very early morning “change” task simultaneously. Some patients merely needed to have their urine and stool output monitored, while others required physical assistance or verbal prompting for what had become a cognitively complex self-care task. As another potential pair of hands on the unit, I also spent much time assisting people to go to the toilet and helping patients to clean up after not making it to the toilet. A number of memorable experiences highlighted my own and the nurses’ involvement in this most basic of personal hygiene areas.

As I enter the main Port Edward unit and head towards the sundeck, Pat grabs me and says, “Look out.” I was just about to stand in some faeces. Pat asks me if I can stand there and guard the “pile” so none of the patients stood in it. Several minutes later, Mary walks passed me. She has no shoes on, and, on the back of her heel, I noticed what looked like faeces. I grabbed her hand. When I found Pat I said, “I think Mary is the source,” and with this, Pat said “Oh, well done,” and then asked if could I stand with her in the shower cubicle and get her to take off her clothes. Once Mary’s clothes were all off, I grabbed the shower hose and started to hose her down. I am saved by the bell when Pat arrives back with another nurse. I gladly let them take over.

Other incidents illustrated that the patient’s experience of being cared for with regard to personal hygiene, while being a largely unspoken and taken for granted task for nurses, were likely to have powerful influences on patients’ perception of care. One nightshift at Janson I witnessed an exceptionally caring and interpersonally skilled interaction between an RN and a very distressed woman who had lost control of her bowels in bed several times throughout the course of the night.

Peter, the SEN, returns to the staff station from the patient he was attending and says to the RN, Cheryl: “Could a lady nurse please come and see Susan, she has soiled her pants and would rather have a lady nurse.” Cheryl, immediately and enthusiastically gets up, and I ask, “Will I come with you?” “Yes,” she says. I follow her and in the room is the woman bent over with her pants down, very distressed about the incident. The woman says through her tears, “I’m so sorry, I’m so ashamed, it’s very dirty.” Cheryl, tells her not to worry at all, that’s what we are here for. Cheryl manages to make it seem like an ordinary occurrence, but
not so ordinary that the woman feels like she is just there to have her bum wiped. Cheryl asks her if she has a laxative or a suppository, and when the woman confirms Cheryl’s thoughts, she explains what has happened. The woman is very visibly put at ease.

Toileting was clearly an area of significant importance for many clients. Sometimes when so much was happening on the units, patients could even be left in the toilet. This could occur when a rushed nurse would get the patient seated, but would then have to run off to respond to a nearby incident. On one occasion at Port Edward, I retrieved a patient who was very upset because, as she explained, “they just forgot me, plonked me down and forgot me.”

Nurses complained about the burden of having to care for 5 patients each, citing an increase in nurse to patient ratios from approximately 1:3 prior to the change of administration from Orana Villa to Portside Health Care Network, to the current ratio of 1:5 at Janson and Brennan. At Port Edward, the size and design of the facility, the nursing ratio, and what some nursing staff believe to be an increase in the number of patients with physical and cognitive impairments were frequently given as reasons as to why nurses had to rush around leaving other tasks undone. Nurses were unable to spend time with patients beyond direct care-giving tasks and, as will be discussed in due course, were unable to offer any input into the units’ group programs. Whether incidents such as forgetting a patient on a toilet were truly indicative of unreasonable work-loads, poor personal time management skills or simple forgetfulness or laziness, sometimes referred to as “slackness” varied, according to who I spoke to. In this vignette, a Unit Manager felt:

As a general rule, I would say they [nurses] do have time. A lot of things around time is how you manage your time . . . When you take a hand over in the morning, I wouldn’t be writing down every detail about what was being read out by the night staff. I would write down my points about what I am going to do about that. So my point wouldn’t be that he had painful urination, it would be I get a urine sample. He didn’t sleep last night, so 2 would be let him sleep in. I suppose, therefore, my morning would be planned at the end of hand-over, because I would already know what I am going to do. I maybe mish mash stuff around, and now is better than it used to be because we used to have team nursing and it was like, 2 of you would look after 10 patients, so it would be a registered nurse and an SEN so therefore two of you. You would have to coordinate with someone else . . . as well.
Being able to plan ahead and formulate problem oriented goals based on a reading of the previous nursing handover notes might be second nature to many RPNs, RNs and some experienced SENS. However, staff also complained about a steadily increasing number of casual, agency or “bank” nurses, usually SENS rather than RPNs or RNs, who did not always make it in time for nursing handover, sometimes did not know the unit and its routines and, as they were not permanent, may have had limited incentive to learn about the total care needs of patients. Such a situation was cited by some ward staff as contributing to an apparent “custodial” and non-interpersonal approach, seen most readily at Port Edward and Janson. Others highlighted the change from psychiatric nurse education toward comprehensive education as being contributory. A nurse from Janson unit felt that:

Since the advent of college based training for nurses there seems to be a general lack of knowledge of the peculiarities of psychiatric nursing. Nursing numbers have been cut to the point where nurses are fully occupied with essential basics and therefore not able to spend time with individuals to assess their mental state...[there are] too many casual/agency staff (that’s when we get people who actually want to work here). Too many short shifts, no cross over of staff for escorts therefore leaving the ward short staffed. Decreased continuity of care.

Alternatively, a nurse at Brennan stated that the new unit “enables staff to have, due to the lower numbers of patients, a better complete understanding of the patient. Better observation of patients is possible and potential problems are averted.”

Assuming that the types of patients do not differ dramatically between units, and the fact that nursing ratios are the same for Janson and Brennan, the likelihood that staff perceptions, attitudes and approaches among Brennan staff may have changed to the extent that one’s daily work situation is viewed more positively must, again, be entertained. A far greater level of interpersonal interaction seemed to predominate at Brennan unit.
Interpersonal approaches to engagement in occupations with patients

The concerns of nurses regarding the cessation of specialist psychiatric nursing have been highlighted in recent nursing literature (e.g., Happell, 1997) and by staff in this study, who believe they have witnessed a steady erosion of special qualities in the nurses who come into the unit. This informant talked specifically about a decreased interpersonal focus and an increase in a task oriented focus.

People don't get the time that they need. And I tell you what, there's a difference too between the psych trained nurses and the comp trained nurses ... the psych trained nurses used to make the effort, even if they were sitting watching the telly ... I remember thinking ... get up and do some bloody work but then after a while I thought ... No, it's good that they're there, because, one, they're keeping their eye on all the group and I know it's their patient next to them and every now and then they're making a comment on "Days of our Lives" and so there is this interaction going on and this rapport building going on between these two people.

A tendency toward decreasing interaction between nurses and patients is, in this informant's opinion, associated with the advent of the new comprehensively trained, or general nurse (RN):

I think comp trained nurses are very task oriented ... and if a task is not being done ... they don't seem to understand the importance of ... just day to day communication and ... just sitting with people, you know these people are severely ill at times and just sitting with them, knowing that there's someone around, it just has such an effect with people I think ... they get very little psych training nowadays and, um, I'm not saying they're bad nurses, they're good comp trained nurses ... but they don't have that psychiatric perspective, um ... You know, people with psychiatric illnesses need time to get to know someone and when you take the time to get to know them, they'll really start to talk more about what it is that's troubling them so ... Yeh, I think that's been a real loss to the nursing system, that loss of the psychiatric focus. ... like [RPN] she is a traditional psych nurse and just, the difference between her and some of the newer ones is ... [raises eyebrows]

Being with patients as opposed to "doing to" patients emerged as a major theme in most discussions revolving around quality nursing (see also Perrin, 1997 and Bray, 1999). Unfortunately, more negative perceptions regarding the quality and
nature of nursing in the period since the 1995 move from Orana Villa to Portside Health Care Network and the subsequent move from Port Edward to Janson appeared visible. A diminishing interpersonal approach within in-patient psychiatric settings is, rather than being unique, part of an emerging trend. In one study, which explored “patient focused nursing” in a psychiatric ward, patients were found to “spend their time alone on the ward while the nurses activities consist of the daily routines” (Lepola, 1997, p. 35). Another study conducted in partnership with patients and staff of another unit at Orana Villa Hospital, (Victorian Mental Illness Awareness Council, 1991) provides a view of how patients see their time as an inpatient and the importance they place on interaction and activity. The study also reveals staff viewpoints and concerns about decreasing levels of staff-patient interaction. One patient informant from that study shared that “staff were bogged down with admin work. I thought there would be therapy, a group or whatever. There was none. I don’t understand the point of being there, filling me with medication and leaving me to wander around” (p.14). Staff informant responses to patients’ concerns included that “staffing levels are low and patients are often moved around too. I would like to spend much more time with patients. But there are so many things to do. There are chores, tasks, messages, sending specimens to pathology, attending the E.C.T suite” (p.31). The nurse informants from this earlier study also talked about an increasing negativity on the part of managers regarding the interaction aspect of the nursing role, and that being seen to be doing tasks was perceived to be more highly valued. One said: “if the assistant head nurse were to see you sitting on the front verandah with a patient, and were to see someone else in the office, I think the person in the office would be seen as doing more productive work” (Victorian Mental Illness Awareness Council, 1991, p. 33).

A number of senior staff from Port Edward and Janson appreciated the importance of nurses spending time with patients. Despite recognising that nursing numbers had been cut in recent years, this former senior staff member, like others associated with the unit, did not feel that this should preclude spending time with patients beyond care giving tasks.

[Nurses] have always complained about staffing. When Port Edward had 8 staff, when I first started there, they complained about not having enough staff for 28 patients! Yes Port
Edward was very big, but part of moving them is changing their attitude about what they are supposed to do with clients... a trend that I have noticed in the adult mental health field [is that] you don't actually talk to patients anymore, you don't interact with them except to tell them no you can't do stuff, and if you look at psychology... the worst thing you can say... "no you can't do that", because... they will turn round and do it. It may be still a hangover from when [previous unit manager] was in charge because you actually really didn't talk to the clients, you ran around with your head cut off.

The question as to whether nursing staff were so overwhelmed that they had no time to interact with patients beyond basic care provision is difficult to answer with a simple yes or no. The answer is complex. It involves staff numbers, workloads, staff personalities and attitudes – their style, the impermanence of staff (the high use of agency nurses) and the ethos of each unit. Perhaps more importantly, the personality and style of particular people, those in power positions, seems to be very influential.

*Nursing work: Avoiding “it” in the office and getting “it” done “on the floor”*

Sometimes staff numbers were low relative to workload. However, within my role as “floating nurses’ assistant” (Salisbury, 1962) I think it is clear that at Port Edward and Janson the potential to interact with patients was impacted, as much, if not more, by the particular mix of staff and the attitudes of staff present in any one shift. During some shifts, some nurses would be running fast to complete their own tasks while responding to situational issues within the unit for all of the clients in general. For these nurses, it seemed that nothing was ever finished, that they were “covering up” or compensating for the “slackness” of other nurses, insufficient numbers “on the floor” and agency staff. The concern of some nurses for the “proper” care of patients may result in these nurses being unable to go the extra mile for their own patients. There also exists a danger that compensating for others results in an inadvertent “cover up” of real problems relating to staff practice and “cover” on the unit. These “hidden shortages” may lead to the “concerned” or “compensating” nurses leaving the job, exhausted and frustrated. It became very clear, who the “concerned compensators” were. They tended to be “on the floor”,

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rarely in the office and were highly critical of those who from their perspective, and my own and others’ observations, spent inappropriate amounts of time in the staff office, socialising with staff, when interacting with patients and their families might seem more in line with their occupational roles. This nurse stated:

I can’t bear nurses. I can’t bear the office mentality. It will be nice in Janson when we have an office that is opened to the ward. There are too many nurses too often in the office...there are a few actually sit up the back of that office and play the computer and do things when there are visitors wanting to talk to them in the foyer and that sort of stuff.

Following the move, it is interesting to note that the “concerned compensators” were almost exclusively to be found at Janson. Perhaps their very presence contributed to the tendency of Janson staff to remain in the office? Perhaps at Janson it was ‘okay’ because there was always a “concerned compensator” out “on the floor” who had it “under control?” This former staff member of Janson felt that nurses seemed to have even less time with patients in Janson than they did at Port Edward. The issue of whether nursing staff actively avoided being with patients or were genuinely pressured was raised.

[Nurses did not have] time to talk, to sit down and be with the patients a lot of the time. I know they spent some time in the kitchen, I don’t know what they were doing there but anyway. I guess because of less staff there were more things maybe for each person to focus on in terms of patient work as well...I just felt that people were trying to hide themselves still in this facility.

Interestingly, my fieldnotes detail the long “chunks” of time I spent interacting with patients in Janson unit:

I decide to see who is seated at the café tables – with a view to just starting some sort of board game...So far I have 3 patients sitting for the game. One has severe dementia, but she is focusing and appears to be responding to my brief greetings. I see Esma walk past and I ask her to join us. Also walking through the kitchen area is Imelda, one of the agency nurses – she says, yes Esma, this will be good for you, and you can meet the others. Imelda stays for about 2 minutes. She stands behind the lady with dementia and gently rests her hands on her shoulders and listens and encourages. I call Max over to join us. Wow, already after 5
minutes or so we have 5 patients at the table. Imelda attends to other duties but comes back again and hovers.

These excerpts describe at least one instance where nurses were not rushing around under pressure to complete other tasks, where there was time to interact, but where being in the office may have been preferable to being with patients. In this instance, there is only an agency SEN for support:

During the game, I notice out of the corner of my eyes, that the other 3 nurses stay mostly in the staff office, every so often they wander through on their way somewhere else. They seem to ignore what is happening and that almost one third of the patients are happily engaged in this game. I ponder how much better the game would go if at least one other nurse sat with us. I see the heads in the office bend down to write, I see phones being picked up and conversations between the 3 nurses and the resident doctor. After the game I go into the office. The nurses continue to do a bit of writing, take a few calls and have conversations of a social nature. I join in where I can. Imelda comes in once or twice, but stays only fleetingly to ask a question. It seems that she, as with other agency and bank staff, spend most of their interacting with patients or doing tasks on the “floor.”

In my reflections in the notes I wondered what nurses were doing during such periods. I wondered why they did not come and join the patients and me. In the excerpt above, the nurse who joined me was an agency nurse. The staff in the office were regular staff. My observations suggest that agency staff seemed more willing to be involved in any group event with patients, including, but not only, the ones I initiated. Perhaps these visitors, these “outsiders” to the units, these temporary members, had not picked up the ethos of “doing to” as opposed to “being with.” The following comes from another afternoon shift at Janson.

The evening meal is served, eaten and cleared in a record 35 minutes. A few stragglers linger, the nurses are long gone, many back into the staff station, and I figure that it is time to break out the pack of cards for a post dinner game, capitalise on whatever energy might be present. I attract 3 patients to my gathering and we begin to play simple concentration. We play happily for 5 minutes and I am aware that one of the nurses is sitting at the table behind, reading a magazine, but really interested in what we are up to. The only other nurse I see in the next 5 minutes comes from the staff station, approaches the woman locked into the chair
who is banging on the table by this stage, and says: "Beryl, do you know where you are?"
"No," says the patient. "You’re in hospital," says the nurse, and walks off to the station again.

The sorts of interactions described above, involved a superficial and cursory action that was unlikely to result in the sustained settling of a patient who was obviously distressed. In this particular instance, this patient, and others who later became distressed as a result of Beryl’s behaviour may have benefited from the considered attention from at least one of three nurses who had the capacity to intervene.

Unfortunately, Beryl is increasing the frequency of her outbursts and this makes the game difficult. The nurse pretending to read the magazine ignores her, and I wonder why nothing is done. One of my players states she can’t stand the noise anymore and leaves. The nurse, more engrossed in our game than the magazine, notices this, but still doesn’t help by interacting with Beryl or encouraging the player to stay.

Opportunities to alter the environment for the benefit of other patients by attending to one particular patient are examples of ways in which ward staff can utilise activity, person and environment to impact on the experience of occupations. This issue is also discussed in chapters 7 and 8 in relation to occupational therapy groups. Adaptation of the environment, both social and physical, appeared to be an underused strategy. The impact of this was that one or two patients requiring special approaches were usually left to cope within groups or situations that they were not suited to and this impacted on other patients.

Distinct units with distinct personalities?

After the move from Port Edward to Janson, hopes about nurses spending more time out on the floor with patients were not realised. From the perspective of one agency nurse, the feeling was that at Janson “staff seem to spend too much time in the station.” At Brennan, no one particular nurse stood out as a “concerned compensator” and no one nurse’s skill and experience set them far apart from his or her colleagues. At Brennan there appeared to be a leisurely pace. The staff station
was occupied for short periods, more often than not by the OTs, social workers or medical staff. In fact, when staff had completed their tasks, they would often join in with whatever else was happening on the floor. In Crepeau's (1994) study of a geropsychiatric unit, where particular workers are to be found, and how space is used is also noted. Crepeau (1994, citing Rhodes, 1990) raises the issue of power and the use of space, where, for example, the "elites" or professionals are in the office, and the nursing aides or "workers" are out with the patients. In my study however, I have picked up on a slightly different theme, that of "avoiding" or "escaping" interaction with patients. This was most visible at Janson unit, and frequently commented on by informants who had spent time in both Janson and Brennan. At Janson, it appeared to be the permanent nursing staff who dominated the office, while at Brennan, there appeared to be no dominant pattern of office occupation.

A number of agency staff worked shifts at both Janson and Brennan. These nurses, like me, were able to reflect on the qualities of both units. As already highlighted, many of the more negative observations of staff practice and levels of patient interaction were virtually non-existent at Brennan unit. In this fieldnote, the involvement of one of the PSAs in starting and helping out in a group was noteworthy.

Polly, the occupational therapist, is trying to rally interest in a walk in the park. There are no takers at all. So she says: "Okay I will get another activity organised." I get Jean and Frank to sit and wait. While we wait, I bait Gina to start the group, she starts getting them to do exercises, and before we know it there are 8 of us lifting legs and arms . . . a great atmosphere. The nurses all watch from the servery area. Polly returns with jumbo sized bingo cards. I sit with Jean, Gina stays with Jim, and Polly manages to keep Ralf on track. One of the nurses keeps an eye on proceedings and directs another patient into the group. The combined effort of the 3 of us means that 3 people with severe dementia manage to enjoy the game, along with 6 other patients.

During my discussions with staff who spent time on both Janson and Brennan units, many opinions were put forward regarding the ways in which the units differed. Data drawn from these opinions and my own fieldnotes have been represented in Table 1 at the end of this chapter. A nurse from Brennan believed
that it was the nature of the people who had moved from Port Edward to Brennan that had contributed to the special feel of Brennan.

Someone said to me that they feel that this place has a lot of hidden energies, and I said: "Yes, I agree with that." I reckon it is because of the staffing, personalities, I think. Like, most of us here are more the calmer gentler type of person, more placid and pacifists I would say, whereas most of them that have gone [to Janson] are more outspoken and more louder people . . . like the quieter ones have come here and the louder ones gone there sort of thing. I think that is just how it has happened I don't think it was an intentional thing, it has just happened that way.

Alternatively, Janson was felt to be cold and "institutional."

[It was] very controlling. I didn't really feel it was very warm or friendly, I felt it had kind of a cold feeling to the place . . . It still was very institutional in its appearance and also the way the staff were in that facility, too . . . the way that they treated the patients.

Another staff member who had spent time in both units agreed that personalities were an important ingredient in how the unit operated.

I don't know what it is. Okay the louder people have come here [Janson], the quieter ones have gone there, but the quieter ones are achieving things, maybe they are not making it known to everyone that they are achieving anything either . . . You have to study the personalities, because it is the people that keeps the ward settled or not, I have noticed that over time, if the staff are calm and settled, the ward is calm and settled. I mean if you . . . went and spoke to somebody and you were angry, I mean what response would you get? It does impact . . . You can tell, people can tell. It is like animals can tell, and babies can. I am sure the elderly can, if you go all gung-ho.

The likelihood that "individual factors" are as important as "organisational climate" in terms of how controlling a ward might be is also discussed by Morrison (1998) in her study that looked at the "culture of caregiving" on a psychiatric ward. Morrison noted that staff who are more restrictive with patients, place strong emphasis on system maintenance in the organisation. According to Morrison (1998)
these staff also have strong beliefs in socially restricting the mentally ill and as a result, perceive and may well invite violence and aggression.

A lack of “spirit” among team members appeared noticeable, even by agency nurses.

[At Janson] there is “no cohesion, no communication, I think the computers are to blame, you know I’ve arrived and been in that station for up to 20 minutes and nobody has said hello or put their heads up. There really is no team spirit – not like there is here – its really noticeable.

At Port Edward, Janson and Brennan, values and expectations around the value of verbally based interaction and “being with” patients versus being seen to be “doing to” patients appear to have changed with each new unit manager and, just as powerfully, with changes in the profile and mix of staff, most notably, the associate charge nurse. In reality, how much time a staff member might devote to being with and talking to a patient depended on who else was rostered on for a particular shift, whether it was day, evening or night shift and whether it was a week day or the weekend. Quite literally, how “uptight,” “restrictive” or “relaxed” the ward was perceived to be had the potential to change on a shift by shift basis. The expectations of a particular associate charge nurse could effectively set the tone for each shift and these expectations had the potential to outweigh the influence of a unit manager, depending on the respect that a particular unit manager was accorded. On closer examination of my fieldnotes however, there was less variability at Brennan, where in general, the unit was more or less settled regardless of who was rostered on.

The staff of Janson and Brennan worked together at Port Edward. When people decided which unit they would move to they cited a range of reasons, most of which dealt with the location of the unit. Thus, seeming by chance, the splitting of staff into two groups appears to have resulted in what seems to be two very different team “personalities.” It is clear that a number of staff believe, like I do, that this fundamental difference is an important factor in determining both how homely and, alternatively, how restrictive each unit may be.
The impact that the approaches, attitudes and personalities of key front line staff can have on an environment and the subsequent occupational experiences that are afforded to patients are clearly powerful. In a unit where staff are motivated to spend time on the floor, to interact with patients beyond basic care routines and to shift towards a more interdisciplinary model of care, the first steps towards realising policy goals are made. An example of this is the change in Gina’s level of involvement with patients and other staff. At Port Edward, Gina’s membership and allegiance to the PSA subgroup prevents performance beyond the confines of a narrowly defined PSA role. At Brennan however, the role visibly broadens.

A “law unto themselves”: The occupations of personal services assistants

At Port Edward unit, the personal services assistants existed as a subgroup that, like the nurses, exerted a considerable influence over the occupational environment. At Port Edward and Janson units, the manner in which the PSAs carried out their daily tasks strengthened, in combination with nursing routines, the impact of institutional constraints on the occupational engagement of patients and other staff. Many of the personal assistants appeared to enjoy strong social connections with their fellow PSA colleagues, and supported each other towards the completion of their daily tasks. There was apparent solidarity in the social and occupational realm and an almost purposive divide between them and all other groups within the hospital, including patients, was commented on by many staff. Through my time spent with the PSAs at Port Edward and Janson, the perception of some of the PSAs that nurses treat them “like shit” seemed fairly plausible. Alternatively, the perceptions of nurses that the PSAs did not push themselves too hard and spent too much time having breaks seemed, at times, equally plausible. From my perspective, PSAs did not take any more breaks than nurses, but their break-taking rituals were more visible. Personal services assistants took their breaks separate from others, but together as a group, at regular set times. At Port Edward, nurses took cigarette breaks as a group and out in the courtyard with patients. The morning, post “getting up” cuppa, was also taken by nurses with patients. As such,
nurses’ breaks were in some way legitimated as work. For the PSAs, however, break times with other PSAs were seen as evidence of slacking off. The possible perceptions of other staff regarding them appeared well incorporated into the PSAs view of themselves as “blameworthy” as this Port Edward fieldnote excerpt regarding a missing patient, Claudia, demonstrates.

I share the news that Claudia is missing with Gina. Gina gets worried and says: “Oh, I bet we’ll get the blame.” When I ask why, she says: “because of the door here.” She points to the outside courtyard that is accessed through the dining room. “Because we sit out there for our breaks.” I glance over to the door, which is open despite there being no PSAs out there. I guess they could slip out there and over the fence, if they were good climbers I think.

Hassellkus (1992, p. 203) discussed the most “dreaded happening of all” of “booking”, when a patient leaves the premises unaccompanied. One of her informants describes “It’s a horrifying feeling. You don’t know where they are and they don’t know where they are.”

For many of the PSAs, their work within the unit was perhaps one of several part-time jobs, a means to other ends, and certainly not a life career. To me, as an outsider, the pecking order appeared very clear. Within Port Edward and Janson, the PSAs occupied the bottom rung of the hierarchical ladder and the attitudes and actions of both PSAs and nurses perpetuated this. The PSAs were not going to push themselves for nurses who treated them “like shit.” The following Port Edward fieldwork entry recounts almost a full day spent primarily with one PSA, Gina.

At 8:00 am I head to the dining room. The door is still locked as usual and all the main lights are off except the servery light. I can see Gina’s outline through the curtains . . . she has the servery hatch all set up with breakfast things in a self-serve style. We set the tables, with me carefully copying the set pattern. Gina has this down to a fine art, and I am probably holding her up. We go back to the servery. Gina puts a large jug of milk into the microwave along with a bowl of oats covered in milk and water for porridge. As this is cooking, she fills a large metal container with hot water and places it on the top of an empty trolley. I have seen this before when I have been in the kitchen with patients . . . used as a receptacle for the used cutlery. Patients and nurses can also stack their plates on the trolley, just like a cafeteria.
In as much as the kitchen is like a cafeteria in some respects, it has some elements of normality. What seems to interfere with this is the fact that patients have only a very short time in the kitchen, they all arrive at once, and they all seem to disappear within 30 minutes. In addition, as the medication trolley is prominently set up just inside the dining room, it serves as a reminder that this is an important treatment event, rather than an opportunity for normal social interaction among patients. However, as the following excerpt reveals, while the morning breakfast routine may be seen as a treatment event and a notable staff “work time,” it also plays an important role in terms of staff socialisation.

I can see a nurse at the door and patients around her. Some patients head straight for a seat, presumably to await their breakfast to be bought to them, many come straight to the servery and form a sort of queue, some know what they want and ask for it. By now, nurses are coming up to the servery, asking for “cornflakes please” etc. Some don’t say please, and I find myself getting angry at their demanding manner. I sense that Gina does not appreciate their manner either. Two of the doctors come up to see if they can get a bit of toast. I hand them some and they hang around the servery, just chatting amongst themselves and periodically to nurses. Carol asks me if I’m making tea. This means, am I making tea for the nurses to have their usual cuppa. I tell her yes, I will. But it now dawns on me that this is something I have never seen Gina do. Hmm, a new face, being used! During the nurses’ cuppa, Pat returns from her rounds and requests a cordial and a tea for Hazel, and the same for John, as they are both still in bed. “And toast and cereal as well,” she adds. I can’t help but feel a bit put out. I had already turned the toaster off, but I get on with it and smile “of course.” Eventually everyone clears out, phew, the doors are closed.

The kitchen/dining area is also an important space for the PSAs, both as a legitimate work space and as a social space where they can catch up for their breaks away from the eyes of the rest of the unit. In this space, nurses had to tread carefully with PSAs in order to complete their work in time to take a break, however, little would get in the way of the PSA “smoko”.

Eddy and Matt, the two other PSAs, come in. They help stack and clear up as well. They ask if there is anything anyone wants from the shop. “We’re off to get breaky,” they announce. When we finish the stacking, Gina says she is having a smoke. We leave the dining room out into an area of the courtyard normally closed to patients. The “boys” return and they come and join us. They have huge burgers, smoke several cigarettes and down cuppas. I ask them
what time they start. Eddy says, “7.30, we have to do the cleaning, all the toilets, bathrooms and bedrooms and make the beds, yeh, and the rest is done later, the big areas.” Later on I excuse myself from kitchen duty after morning tea is cleared up and attend a meeting that goes until just after lunch. When I return, I go and join all 3 PSAs who are out having a break. They are joking around and there is plenty of laughter and cohesion amongst the group. I reflect on how much I enjoy working and socialising with them, the work really seems very secondary.

Apart from the very public and social task of serving breakfast, one striking aspect regarding the occupations of PSAs at Port Edward was that the tasks engaged in by PSAs demanded relatively little social interaction with patients or other staff. The PSAs seemed to exist on the sidelines; they were the people that other staff and patients walked past and did not really need to talk to. The nature of their work involved preparing for patients and nurses — or cleaning up after patients and nurses. A PSA who was seen to be quietly cleaning was not noticed, however a group of PSAs together having a break from their backdrop position in the unit were noticed. Thus, due to their reluctance or inability to integrate themselves socially and occupationally with patients or other staff, PSAs were destined to stand out as a subgroup that socialised at the expense of their work. A number of more senior nursing staff were critical of the contribution that the PSAs made to the running of Port Edward, and it seems that the constant scrutiny of supervisors and general nursing staff provided no motivation to the PSAs to work collaboratively. Being included in problem identification and solving and, therefore, having the perception of some choice over their daily occupations may have been the key to changing the attitudes and actions of PSAs. The potential to improve performance given due recognition, however, was commented on.

PSAs are pretty much a law unto themselves. When I came here, the nursing staff would go around and check up on their work, there was a checklist in place where you had to go around every day and check up on their work and then just hand it to them and say you haven’t done a good job, so they were very loathe to do anything or try anything. They are not included in anything, they are not included in staff meetings, if there is a function on, nobody actually sends a notice down to the kitchen, people forget to tell them things, sometimes I do too because of the size of the place. We have now got a quality plan in place for staff across the network, and, interestingly enough, the PSAs are the ones who have actually done it best, they have taken it on board and run with it.
At Brennan, a change in the social relationships among the PSAs themselves and between PSAs and nurses contributed to a powerful change in the occupational environment, which meant that patients and staff alike could engage in the unit in a more meaningful, pleasurable and productive manner. With the move to the smaller units, the PSA staff at Brennan continued to "run with" many positive changes. These changes included an increasing social and occupational integration with staff and patients, and a relaxation of strongly ritualised routines.

At Janson, staff appeared less enthusiastic about their work and social integration with staff and patients was almost non-existent. Possible explanations for such differences may relate to differences in the occupational demands of PSAs in Janson and Brennan and, secondly, to a difference in the social/occupational structure of PSA staffing between the units. With regards to occupational demands, the nature of the kitchen work at Brennan changed significantly, with less serving and dishwashing required, compared to Janson. Sylvia, a PSA from Janson, felt that the Brennan PSAs "got it easy, because their meals come all plated and so they don't need to wash any dishes at all." While this observation is more or less accurate, it was also the justification for increased PSA coverage at Janson, where two PSAs were rostered on to cover the increased workload. At Brennan, only one PSA covered each shift, thus, at Brennan, there was no other PSA peer to share work tasks or social time. In terms of the social occupational structure, it is likely that having another PSA colleague present on a shift at Janson decreased the incentive to integrate with other staff and patients, both at a social level and in terms of the completion of occupational tasks. At Brennan unit, nursing staff appeared to willingly assist the PSA during meal times and, on a number of occasions, one or more able patients took on the dishwashing task themselves. Again, the change in social interaction and the positive flow on into occupational relationships, an interdependent and interdisciplinary approach to task completion, is evident.

While discussing the apparent differences between the PSA staff at Janson and Brennan, a senior member of staff raised the notion of task rigidity yet again. This person highlighted how a change to strictly observed occupational routines could empower the Janson PSAs and allow them to orchestrate their work in a more
meaningful way and, perhaps, in the process, enhance the occupational potential of some of the patients.

The PSAs have 2 people there to do it. There is only one at Brennan, and she cleans and does everything. It doesn’t, with my financial hat on, make any sense to me, there is two people out there on 8 hours shifts to do cleaning and food, and they are not locked into doing things at certain times, yet I find that [like] the nursing staff, the PSAs will lock themselves into these tasks [that] have to be done at these times . . . We have got 3 kitchens out there, 3 domestic kitchens where you could actually . . . The functionally disordered client could get their own breakfast. How do you empower staff for them to make decisions for themselves?

Changes to social relationships among and beyond the PSAs while being most visible in terms of impact at Brennan were, according to Megan, being felt even at Janson, but in a less positive sense:

I start helping Megan bring in cups and bowls. She asks me how I find Brennan. “Nice,” I say. “I don’t like it here,” she says. “Why,” I ask? “It’s too far from home, I’ve gotta drive further.” “And what if it was just around the corner,” I ask. “Well I’d like it better,” she says. “But now we have no place to get away from the patients, we haven’t got a cubby hole, nowhere we can be together . . . before it was better . . . there were 4 of us and we had a laugh, now we don’t have that.” Megan asks me if I smoke. I say no, and she says, “oh so you won’t want to come out for a smoke then.” I say no but I offer to come out for another cuppa. We go out. Initially we go through the regular door where the patients and nurses smoke. We sit down. I don’t think she is feeling so comfortable and then she tells me there is a better spot. We get up and go around the side to the more private spot, which is where the PSAs usually sit. “They can’t see you from here.”

In the above fieldnote entry, the importance of being able to escape from patients and nurses is evident and is indicative of a need to maintain the sort of social separateness that characterised the PSAs while still at Port Edward. At Janson unit, the PSAs remained in the background, a law unto themselves, lacking an interdependent approach to their occupational tasks and relationships with nurses and patients.

The observations with regards to the influence that PSAs can have over the occupational environment highlights the degree of control and power that this group
have within the inpatient unit. In terms of status, personal services assistants at Port Edward and Janson units could be perceived as occupying the lowest position on the social prestige scale (Whyte, 1969), below that of nurses and only marginally higher than patients. The attitudes and practices of PSAs, however, have the potential to powerfully alter the occupations of other groups of people within the units, most notably patients and nurses. While a number of more senior nurses may have legitimate power, which is vested in the supervisory functions that they carry out in relation to PSA work, PSAs have actual and effective power. This power, while being significant is not generally overt, but deeply ingrained within daily routines to which both nurses and PSAs have become habituated. Consequently, it may be less visible as a tangible occupational constraint. Despite this lack of “visibility,” I did observe interactions between nurses and PSAs that were “heated.” Many of these interactions related to directives given to PSAs by nurses. On one such occasion a veritable “screaming match” occurred between one PSA and the Charge Nurse for the shift. Every nurse talked about the “showdown” for the next hour or so, with comments such as “they needed to be put in their place” and “they set things up for themselves to make it easy for them and then get angry when we challenge them.” My own perceptions of this particular PSA was that “I wouldn’t want to cross that person,” and given the extent to which other nurses carefully approached this PSA, I was not alone.

In Hart’s (1991) study of hospital domestics she is told by one of her informants that staff could be “a bit militant” if not handled properly. The analysis that such assertive behaviour was “something of a defence mechanism in a situation in which the women felt themselves to be looked down on and at the bottom of the hospital hierarchy” (Hart, 1991, p. 103) is a fitting interpretation. A number of the overt “powerplays” were observed between nursing staff and PSAs at both Port Edward and Janson. It was very clear that one or two PSAs were not going to allow nurses to dominate them, however, incidents such as the one described above were not common, and any “militancy” on the part of PSAs was far subtler.

The observation that organisational sub-groups occupying the lower social strata within a workplace manage to exert significant influence is a phenomenon also uncovered by Van Maanen (1991). In his ethnography of ride operators at Disneyland, Van Maanen noted how workers developed “inventive ways to increase
the number of time outs during the day” (p. 63), and were drawn into “cohesive units who must look out for one another while they work and shirk” (p. 64). The interpretation that PSAs at Port Edward and Janson control their environment through management of basic routines appears little different to Van Maanen’s observation that ride operators utilised passive resistance and covert controlling techniques during their management of ride “queues.” For ride operators, such control enabled workers to “preserve a sense of individuality” (p. 75) and control over occupations that possessed little freedom from direct supervision, and responded to others desires rather than organised and directed it.

Summary: Creating an interdependent culture

In this chapter, I have described the work of ward staff. I have also revealed some of the challenges that I have experienced in my role as a participant observer of ward staff occupations and observer of patient occupations. In particular, I have attempted to explore and uncover issues associated with nursing and PSA work that impact on patients’ ability to remain engaged and connected to usual daily occupations, to exercise some choice (Langer & Rodin, 1976) and, while difficult to gauge, to find meaning and pleasure within their day. Some of these issues include: staffing ratios and skill mix, routine practice versus flexibility in practice and “doing to” versus “being with” patients. I have also suggested that the social relationships and cooperation among staff belonging to these groups have an important influence on how restrictive and homelike a unit will appear. The influential issues that have been raised in this chapter are numerous, and the relationship between these issues and how each unit is perceived is complex. As a brief summary, and by way of contrasting the Janson and Brennan environments, I have outlined the possible influential issues in Table 1.

Just as numerous studies and critiques of organisations undergoing change have found (e.g., Feldman, 1991; Schwartzman, 1983), leadership and management efforts to build a team at Janson that is characterised by interdependability rather than sub-group rigidity, must focus on ascertaining and understanding the
perspectives of all members of the inpatient team and, in particular, the more marginalised PSA group. This may necessitate a more serious consideration of how to draw members of various subgroups into shared occupational tasks, including those surrounding planning and decision making with their team members, patient interaction and social interaction. Finally, according to one staff member from Janson, what Janson needed was:

...a unit manager who would encourage changes and help to create a culture that would be more interactive with the patients, 'cos there always seems to be a disparity between the staff and patients...

Whether officially sanctioned or not, an interdisciplinary approach to daily work occupations and an increased social integration between subgroups is characteristic of the Brennan team, a team both members and outsiders perceive has "hidden energy."

In the next Chapter, I add a new layer to the description and analysis of the aged persons' mental health units by exploring the occupations of occupational therapists, social workers and doctors, and their relationships with ward staff and unit managers.
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<th>Brennan</th>
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<td>Unit has seen 2 unit managers. Third UM is 'acting'</td>
<td>Permanent, and with unit prior to move</td>
</tr>
<tr>
<td>Occupation</td>
<td>No OT present; No activity groups. Clients under-occupied, sleepy and wandering</td>
<td>OT and activity group options. Clients engaged</td>
</tr>
<tr>
<td>PSAs</td>
<td>2 PSAs. Remain in own subculture.</td>
<td>1 PSA. Interacting with patients and nurses</td>
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<tr>
<td>Nursing Personalities</td>
<td>&quot;Gung-ho&quot;; noisy, aggressive</td>
<td>Quiet, &quot;pacifists&quot;</td>
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<tr>
<td>Concerned Compensators</td>
<td>High levels of compensation. Rushed</td>
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<td>Time in Office</td>
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<td>Ward climate</td>
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<td>Nurse skill / experience</td>
<td>High skill, exemplary nurses, ++experience</td>
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CHAPTER 7

THE “NINE TO FIVERS”

In the previous chapter, the focus was primarily on the nursing staff and PSAs. In that chapter, we saw that the occupations of these staff, their relationships with each other, and their attitudes toward patients and other staff have a significant influence on the unit environment. In this chapter, we turn to the other health professionals who make up the staff of these units. This includes the allied health professionals, namely occupational therapists and social workers, and those who have legitimate and ultimate clinical leadership within the units – the medical staff. The issues for these staff include their expectations of support and leadership, and their ability to work collaboratively with ward staff in order to achieve the goals associated with their respective disciplinary field. The point to be made in this chapter, is that collaborative working partnerships with other staff and supportive leadership to enable this is crucial if patients are to be occupationally engaged in the unit environment.

Occupational therapists: Supporting meaningful engagement or merely having fun?

Apart from ward staff, or nurses and PSAs, the next most visible staff member present on the ward was the occupational therapist. From my own perspective as a fieldworker with an occupational therapy background, the occupational therapists at Port Edward, Janson, and Brennan appeared to have adopted key responsibility for planning and running each unit’s “group program.” Other responsibilities included the assessment of patients’ ability to engage safely in the basic self-care tasks required for various levels of community life, such as meal preparation, personal hygiene maintenance, and treatment that revolved around enhancing these patients’ skills. From the perspectives of past and current occupational therapists, their occupational responsibilities included assessing patients’ abilities to “manage in their daily lives” and provide “the opportunity to address those issues” through
treatment. The occupational therapists I spoke to had varying interpretations of their role, some focusing on how patients use their time while others talked about the need to ensure, through assessment during groups or individual contacts with patients, how safe and ready they were for discharge from a “functional” perspective. One therapist suggested this might involve getting “some sort of community service involved or some involvement in a community activity or leisure program” and that they were “responsible for assessing the function, and safety, and ability, and potential of the person.” Assessment was described as happening “in all sorts of different ways . . . through . . . home visits, groups and individual treatment . . . talking to family, talking to the case managers . . . but the idea is to get a overall picture of the person.” One occupational therapist described the role in terms of its similarities and differences to the role of the psychiatrist, where the occupational therapist “tries to provide . . . an accurate assessment of a person’s function and advice on whether its safe to discharge them home, the psychiatrist decides from a mental state perspective.” Although at no time did the occupational therapists in this study define what they meant by “function,” their use of the term was interpreted to relate primarily to patients’ ability to safely engage in self-care tasks and leisure occupations. When questioned about some of the purposes of groups beyond assessment of function and social interaction with others, the benefits of “diversion” for some patients were mentioned.

It gives them space and time out from their . . . anxieties about where they are and um...now with Jim I used to get him down on the computer . . . his son works in an office in the city and he knows about computers just from his son . . . and we did some pictures for his room on powerpoint, [to put] outside his room . . . and he could have been yelling before hand . . . You know, “I want to go home, I wanna go home” but for that half hour that we’re there he’s not screaming and he leaves and I, I did watch him once, I only watched him for about 15 minutes and he seemed relatively settled and 15 minutes later he was back to where he was but at least it gave him 45 minutes that I know of and maybe up to an hour of being a bit calmer . . . and you know not so distressed . . . He felt really good afterwards.

This informant’s observations are similar to those made by Salisbury (1962) who stated that patients who played games of baseball or engaged in other activities with the occupational therapist “show an excited cheerfulness when they come back
to the ward after therapy, and that this cheerfulness contrasts sharply with the flat
behaviour of the other patients” (p 59). Responsibility for the design and running
of activity programs in psychiatric in-patient units is frequently associated with
occupational therapy. In relation to psychosocial approaches to dementia, Opie,
Rosewarne and O’Connor (1999, p. 793) state that such programs offer “diversion,
stimulation and physical effort” in the hope that the anxiety and agitation underlying
much disturbed behaviour will be reduced. A systematic review of research
findings conducted by Opie et al. (1999) into the efficacy of activity programs found
evidence to support the value of such programs in terms of behavioural outcomes.
Rather than outcomes, my informants offer rich descriptions of both activity
(occupation) and the benefits that patients such as Hazel (see below) are thought to
experience on a personal level. These benefits are frequently difficult to capture in
more outcome-oriented research. This senior occupational therapist talked about the
ways in which being engaged in certain occupations can trigger pleasurable
recollections of earlier interests and meaningful life themes among even the more
severely impaired patients, such as Hazel.

She’s been a very active lady in her life, a very socially active lady and so she feels like . . .
Even though what she might have done is gone for a walk . . . It’s like going for a round of
golf, so her interpretation of where she’s been is good . . . It’s wrong, but . . . not for her . . .
It’s “I’ve just been for a round of golf this morning.” That’s what meaning it has for her . . .
that’s fine.

Such observations about the meaning of activity for patients reveal how
opportunities to engage in meaningful occupations can provide a respite from
boredom, from anxiety and can reconnect patients with their personhood, despite
significant cognitive limitations. Hasselkus’ (1998) notion of arriving at an
“occupational place” exemplifies the sorts of experiences conveyed in the vignettes
above. According to Hasselkus (1998, p. 431) the occupational place is sometimes
just a “split second”, a moment where the “person with dementia experiences once
again a brief sense of self and identity. . . .[helping to] rescue the past and make it
accessible.” Apart from reconnection with meaningful past experiences,
occupational engagement had numerous other purposes and benefits. Another
therapist talked about how providing opportunities to engage in meaningful occupations were crucial to the assessment process, and, the prevention of boredom.

When you are creating these activities, you are creating normal environments where you can see how people interact and see what is going on . . . without those opportunities how can you really get a picture? It is not a natural environment, it is an artificial environment and it is not really humane either [without activities] . . . you are creating boredom.

Boredom is of significant concern to occupational therapists and occupational scientists, and allowing it to “develop” appears as problematic for the older person in this environment, (not normal and inhumane) as it appears to be for other groups, such as young people, who as a consequence of boredom may engage in crime or problematic drug use (Farnworth, 1998).

During fieldwork in Port Edward, I assisted occupational therapists to run a variety of groups throughout the week. Each morning, at approximately 9.30, the morning meeting group was held in one of the two large open lounges in Port Edward. Open to everyone, this group was stated to be an orientation and information exchange group, aimed at introducing patients to each other and maintaining their connections with what was happening around them, both within the hospital and the wider community. The following fieldwork excerpt portrays a typical morning meeting.

Bill starts by going around the room and encouraging each person to introduce themselves. Hector is slumped on the arm of the chair and dozing. Bill encourages someone to call out what day it is, then the date, the season. One woman offers, “I think we’re in the Town Hall.” Another patient rolls his eyes, presumably indignant that he is in the same place as someone who doesn’t even know the most basic of details. I notice that of the 10 patients, about 4 people have their eyes closed or are dozing. Sally stands up and moves out of the room. She comes back again, sits and then goes again several times during the group. Each time she gets up, people watch her, breaking their concentration with what is happening in the group. Very frustrating. Another patient wants to go to the toilet. I offer to take her. Bill attempts to get discussion going about what anybody has seen or heard on the telly. No answer. He redirects his question to Patrick. As Patrick talks, another patient, Irene, is brought into the group by one of the doctors and is assisted to sit down. Later on, another doctor takes a patient from the group. Bill starts to work his way through the newspaper, showing people
interesting pictures. I try to enliven the discussion by chipping in, giving my opinion and asking questions but it is very hard work, with so many dozing people. I feel like having a sleep myself. There are only 4 people involved in the discussion, 4 are asleep and 2 watch, but do not say anything. I nudge a few of the nearby sleepers every few minutes. In the last 5 minutes of the group, just before the patients are called for morning tea, Bill starts some simple exercises. Everyone is now awake and participating. Arms are moving and everyone is in time. I think to myself, this is what we need more of. Why didn't we start off like this?

The difficulties of conducting the morning meeting were frequently commented on by the occupational therapists. Given the very diverse abilities of patients who attended the group and the inability to control the number of people who might wander in and join, finding topics of conversation or activities that held meaning for everyone proved difficult, particularly when only one staff member was present. Despite this, the importance of having something like the morning meeting, even if only half of its attendees were participating, was felt to be "worth it." Short of selecting only those patients who could be guaranteed to participate at a high level, the occupational therapists saw it as a chance for everyone to get together and to create a more social environment. This occupational therapist recognised that patients perceive the benefits of groups in various ways and that while these might not always concur with the aims that occupational therapists may have intended, they are viewed as beneficial regardless.

From the patients perspective we provide something completely different and I don't know that they are necessarily particularly bothered about what they used to do functionally and what they now can do... so, ah... We've collected a lot of feedback now over the years from the patients... from the group program... It gives them something to do, it offers them the chance to get to know other patients, it gives them opportunities for fun, alleviates the boredom, these are not the aims OT has, but this is what the patients say they get... We want them to increase their social interaction, but getting to know other people, they probably are increasing their social interaction.

My experiences of occupational therapy within Port Edward and Brennan units were shared with occupational therapists who had recently graduated from university and, for the most part, experienced integration difficulties with their nursing colleagues in terms of a shared philosophy and negotiations surrounding the
performance of daily occupational tasks and roles. These difficulties, while always present to a degree, escalated with the resignation of a senior occupational therapist (who did not want to relocate) who provided on-site supervision and support at Port Edward unit, and continued to escalate following the move to the new units. The occupational therapist, assigned to Janson resigned within 2 months of the move. Thus, my fieldwork period at Janson unit occurred in the absence of an occupational therapist. At Brennan, the occupational therapist resigned several weeks after the completion of my fieldwork period. Gradually increasing frustration surrounding occupational relationships with colleagues within the inpatient unit, and an apparent difficulty in proactively changing these relationships, had negative consequences for these individuals and, it will be argued, the overall occupational environment.

Speaking of the initial attraction to working within Port Edward unit, one of the occupational therapists stated “Some of the reasons that I took on this job is I wanted to get some good background experience in psych, I wanted a good supervisor . . . something that I saw as a very positive thing.” In reflecting on the difficulties of survival within the inpatient setting after Port Edward divided and relocated, lack of support for the occupational therapy cause, and the need for someone at a higher level to “pull some weight” and help junior staff members to “represent needs” were felt to be key factors contributing to occupational therapists’ negative experiences within the units and their eventual resignation. At Port Edward unit, the departure of a senior occupational therapist, undoubtedly more skilled in negotiating with fellow team members and managers, necessitated that relatively inexperienced therapists were now required to negotiate for resources with managers who they felt did not understand the importance of their roles to the overall functioning of the unit.

The overwhelming “need” articulated by the occupational therapists in this study revolved around support for the running of the “group program.” Past and present occupational therapists, both senior and more junior, talked about their perceptions that responsibility for the group program rested solely with them, and that other staff, particularly nurses, did not see that participation in the program was part of their responsibility. Consequently, occupational therapists believed that the groups that did run had limited effectiveness beyond occupying peoples’ time. In order to achieve the specific goals set for participation in groups, occupational
therapists believed that co-leaders or more than one staff member were required. This resource was felt to be present within the nursing group, however, for various reasons, was never realised as an effective and sustainable solution to the problem. Not only did nursing support for the program appear elusive, but so to was understanding of, and respect for, structured group occupations. A former occupational therapist of Port Edward unit reflected on some of the frustrations.

Quite often I would get people coming in to take blood pressures during groups and take patients out because they had an appointment... In the early days... I really had to start from scratch to educate staff about why we do groups, it is not just to keep the patients all together in one room so that staff can clean the bedrooms... I would try and talk to them afterwards... and try to explain... that groups only go for one hour and usually you can wait for an hour for something.

From this it is clear that while occupational therapists may have taken seriously the need to create an occupational milieu, a shared understanding and value of this had managed to elude the wider staff group. In fact, there is the feeling that occupational therapy was not real work and was only good for a bit of fun. All of the occupational therapists that I spoke to as part of this study talked about a perceived devaluing of the therapeutic aspect of the group program by other staff, particularly nurses.

People see you doing cooking and gardening and they think: “Oh that is a bit of fun,” but unless they kind of watch people involving themselves in activities they don’t perhaps see the real value of it. I guess overall it has always been a struggle to get other disciplines, not just nursing staff, involved in a group therapy program. And it has always fallen back onto OT no matter how we have struggled to make it a multi-disciplinary program.

Both former and current occupational therapists talked at length about the difficulty of getting other staff involved in the group program.

When we first came here [we tried to] educate other staff [about] being involved in the group program, and verbally we had some success. We had some agreement that people would be quite happy to be committed in terms of assisting people to groups, just sitting in on the
groups and providing some assistance when required, or even running a couple of groups as well... Then it just wasn’t followed through.

When I talked to occupational therapists about how to problem solve around the issues of interdisciplinary staff support for a group program, the importance of the unit manager was highlighted in a number of ways. Negotiations with nursing and other staff and explicit support for the program through a commitment to “resourcing” with dedicated staff were seen as crucial to the success of a therapeutic program. A former occupational therapist revealed that at one point in the late 1980s the program was run as a successful interdisciplinary program, because it had the support of the unit manager. “I was always encouraged by the unit nurse manager, she was always very encouraging of OT.” More than being encouraging of occupational therapy, the previous unit manager at Port Edward described how a new position was created to support the group program.

With the development of my roles, I then actually brought a position of program nurse onto the roster, an RPN who had some experience, post grad experience, wasn’t just fresh out, and actually could support the patients’ program.

Leadership support for the group program appears vital. The above vignette also conveys a sense of strategy, that the need to make the program work required conscious thought and targeted resources. A former occupational therapist talked about the success of the new position with regards to overcoming some of the difficulties “we were having of getting nurses involved.” This occupational therapist talked positively about the contribution of one particular nurse who “assisted” the occupational therapists. Conversely, when this helpful nurse left to be replaced by two rather more independently working program nurses, the situation was perceived to have reverted to a less interdependent relationship.

[It] worked really well ‘cos this particular nurse worked as our assistant in some ways but also could fill the gaps where OTs weren’t available and so he would help us get patients into groups, if it was a particularly big group or a disturbed group, he might stay and assist and it was great to share ideas, and we would meet each morning to kind of say what we were going to do so then we could each work out what the needs were and plan appropriately... He left.
unfortunately, and the next sort of strategy ended up being 2 nurses in the one role and that didn’t work so well, because they tended to work separately from us. It wasn’t as collaborative as we had worked previously with the other nurse and I think probably I can remember some animosity between the OTs and these 2 particular nurses.

The above informant talks about “it working” because the program nurse acted as an “assistant”, implying that the occupational therapists were able to delegate tasks as they saw appropriate. What if the new program nurses did not see themselves as the occupational therapists “assistants”, but as equal players in the group program process, able to make decisions about what and how might happen in groups, and unwilling to take on the “assistant” role? Such a question is surely relevant as one ponders why the group program continues to this day, for the most part, without nursing support. A number of staff cited leadership as the crucial ingredient in the success or failure of the group program. One therapist, practicing during the fieldwork period at Port Edward in 1998, shared other therapists’ disappointment at a lack of commitment to the program on the part of unit management.

Something that I have realised, it really needs to come from management. We have had some discussions with the unit managers about groups and on the surface it seemed like they were quite keen for all the staff to be involved, but then when we really got down to it, it sounds like the managers, at least at the moment, don’t even want to commit the nursing staff to be involved with those groups.

At this particular time, towards the end of 1998, the relocation of Port Edward unit was already two months overdue. As a participant observer during this time, there was a sense of being “on hold,” of waiting, that nothing new or different was worth worrying about until “the move.” The group program, like the unit, was in limbo and there seemed to be little incentive to advocate for the type of support required to make it more than a bit of harmless fun to keep the patients happy. Despite this, the occupational therapists continued to attempt negotiations in the belief that unit management support would enhance the group program. However, the ability of the two occupational therapists to clearly articulate the benefits of aspects of the program, coupled with a perception among the nursing staff that they
had no time to contribute to extra tasks, such as groups, created a stalemate. One
unit manager working in Port Edward just prior to the relocation verbalised a
number of perceptions around this interdisciplinary problem, and of the roles of the
occupational therapists. She stated:

I am not really sure they are quite sure where their boundaries lay with a lot of things, so that
is one of the areas we are working through. We are going to have regular meetings and, we
are reviewing the program 'cos I am not happy with the program. I don't think that a lot of
the groups that they run are proving to be beneficial and yet they argue. Like "breakfast
group." I said to them, "what is the outcome?" and they said "well you know people can just
wander in and make their breakfast."

My interactions with the more newly graduated occupational therapists during
the final months of life at Port Edward led to my own perception that in fact these
therapists were not particularly articulate about the occupational relevance and
significance of many of their tasks and roles. Such an observation could be applied
to the profession in general, which has tended to rely on their actions speaking
louder than their words (Creek, 1998; Gooder, 1997). Pressure to identify the ways
in which therapeutic actions enable engagement in meaningful occupation and how
this contributes to health and well-being is a current issue for the profession. In a
study focusing on occupational therapists working in child and adolescent mental
health, occupational therapists' roles were described in terms of "gap filling"
(Fortune, 2000). The study highlighted a lack of occupational clarity regarding
rationale for treatment action and the likelihood that therapists continue to
perpetuate role incoherence because of difficulties in articulating the nature of and
aims of their work and how it relates to occupation, the profession's guiding
paradigm. In this environment, clarity as to the benefits of the sorts of approaches
taken by occupational therapists, which could be provided by sharing empirical
evidence with their colleagues and managers, may also assist occupational therapists
in their quest to establish the issue of engagement as being more than "a bit of fun".
Quantitative evidence as to the efficacy of patients' engagement in "activities",
while not always statistically significant, does exist (Opie, Rosewarne and
O'Connor, 1999). More recently, a number of well-designed studies have
demonstrated benefits in terms of improved patient behaviours as a result of
exposure to the sorts of psychosocial approaches adopted by occupational therapists. In an Australian study adopting a repeated measures design (Bird, Jones, Smithers and Korten 2001), both clinically and statistically significant reductions in behaviours such as aggression and agitation were found among clients with dementia who were exposed to a predominantly psychosocial, non-pharmacotherapy approach. Such approaches included allowing clients to engage in valued activities, using activity to divert, and altering the physical and social environment. In a non-randomised controlled trial that focused on improving morning care routines, decreases in disruptive behaviours were found among those dementia patients who were assisted to engage more in their own bathing and dressing using prompting and other skill elicitation techniques (Rogers, Holm, Burgio, Granieri, Hsu, Harkin & McDowell (1999).

The perception among other Port Edward staff that two occupational therapists should be able to run all of the groups as part of the program, without assistance from nurses, was felt to be unreasonable by the occupational therapists. The occupational therapists felt that there was a lack of understanding regarding their role, that they were not there just to occupy patients, but had other commitments, such as performing home based client assessments in preparation for discharge. This unit manager's perception of the situation clearly frames the group program as belonging to the "OTs" rather than the unit:

I know there has been a lot of resistance from the nursing staff to helping with the OT program, but I guess I can understand their point of view. I have cut their staff on this unit and essentially I am asking them to do something else which isn't necessarily their job, although years ago we didn't have OTs, the nurses used to run groups . . . but I think they also feel that the OTs aren't particularly visible on the ward and they are [not] going to be doing their jobs.

The issue of ownership of the group program appears indeterminate. No one discipline feels that the program is totally their responsibility. Nurses used to run groups when there were no occupational therapists and program nurses have been employed specifically for the program in the past. Occupational therapists now adopt a lead role in maintaining the program, however, they also want other staff to be involved in the program, as the responsibility for running the groups is stated to
be beyond their capacity. It appears that the group program has become the “problem” of whoever has taken responsibility for it. Rather than being seen as a resource belonging to the unit, a vehicle through which patients can engage with other patients and/or occupations in meaningful and satisfying ways, or an opportunity for staff to assess a client’s capacity in numerous areas, it has become the site of disciplinary boundary fighting. In this fight, the occupational therapists appear to want to maintain control of the program, but want other staff to “help” them do so. Nursing staff, on the other hand, have picked up on an underlying message that this is an occupational therapy controlled program and that, as nurses, they are assistants rather than co-leaders. A unit manager explained: “We have had a couple of major hiccups along the way and the OTs writing in the diary “a nurse to attend this group” with no consultation with anybody, and all that did was cheese everybody right off.” This unit manager also voiced what was felt to be a consensus opinion among nurses that “it should be the OT’s job to run groups” and that nurses tend to feel that “we only get asked to go on outings so we can drive the bus.”

A former senior occupational therapist hinted at how disciplinary typecasting may have helped to contribute to nurses’ perception that their contribution in groups was required to help with physical management of patients rather than to be an equal partner in the group program. She revealed: “You know we’ve had OTs in the past that as soon as someone required the toilet, even if it wasn’t in a group, they would come running for a nurse.” It is likely that these sorts of incidents still remain in some nurses minds. It appears evident that a lack of disciplinary respect and commitment to an interdisciplinary approach to unit tasks and roles has helped to maintain a rift that has angered and frustrated several generations of nurses and occupational therapists (and PSAs). The lack of mutual respect for others’ roles is touched on by Salisbury (1962) in his ethnography set in a state mental hospital. He states:

For the attendant, therapists are just another difficulty added to his job. . . in a way he is pleased when eventually the therapy ceases and the patient becomes an ordinary patient again. Thus, the attendant fails to cooperate fully with the therapists in what to him is a somewhat pointless activity (Salisbury, 1962, p. 60)
From the perspective of some nurses, the occupational therapist in each unit was their own worst enemy. One nurse in particular felt that the occupational therapists' contribution was minimal, and that lack of supervision was a big part of this. The appointment of newly graduated, inexperienced therapists, coupled with the departure of a supervising therapist, appears to have been, in this nurse's experience, disastrous.

The OT's here at the moment are useless, but I think they are useless because they are very young and they have got no one to guide them, they have got no supervision at all and they have run riot, they do fuck all. They have got no idea and I don't know what we do about that. I feel really sorry for them, but they annoy the hell out of me at the same time, because they have got that cockiness of youth that doesn't allow them to listen to other people's advice either.

Through this excerpt, it can be seen that individual occupational therapists are seen as being useless, rather than the discipline per se. It appears that judgments about individuals and their skills are being made at the expense of the needs of patients that could be addressed with a group program. Such an interpretation may, again, suggest that the social relationships between staff are a crucial determinant of occupational relationships and, in turn, successful interdisciplinary practice. In Port Edward, Brennan and Janson units, if no occupational therapist was present, groups were cancelled. If an occupational therapist was present only small numbers of patients, and usually those less cognitively impaired, could attend, leaving a far greater number sitting or sleeping, either unengaged and/or isolated, or worse, engaged in disruptive and potentially dangerous activities. The behaviour of patients in such occupationally un-engaging environments, who may be bored and unable to exercise their capacities, may be taken as evidence of continuing poor psychiatric status. Viewed in this light, the occupational environment of the psychiatric ward is a powerful determinant of patient status and subsequent treatment decision making, for example, the use of restraint and other physical and behavioural strategies, medication and discharge options. Staff relationships, respect and difficulties in task cooperation clearly impacted on patients' occupations and their well-being.

One other noteworthy observation regarding the differences between Janson and Brennan units at the time of this study was that an occupational therapist
remained working in Brennan for the duration of my fieldwork. At Janson, the assigned occupational therapist resigned some three months prior to the commencement of that phase of the fieldwork. While the group program at these new units was not as extensive in terms of the amount and range of activities offered in comparison to the Port Edward program, at least one or several group activities were scheduled to occur each day. However, during my time at Janson there were no actual activities at all with the exception of meal times. In Janson, the TV was routinely switched on by 9 am and patients wandered, slept or sat. Patients engaged in no organised activity unless prompted by me. During the first week of fieldwork in Janson, a number of nurses stated that a morning meeting had been running and that this would continue, however such an event was not witnessed during my presence. Even when I offered support and assistance to help run the group, it never eventuated. Despite this, a full group schedule remained posted on the information board at Brennan with the current date on it. One staff member observed that having an up-to-date program posted on the wall was more about ensuring that the “community visitors” were kept happy, than ensuring that patients had opportunities to engage in meaningful occupation.

Although the very different ward atmosphere and levels of occupational engagement at Brennan appeared to reflect an environment of greater “doing” and engagement with staff and fellow patients in both structured and unstructured activities, it is unlikely that this can be attributed solely to the presence of an occupational therapist. It is more likely that in addition to changes in the social and occupational relationships among staff, the presence of the occupational therapist and the structured group program that the occupational therapist provides, has multiplied the positive environment of that unit. In Janson unit, on the other hand, the absence of an occupational therapist and the associated group program is likely to have had a far greater impact. At Janson, unlike Brennan unit, social and occupational relationships between staff were less interdependent, interactions between staff and patients appeared more limited and the level of disturbed and/or aimless wandering appeared more noticeable. At Janson, more than anywhere, the input of an occupational therapist appears acutely missing. One psychiatrist commented on this in the following way:
The biggest need that this unit has got at the moment is for an occupational therapist. To me that is the biggest need. Every study that has been done on violent and disturbed behaviour in psychogeriatric in-patients showed that it is less when you have an occupational therapy program... If people are doing something meaningful they are not going to be walking around bashing people in the nose.

In seems clear then, that for Janson unit, the lack of opportunity for "meaningful" engagement had a negative impact that was clearly visible among staff who worked there. Given that the unit retained, and in some ways strengthened its institutional nature, the need for an occupational therapist who could work proactively with other staff to promote a more engaging environment seems paramount.

An individualised approach to nursing, and occupational therapy, despite the provision of groups, does not situate the focus of change on the "unit" or the environment, but on individuals. There appears to be potential for individual patients to be influenced by purposeful alteration of the social and physical environment, however while the main context of change is focussed on an individual patient, this potential remains untapped. A pre-requisite to changes that will impact on patients are changes to staff relations and how the work of the unit is conducted by staff as a team.

Social Workers: Unofficial gatekeepers in the in-patient environment

Alongside occupational therapy, social work was the other full time allied health discipline "on deck [with] day to day contact," providing a service as part of Port Edward, Janson and Brennan units. Like the nurses, the social workers provided little support to the group program. However, unlike nurses and occupational therapists, the social workers and occupational therapists enjoyed close social and occupational relationships. While the occupational therapists played a key role in the maintenance of the group program, for social workers discharge planning was the key area. One social worker described that while the multidisciplinary team had come to rely on the social worker almost exclusively with regard to their discharge role, the social workers saw themselves as offering the team expertise in working with the family around a variety of issues, including discharge and accommodation.
[We are] the resource person for accommodation. The social worker gets the forms filled out. . . . Social work very much takes a lead role in working with the family, and I think that is something . . . that we offer the team. It is built in family work and we are trained in family work, so that is something that we offer. So the accommodation issues, they are very much what we offer to the team, legal and financial stuff. A lot of our clients need administration or guardianship or those kinds of things as part of their discharge planning so the social worker again is the resource person for that.

From my own perspective as a participant observer, who spent large chunks of time on the “floor” with patients, nurses and occupational therapists, the social worker was not a particularly visible team member. In general, my observations of the role of the social worker occurred within the context of the psychiatrist led "ward rounds," within the staff station, and, to a limited degree, on the ward. Within “ward rounds” in which patient status, treatment and discharge decisions were discussed, the social worker's role as the gatekeeper of the discharge process became apparent.

Nurses, occupational therapists, social workers, psychiatric registrars and the consultant psychiatrist attended ward rounds. While an occupational therapist made recommendations regarding suitability for discharge based on a home assessment of "function" and "safety," the availability of suitable accommodation appeared to be the more pressing issue. Pressures to discharge patients before reaching the end of a 30 day funded stay limit and to “free up” beds in order to be able to admit waiting patients seemed ever present. In this respect, the social worker appears to have considerable power over institutional process despite the consultant psychiatrists’ official control over admission and discharge. The following fieldwork excerpts highlight the “gatekeeping” function that a patient’s response to medication and ability to be discharged due to bed availability confer on the consultant psychiatrist and the social worker. During a Port Edward ward round:

The consultant psychiatrist asks: “So what's the plan?” The “plan” seems to revolve around the discharge details. When? Where? There are two distinct “whens.” When the patient responds to the drugs, and when a bed becomes available in a hostel or a nursing home. The MOs seem to be mostly concerned with medication details, test results. The social worker brings up the issue of the family situation in terms of whether the person can return home. If
the patient is well and they cannot return home due to accommodation issues, the person is transformed from a psychiatric patient to a "placement issue."

Crepeau (1994) explores the professional, constructive, and ritualistic elements of team meetings on a geropsychiatric unit, similarly noting how patients are "objectified". In her focus on the inter-disciplinary team, Crepeau (1994) also reveals the dominance of the social worker around discharge. During a ward round at Janson unit:

Accommodation issues dominate. The social worker is softly spoken, almost unconfident. The manner of this social worker would not command attention if the subject matter was not so important. Because the topic is discharge, getting patients out, everyone listens. Medication issues also dominate, the changes that are required, whether to stay on for a bit longer or to be discharged because nothing more can be done.

The work of the social workers in each unit, and more specifically, the sense of pressure surrounding the need to sort out accommodation issues so that discharge could be affected, led me towards the consultant psychiatrists. I wondered if they perceived pressure, or had thought about the follow-on effect for the social worker. During my time on each unit, nurses had much to say about how long a patient had been in the unit, and many nurses were very clear about their concern about patients who "shouldn't be here." Nurse unit managers appeared to worry mostly about the number of days the patient had been on the unit in terms of how much they would "cost" the unit. As a small business unit that needed to come in "on budget," I wondered how much being well, safe, and independent really mattered. One consultant's perceptions of the impact of discharge pressure on clinical decision making, other staff, and the unit budget was as follows:

I think the chief parameter is clinical need, and I think somebody like [patient] who is on the unit at the moment, when he goes home he will probably scramble with his wife and there is a lot of doubt about whether he can be managed even at [hostel]... He is remaining on the unit as a clinical need and he is probably costing the unit some money, but ultimately you know I have got responsibility for his care and I am not happy to discharge him... Some of them [have been in for] 4 months and longer... That is something that gets passed on to [social worker], that then becomes their pressure. I suspect our social work staff do sometimes feel

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under pressure. I am conscious of the fact that I don’t [get] heavy [with] [social worker] but I kind of talk to [social worker] about some of the issues of waiting for a placement and how it is going, and [if] something is coming up. I don’t think that I am pressured to put people out before they are cooked. I know . . . the family has to agree, the patient has to agree, and there has to be a place and it has to be an appropriate place, someone has to die or move out and [as a social worker] you can do this with half a dozen facilities . . . It may take some time. I am very conscious of not trying to make them feel under personal pressure, like if you don’t get this person out you are a bad social worker . . . Sometimes there are perceptions that some social workers are more effective than others at finding care for the patients.

In relation to the adoption of a primary role in working with the patient and family surrounding accommodation and discharge, there appears to be no debate as to which discipline took the lead. Apart from one-off home based functional assessments performed by the in-patient unit occupational therapist or by community based case managers the social workers appeared to accept this major role function. However, as with nurses and occupational therapists, there were indeterminate tasks that social workers felt had been thrust upon them unreasonably. This social worker explained that while cigarette purchases and laundry arrangements were the main areas where nurses turned to social workers for solutions, there were a number of tasks that belonged to no one discipline.

I don’t think you need a social work degree to buy someone a packet of cigarettes. I don’t think it belongs anywhere. When we did some restructuring a while back we had an allied health assistant and I agreed that [cigarette purchases] would be part of the role . . . she did banking, shopping, ran around and collected clothes from home, took people to look at accommodation and it was just wonderful having her, but that position is gone. We have been having several meetings with allied health and nursing staff to try and sort that out, our belief is that it is a shared thing, that the three cores, nursing, social work and OT, could share these tasks and it doesn’t have to fall in any one area, because none of us . . . because traditionally social work come up with it because of the allied health assistant [and] because we dealt with the money thing.

Disciplinary task divisions characterised the inter-staff relationships between nurses and social workers and nurses and occupational therapists in all three units. Movement toward a more interdisciplinary approach, as witnessed between personal services assistants and nurses at Brennan unit, does not appear to have extended
between allied health and nursing at the new units. Each group has expectations of the others’ role, and these seem to focus on distancing themselves from tasks perceived as belonging to the other, rather than focusing on what patients need according to their priorities. Compromise in the form of periodic role and task sharing appears a crucial need, which through appropriate leadership and managerial support, could positively impact on allied health and nursing relationships and, in turn, the service received by patients.

Psychiatry: The medical face of mental health services

During the course of fieldwork at Port Edward, Janson and Brennan units, I was able to observe some of the work of the medically trained staff that provided a psychiatric assessment and treatment service for the aged people within the inpatient setting. As discussed earlier, the medical members of each team, like social workers, were not, when compared with nurses, PSAs and occupational therapists, particularly visible on the units. Unlike other staff in the unit, the registrars and consultants provided coverage to a variety of related services, including the area nursing homes and community assessment and treatment teams. Despite the “visitor” oriented nature of their presence on the units, each unit received 24-hour medical coverage, however this was not on-site coverage. Psychiatric registrars, undertaking their post-medical internship in psychiatry, were responsible for day-to-day patient management from a medical and psychiatric standpoint, receiving supervision from a consultant psychiatrist, who had ultimate responsibility for patients, legally and medically. In specific, the consultant psychiatrist makes final decisions surrounding admission and discharge. As already highlighted, it is the consultant psychiatrist, as advised by more junior medical officers, and the allied health and nursing staff, who controls the flow of patients through the unit. As one consultant noted:

If Mrs Jones has a headache and she needs some paracetamol . . . [or] . . . somebody falls over and they need an assessment, then that is the junior medical staff’s responsibility . . . My role really is to ensure that if a patient is admitted it is an appropriate admission . . . that there is a plan of treatment and management and [to] make sure that that plan is followed and reviewed, adjusted and carried out, that the patient gets the best outcome they can from all the available
help that is here, whether that is nursing staff support, medication, occupational therapy, social work, whatever, and to see that they are discharged, you know, under the terms of the mental health act... No one can come in here without medical input and no one can stay in here without consultant input in 24 hours.

One particularly visible arena for the work of registrars and consultants is the “ward round” or team meeting for each unit. In these, the interdependence between psychiatric registrar and consultant was striking. As an onlooking fieldworker, the team meetings appeared to be comprised of a one to one dialogue between the registrar and the consultant with infrequent interjections from nursing and allied health staff, with some variation depending on the personality of the consultant. Dialogue regarding accommodation options for discharge, was, after discussions surrounding response to medication, a secondary focus. One fieldwork entry details a typical team meeting dynamic.

The charge nurse announces the patient’s name and hands the file to the registrar, who, if he knows the patient, will launch into their previous and current medical status. Lots of medical jargon! The consultant psychiatrist listens, adds and offers an opinion and advises on any action needed. Allied health staff and nurses add information about the patient’s behaviour during groups, their self care abilities, whether they are aggressive or not. Words such as disoriented, impaired, insightless, resistive, aggressive, high functioning, destructive, and paranoid are used even by the non-medical staff. The registrar and the consultant dominate the conversation with medication talk... more jargon...” TD”, “ESP”, “Depo” “IM” and “PRN”...

Within the team meeting situation the hierarchical nature of staff relationships is apparent, and in particular, the position of nurses relative to registrars and consultants. The nurse appears to function within the role of doctor’s assistant, selecting the file announcing the patient’s name and carefully recording the nursing actions, as determined by medical opinion, in the patient’s file. The tendency of nurses to function as virtual “hand-maidens” is discussed by numerous observers of nurse – doctor relationships (Chambless, 1996; McCormick, 1997; Salisbury, 1962; Strauss et al., 1964) as is the “subsidiary” role that nurses tend to play in geropsychiatric team meetings (Crepeau, 1994). During interviews and informal conversations, nurses were particularly vocal about their relationship with medical
staff and their opinions regarding what they saw as either problematic or stressful in this relationship. One nurse commented on the fact that there simply was not sufficient medical coverage for her particular unit.

We have 2 part-time consultants, we have two very good part-time consultants, but they still do not make up for somebody being here full-time to be able to advise the junior medical staff that are normally very good, but who do require a bit of supervision... a bit of input from their superiors. I think that should be improved.

Later on in the interview, this same nurse was critical of the powerful influence that the doctors had over the unit and the attitudes of some medical staff, toward, primarily, nurses.

They impact on the Unit by the mere fact of the patients they allow into the Unit. I don't think at times there is a proper assessment done on who comes into the Unit... Two of the patients were 63 year olds, so one asks, if there is such a pressure on psycho-geriatric beds, why the two 63 year olds were not next door in adult care, and I believe we had a 58 year old coming in last night, admitted by the captain, that to me should have been able to be corrected by somebody putting their foot down and saying: "She is 58. She goes next door." So doctors do impact on the Unit. Dr [name] always objected to being questioned about why someone was coming into the unit, he felt that he was the big chief so why should he have to answer to a mere Indian like myself. Basically it was out of curiosity that I asked why is so and so coming in, is there anything that can done about it and he says who are you to be questioning me... There is a big gap between doctors and all of the other disciplines.

Another nurse touched on similar issues regarding nurse-doctor relations.

My point of view [is] that nurses don't have anything to do with who is coming into hospital and that really frustrates me. It is like we are told that someone is coming in but we are not... [Dr – name] has got this theory, I feel, that nursing have got nothing whatsoever [to do with] who is admitted, they just look after them when they arrive. [Dr – name] sees us down here [points to ground]. I feel sorry actually that some nurses have allowed themselves to go down there... We look after them when they are here and we will just keep our noses out of it thank you very much.
A number of interpretations may be made regarding the above transcripts, which at a most simplistic level reveals the hierarchy evident between the two disciplines. In reality, it is likely that other factors, such as the personality and training of both nurse and doctor influence the presence of a “gap” that is felt to exist between doctors and nurses. It is also likely that the “gap” is reflective of the hierarchy that exists in institutions, a reflection of the hierarchical manner in which society is organised (Goffman, 1973; Parks, 1985; Schwartzman, 1993; Van Maanen, 1991). From some nurses’ perspective, the medical staff, and in particular the registrars, were seen as needing much guidance from the nursing staff. This nurse touches on the need for nurses to “put their foot down” where the medical staff are concerned.

Doctors when they come I don’t think get adequate orientation … to what is expected of them, communicating with the nursing staff, little things like what you do with scripts and blood forms and how you label things and where things are kept. Nobody seems to take on that responsibility. So, they all come with bad habits and you end up nagging them all the time. Some of them are just down right rude and I have reported some of the doctors. They interview their patients in the dining room, they lie on their beds, they are just. … Some of them have been appalling; they shouldn’t be allowed to be doctors. I have never seen so many patients come into hospital that don’t need to be here. It certainly didn’t happen when [former nurse unit manager] was in charge of the ward … She was very proactive … said her piece without fear of death or destruction.

While nurses enjoy a dominant position in the unit hierarchy in relation to the personal services assistants (PSAs), the same is not true of their position relative to medical staff, who appear to dominate in terms of decision making surrounding patient management. In talking to nurses, one comes away with a sense that nurses have to do all the work with minimal say in the decision-making surrounding their work. Nurses’ oppositional status has also been discussed by Chambliss (1996) who described nurses as “stage managers for dramatic stars” (p.74), as having to behave like a “professional” while being treated as a “subordinate” (p.84), and while the physicians do the talking, the “nurses stand by holding the chart” (p. 85). As the largest discipline group within the setting who have 24-hour knowledge of patients it seems unlikely that nurses are as powerless as it appears, but as Chambliss (1996) states, “nurses don’t always want to be subordinate but without doubt they are, and
for the most part they accept this as part of their role” (p. 74). Perhaps nurses are
talking more about a lack of respect that stems from a perception that they are not
consulted about important decisions relating to patient care, including admission and
discharge. A primary nursing approach that casts nurses in the role of case manager
should create a more equalising role in relation to patient management decision-
making, however there are two possible impediments to this that should be
considered. First, a true primary nursing approach does not operate within the units,
rather, a task oriented approach is maintained. The consequence of this is that
individual nurses, if they are not RNs or RPNs do not have total nursing knowledge
of the patient and may not be able to participate at an informed level regarding such
decisions. Second, consultants and registrars, as advised by community team
members, have legitimate authority to refer patients to admission based on
circumstances not always known to inpatient nurses. One consultant commented on
nurses’ “failure to appreciate” all the issues surrounding nursing home patients who
are admitted to the units or who stay in the units for what is perceive to be too long.

Sometimes I think on both sides there is a failure to appreciate difficulties and challenges that
staff are facing in the other facility so sometimes it is “those terrible nurses down at…” or
“those lucky nurses at…” I perceive anxieties on behalf of the nursing staff when we don’t
move people through and I sometimes think it’s a bit inappropriate. We don’t keep people
here for amusement. I think it is something they worry about incessantly personally.

Respect for the decision making of community colleagues and not just the
admitting doctor arises as an issue here. Nurses perceive a lack of respect and it
seems that these perceptions are focused on professionals who have legitimate
control over their occupations. This perspective would appear little different to that
made regarding PSA-nursing relations. Similar to PSAs, the issue of respect for
nurses and how this is communicated appears as a crucial issue in the medical staff-
nursing relationship.
Controlling relationships or respectful and collaborative working partnerships?

The notion of inter-staff respect is, in this study, a powerful theme pervading all interpretations of staff communication and work organisation. While staff communication may not be readily recognised as having a direct impact on the service that aged people within each unit receive, decisions surrounding what and how work is carried out does impact on how restrictive and/or custodial the climate of the ward appears, and how much it supports or constrains engagement in valued, meaningful occupations. Distinct and opposing evaluations have become evident during fieldwork. First, that some nurses appear to be custodial and either knowingly or unknowingly mediate against occupational therapists attempts in creating therapeutic change and/or a therapeutic environment. Second, there are some nurses who are of the belief that the current occupational therapists are "useless", do not appear to do useful groups, and seem to restrict therapy to the more functionally able patients on the ward. There also appears to be a perception that what OTs do is just for fun, is not real work and it is certainly not like the "dirty work" that some nurses believe therapists don’t usually deal with. There is also the perception that social workers are concerned with being seen as solely responsible for clearing beds, and/or ensuring that patients have sufficient cigarettes and clothing. A number of other studies focusing on the role of staff in institutionally-oriented ward environments reveal the potential role that unsupportive staff relationships can play in maintaining an occupationally constraining environment for patients (Edelson & Lyons, 1985; GIllices, Franklin, & Child, 1990; Parks, 1985). In this study, each occupational group has expectations of other occupational groups. This expectation does not appear to focus on an interdependent relationship that will influence the overall environment or "the ward," but focuses on individual tasks, each with disciplinary role boundaries.

Decisions regarding what and how members of each discipline choose to execute their duties may be highly influenced by an implicit need to maintain control or exert influence over another discipline. In a climate where staff perceive minimal autonomy and support, each group clings to its own tasks while attempting to transfer responsibility for tasks that each perceives diminishes its prestige or
professional standing. Patients’ needs to engage in meaningful occupations takes second place to staff members' need for occupational control, autonomy and respect.
CHAPTER 8

LEADERSHIP AND MANAGEMENT: CHALLENGING STAFF AND PATIENT OCCUPATIONS IN RAPIDLY CHANGING CONTEXTS

This study of an aged persons’ mental health service focused beyond direct care and clinical staff to include an exploration of middle level management, or unit managers, who had daily or infrequent direct contact with care giving and clinical staff on each unit. Given the influence that leadership and budget management initiatives are likely to exert on how services are run, in-depth interviews, informal conversations and participant observation surrounding the tasks of a number of these personnel were conducted.

As discussed in Chapter 3, the aged persons’ mental health service has evolved in an administrative sense, from being provided under the auspices of a stand alone psychiatric institution to a specialist service as part of increasingly mainstreamed health care networks. Along with this came significant changes in management and, it will be argued, the leadership provided in respect of the acute inpatient aged persons’ mental health service. Changes in administration coupled with new policy driven mental health initiatives have resulted in staff changes, in terms of personnel and the roles of those personnel. The division and relocation of Port Edward unit into Janson and Brennan units was the most visible change that direct care and clinical staff referred to in terms of changes to their day-to-day work. Managers also cited the division and relocation as the event that exerted most change to their daily practices, however other changes were also highlighted.

Notions of management and leadership are often confused and lack of clarity regarding these concepts remains (Sinclair, 1998). At a simplistic level, management and leadership can be thought of as two distinct, but highly related functions, as skills with associated tasks that aim to maintain or enhance an organisation’s productivity. According to Marquis and Huston (2000), management tasks are typically those that emphasise control of the assets of a workplace, including hours, costs, salaries and other resources. In contrast, leadership aims to increase productivity by maximising work force effectiveness. The effectiveness of
staff appears more an outcome of individual leader influence, guidance and direction (Marquis & Huston, 2000) provided to workers, than control of the resources of the organisation, of which the worker is only one. Leadership is described by Gardner (1990, p. 1) as a process of “persuasion and example by which an individual induces a group to pursue objectives held by the leader or shared by the leader and his or her followers.” Similarly, Handy (1993, p.117) summarises a leader as “someone who is able to develop and communicate a vision which gives meaning to the work of others.” Contrasts between leadership and management have been extensively written about (Bass, 1990; Gardner, 1986a; Zaleznik, 1977) within the management studies field. Both Zalznick (1977) and Gardner (1986a) comment on the tendency of leader-oriented managers similarly in that both see that such people motivate action through providing vision and articulating ideas that provide a unity and purpose for what needs to be done.

Leadership as a concept, and as a collection of abilities that an individual possesses, appears as a far more complex phenomenon, when considered alongside the concept of management. While I have adopted the position that management and leadership functions are distinct, I am also aware that elements of both are necessary given the current organisation of institutions and other social and welfare services as “businesses”. As Bass (1990, p. 383) states, “leaders manage and managers lead, but the two activities are not synonymous.” In this study, the use of the term “unit manager” could imply that the key function of the manager is to “control assets,” to focus on rational processes and largely, non-people oriented concerns. While the unit managers discussed in this study are required to control assets, it is my belief that their role as leaders would appear to be of greater relevance to the success of the units at this particular time of change.

Having briefly introduced leadership and management concepts, I would now like to elaborate on findings that I believe are focused on leadership, and ultimately, how leadership is a crucial element in enabling occupations.

During the several years that preceded the period of fieldwork for this study, staff experienced a shift in organisation focus. In this shift, a charismatic leader, a nurse unit manager, was gradually seen to focus less on the daily clinical and staffing issues of the unit and more on issues such as resource management. It is apparent that a number of staff welcomed such a shift, which resulted in direct care
and clinical staff "being left to their own devices." A number of other staff, however, saw the shift as the end of an era, the end of strong leadership, which tended to focus on the unit, its staff and patients, rather than the unit's budget. In short, it is argued that the essential shift that occurred before and during the division and relocation of Port Edward into Brennan and Janson units in terms of a unit manager role was a shift from leadership to management. One unit manager discussed some of the impacts that this appeared to have on staff and how nurses, in particular, needed to break away from the routine way of performing duties that their previous leader appeared to encourage.

I think probably one of the biggest challenges for staff and clients was coping with somebody who was so different to their previous unit ... "You don't yell at us." And I say, "Well why would I? ... I am not going to yell at you, if you do something wrong we will talk about it, if you do something I don't like we will talk about it." So from their point of view they have found it very difficult to adjust, they have suddenly got responsibility, which they said they wanted, but are now having difficulty coping with. ... They stick to [routines] because I think they feel they need the safety. The previous manager was here for 14 years and that is the way the ward ran and I think, you know, I am trying to change their boundaries. I don't necessarily believe that the obs have to be done by 10 o'clock in the morning ... Beds don't have to be made by 11, if they are not made till the afternoon I am not going to sweat it. Provided they are spending time with the clients. They do still stick to it [routine] because all nurses are institutional.

This transcript implies that staff operated in a highly institutional and routinised fashion, that this was what had been expected and rewarded. There is also the hint that changing expectations may not readily result in change because "all nurses are institutional." This raised questions like: Is being "institutional" an occupational hazard for nurses? Will it be impossible to change or is easier to "go with the flow" in times of change, to get the unit moved and then worry about changing the institutional behaviour?

Following the departure of the nurse unit manager who had been involved with the unit for the past 14 years, two nurse unit managers were appointed. These new managers were to plan and prepare for the impending move, and were allocated to Brennan or Janson respectively. Their focus and styles clearly represented a shift
that was challenging for some staff. One nurse voiced the perspective that more
direct intervention was needed from the new managers and that if they did not get
involved in providing leadership around clinical problems, they were not doing their
job.

[The previous unit manager] was always a hands on sort of a nurse, so [name] found that
letting go of that patient care thing very hard . . . People got pissed off . . . because they
thought [name] was interfering . . . But in actual fact when I see the unit running now, with a
unit manager that seems to have no interest . . . or not want to get involved in the clinical side
of things, I think it is very difficult, because I do find now that there is nobody anymore that
takes clinical responsibility on the ward (Port Edward unit nurse, who subsequently moved to
Janson Unit).

It is apparent that the pre-move unit manager took control of the unit, led by
example, and was a very hands-on nurse leader. Staff had mixed feelings about this
style. Another nurse commented that the previous nurse unit manager had gained a
reputation as a "hard task-master." Despite this, there is a sense that many staff held
significant respect for this leader's commitment to the unit and a certain "standard"
was obvious. What is also revealed is that this unit manager was not, in fact, a
manager, as characterised in the following excerpt as the "administrative things,"
but a nursing "leader," the head nurse "clinician."

At the time [name] was Unit Manager and had a high standard . . . was clinically supervising
everybody . . . didn't have to do the administrative things . . . [name] was a hard task-master
at the time, and if you didn't abide by the standard you would know you weren't abiding by it.
So yeah, and there was a good core of people, some are still here, but there was a good core of
people at the time, who were prepared to make that standard . . . it was a high standard as well.

Staff being "prepared to make that standard" reveals the ability of the unit
manager to lead by example, to serve as a symbol and to motivate staff. One SEN
expressed her respect for the previous unit manager in a "backhand" way when she
said that she was "there for staff as well as patients" despite being "one of those
matron types, from the old school." There was the opinion that staff needed a
"strong personality" if they were to get into a disagreement with the nurse unit
manager. This seems to be further evidence that this leader was a powerful force who was prepared to “stand up to the doctors,” was able to foster cohesion, and set a high standard of patient care. That these conditions may have been achieved through what may be perceived as authoritarian means rather than a collaborative and transformational approach (Marquis & Huston, 2000) to leadership necessitates further exploration. Also requiring further exploration is the relationship between the leadership qualities of the subsequent unit managers for Brennan and Janson and the quality of staff cohesion in those units. Such queries are relevant if we assume that elements of both leadership and management have an impact on how occupationally engaging the environment is for patients. This relevance is further strengthened with the assumption that effective leadership can enable staff cohesion, and inter-dependable work practices that enable patients to engage in meaningful occupations while they are in the units.

Although the organisation of the relocation required sound management ability, the need for a shift toward strong leadership was required in the period after the move to each new unit. According to Bass (1990), any individual in a group can emerge as a leader. However, if there is a lack of leadership emergence or non-functional leadership, the situation can be “characterised by [or result in] patterns of behaviour such as aggression, blocking, self confessing, competing, seeking sympathy, special pleading, disrupting, seeking recognition, and withdrawing” (Bass, 1990, p. 383). I would argue that a number of these non-functional leadership elements emerged within Port Edward unit at least several months prior to relocation and persisted within Janson unit following relocation.

Several years prior to the division and relocation of Port Edward unit, a shift in emphasis around the delivery of health care was experienced throughout Victoria and other Australian states. The notion that social services such as health, welfare, education and employment support services could become independently functioning financial units in a new lean, “mean” global market was seized upon (McDonald, 1997; Muetzelfeldt, 1992). In Britain, the practice of “contracting-out” (Parker, 2000) local government services and the devolution of budgets to health professionals, educated primarily to engage in direct clinical work, now expected to be responsible financial managers, was quick to spread to Australia (Donaldson, 2001; Muetzelfeldt, 1992). The coming of the global economy, as Neubauer (1998,
p. 3) notes, is characterised by "economic rationalisation, downsizing, reinventing government, deregulation, the primacy of the market and market relations and from this the paramount value of competition, and reform of any number of things including health."

Port Edward became a health service unit that was successfully acquired, via a tendering process, by Portside Healthcare Network. The tasks of its clinical leader, the nurse unit manager, had to shift from leading nurses to managing budgets and delivering concrete outcomes. The daily clinical support and leadership of ward staff needed to be transferred to the deputy unit manager, the associate charge nurse, to allow the unit manager to focus on financial management, service planning and higher order staff management. Discussions with staff reveal the perception that Portside’s first unit manager had difficulty in successfully making the transition from clinical leader to financial and systems manager. When the unit manager finally left there were again mixed feelings among staff regarding the losses and gains to the unit.

One possible legacy of the pre-Portside leadership era is that some staff, used to external directives, were now experiencing difficulty in accepting responsibility for daily work without an external force driving practice and making clinical decisions on their behalf. In effect, staff used to being directed, were now struggling with autonomy. It is further argued that these struggles and transitional difficulties have had an impact on the ability of these staff to demonstrate respect and trust for staff taking on new leadership positions. An example of this is reflected in the frequently critical comments regarding leadership ability levelled at Janson unit managers. It is my contention that a good balance between leadership and management elements has engendered respect and trust among staff at Brennan, but not at Janson. Non-functional leadership emerged (Bass, 1990) at Janson in the absence of effective leader-oriented management, while staff at Brennan have been enabled to think and act through a consistent and respectful leadership style that has valued and supported them to "be the best at what they do." Brennan’s unit manager revealed:

... as a clinical nurse I was always more driven to setting up systems and processes to make things work and I don't sort of put myself in the same grouping as [nurse/name] or
Clinically I am not as good as them, I am more systems and paperwork. I suppose my goal is to surround myself with people who can do that and people who can do the other. That is why perhaps I have evolved to a unit manager, because I position myself in a way that I get those people to be best at what they do and acknowledge that. I don’t think that I am the unit manager because I am the best clinical . . . even when I was the deputy . . . if there was an aggressive situation, I wouldn’t always be the person to deal with it, if there was a SEN on the ward that could deal with it they would deal with it . . . (I don’t think): “I am the unit manager I should control this.” I would back [their] judgement in a direct clinical sense.

The sense of empowerment embodied in the above vignette, a key factor in Brennan’s success, was less apparent as an influence impacting staff morale and practice at Janson unit. Significant leadership troubles plagued Janson from day one, and pre-requisite conditions such as respect, trust and support could not become established in the absence of these. In Chapter 6, I outlined that the “feel” of Janson appeared to be dictated to some extent by the mix of staff present on any given day. In particular, highly assertive nurses seemed to have an influence on how other staff approached tasks and patients. That a mix of staff can so readily set the “mood” may be further evidence that leadership issues were of prime concern. In the absence of a template to work within, staff who took the initiative could set the pattern for the shift. Leadership “voids” are described by Delaney et al (1995) who observe that without a leadership framework that articulates a sound philosophy to guide nursing actions and nurse–patient interactions, “rigid rule making, coercive interventions and staff’s personal ideologies” (p 39) come to dominate the climate of a unit. In particular, the “strongest staff voice may dominate how a particular shift is organised and the response to patients” (Delaney et al., 1995, p. 39). Leadership voids and the possible emergence of non-functional leadership (Bass 1990) behaviour may have contributed to an organisational environment that seriously limited the occupational capacity of staff and patients at Janson.

Despite this sense that there was a lack of vision and a leadership void at Janson, a planning process that aimed to convey a sound organisational mission for the units, and coherent statements of how each discipline would work toward the mission, was in operation at least six months prior to the division of Port Edward Unit. A “Model of Care” committee, whose membership was comprised of both unit managers, senior discipline clinicians and key members of the community
assessment and treatment teams, met on at least five occasions. The committee aimed to explicate important aspects of care and identify discipline and unit wide "systems" that would be required to support the mutually agreed care approach. This resultant "model of care" was to form a guide, a formal document, describing the values, goals and roles of discipline staff toward achieving the mission of the service. Such a process represents a valuable exercise and commitment to organisational development at the outset. Despite an initial commitment to this process, a shared understanding of each discipline's model of care does not appear to have been achieved. One possible factor is that many influential (though not senior) staff such as direct care nurses and the therapists and social workers with whom they would interact, did not attend these meetings with any regularity. Important aspects of each discipline's functioning within the broader team, its interdiscipliary roles (versus its multidisciplinary contribution) and associated interdisciplinary relationships/communication issues, were not addressed in a way that mutual agreement by those who would enact the vision could occur.

By the time I had commenced fieldwork at the new units, both Janson's occupational therapist and its unit manager had resigned. Each shift was composed of two, sometimes three agency nurses. An "acting unit manager," a Level 2 RPN, who was previously an associate charge nurse from the same unit, was covering unit management. Although staff appeared happy with this situation, it was not to last. This acting unit manager resigned and was replaced by another acting unit manager, one of the associate charge nurses from Brennan. Concerns regarding the new acting unit manager's ability to support the needs of staff and "stand up" to management were apparent in statements such as: "we need someone who will not be a puppet for management...[program manager's] lackey."

But, at the same time that concerns existed among staff as to their new unit manager's capabilities, the new unit manager also had concerns about working in what was considered a "difficult" unit.

I like my job at Brennan, I like going to work there. I mean...we sing while we are working, we are singing and acting crazy because we enjoy ourselves...Okay we might grizzle and grouch sometimes, but we are singing and the patients are singing with us. And there is a lot of jokes. It is relaxed and laid back and the ward is often very settled. People
here [at Janson] are good people, but it is very guarded. I don’t know ... they don’t appear to
be very happy. [Question as to why it is different here] ... I really don’t have the answer in 4
weeks, [I am too busy] trying to fit in ... I feel left out.

The above informant’s transcript reveals the reality that it was not the unit that
was “difficult,” rather it was that staff were not relaxed, laid back or happy. The
statement by the above informant that Brennan was “often very settled” implies that
Janson was not often very settled. I have proposed that the combined influence of
staff “personalities” and a lack of consistency in Janson’s leadership retarded the
establishment of a supportive, environment in which staff were empowered to “be
the best at what they do.”

For some managers, there was an apparent sadness and, at times, anger as each
told their story of why things had become difficult or why they remain difficult.
The conduct of these interviews and the subsequent analysis of the interview
transcripts presented a number of challenges. The first of these challenges related to
my own ability to maintain an objective perspective in the face of such compelling
accounts from all sides. The second challenge, one that Fine, Weis, Weseen and
Wong (2000) also touch on, relates to the discomfort of representing those who have
been “bad-mouthed” by other informants or those who are critical of others. In
addition to providing a view of how some people experienced the organisation, and
an insight into why one unit is not functioning as was hoped, the following extract
adds a new dimension to Janson’s difficulties. This informant felt that
“consultation” was lacking. A perception of disregard, clearly beginning back in
Port Edward, is carried through to Janson.

When I started there was actually no discussion with me about which unit I was going to, it
was when I was speaking to the relocation officer ... He said which unit do you prefer to go
to and [program manager] just said, oh she is going to Janson, and I said well I actually
thought that we were going to discuss that, and [program manager] said well that is where you
are going. I said okay and I said to [program manager] a bit of discussion would be nice and
[program manager] said well you are going there because it is the one which is going to have
the most problems and you are the one who has got the most experience.
The above vignette is another example of a “backhand” compliment, and raises two recurring issues or themes. First, there is clearly the perception that basic respect had not been forthcoming with regard to choice of work location. Second, in the context of this discussion with the relocation office, the respondent learns that others have already decided that Janson was going to be a problematic unit long before it opened. The respondent is also told (not asked, told) that she is to go into this already identified problem situation and to deal with it because she has the most experience. The above comment also adds another layer to the findings about Janson as an environment. It is clear that Janson was not functioning as hoped, however, it was functioning as expected.

The perception of Janson was always negative, that the unit wasn’t well designed, which I don’t think it is, it is functional but I wouldn’t say it is well designed... They thought it was going to have a lot of problems because there were so many services going in there and nearly everybody from the redevelopment team had a very negative attitude about it. So the whole time I was there everything was really negative... and you know somebody on the redevelopment team told me what a lemon it was going to be, and like you are really doing nothing to engender... any desire to go there.

Janson’s former unit manager also talked about the difficulties she perceived in supporting staff. The impression was that she had to fight very hard for staff against a backdrop of constant cost saving. Thus, despite a unit manager’s best intention to support staff, higher-level constraints, such as budgetary controls, which were applied equally in respect of both Janson and Brennan, often served to undermine this.

When I took it [approval form to do 8 hour shifts] into [name] to sign, [name] basically told me that I should have cut them to 6 hour shifts, I told [name] that if I did that that they would resign, that they were a valuable staff member, that they worked well within the team and I felt that they had a lot to offer... with all the cost saving things they have in place... using casual based staff... not employing anybody so they don’t have to give holidays, sick leave, long service leave... it does an awful lot to [harm] the ward.

Budgeting difficulties are also felt by psychiatrists. For example, Ames and Stafrace (1999, p. 783) discuss with concern the “yearly drive for efficiencies” and
the challenges this poses in terms of the retention of quality staff and maintenance of quality service. Janson's previous unit manager felt that lack of respect for the managers of the aged persons' in-patient units was evident in a proposed move to increase the salary and benefits of their peers who managed the community teams or APATTs. The intimate relationship between respect, retention of staff and provision of resources comes to the fore, once again:

[When it was proposed that] the two team leaders in the APATT could actually get paid more and would receive a car, and I kind of sat there and said well I would be very unhappy with that because you are going to... give them a car and they're managing 4 full time staff, I said I currently manage 44 and I get paid less than every other manager around the table. I don't think that what I do is any less important than any other manager around the table. They said well that is just the way it is. I said well I am here to tell you that if you give cars to the APATT team leaders I am resigning, I am leaving. That is not a threat, I will just go and [Brennan's unit manager] pretty much said the same thing.

The respectful organisation?

From the outsider's perspective, respect constantly resurfaces as a major theme of relevance in this study. One of the strongest messages to appear throughout this study is that provision of appropriate resources, investment in leadership, respectful negotiations and interactions have great potential to empower, but lack of respect contributes to constraint. This message is echoed by Kitson (2001, p. 82), who, in a futuristic vision of nursing leadership in the United Kingdom, discusses the impacts of investments such as "personal development" and "coordination of individual empowerment and development of leadership potential" as being responsible for what patients notice in terms of "order" and "calmness and being "dealt with respectfully and courteously."

Analysis of fieldnotes and interview transcripts from Port Edward, Janson and Brennan reveal instances of both empowerment and constraint: these impact on staff attitudes and actions and ultimately the experience that outsiders and patients have within the unit. Lack of respect among nurses and occupational therapists has constrained the group program. In the process, this constraining lack of support is
likely to have contributed to the resignation of key staff and lack of meaningful occupation for patients. Lack of respect between nurses and personal services assistants has perpetuated constraining routines that have not allowed for individual patient preferences in terms of eating, sleeping and drinking. Less than respectful communications between higher-level management and unit level management has constrained the desire of a unit manager to invest in the new unit beyond its relocation. Constraint perceived by staff is eventually passed on to patients. When patients’ potential to engage in occupation is constrained, staff have more work to do. This “work” revolves around managing the consequences of boredom, the patient’s search for “an optimal level of arousal” (Farnworth, 1998, p. 143), or “overload boredom” (Klapp, cited in Farnworth, 1998) where patients’ negative behaviour may be a result of information overload “experienced as loudness, decoding difficulty. . . .essentially confusion in messages” all to be found in the chaotic environment of Port Edward and Janson units. The observation that one of the units, namely Brennan, is perceived by most people who enter it to be homelike, warm and non-custodial, that its staff report “hidden energies” and its patients sing alongside staff, provides some evidence that empowerment is possible, that respectful relationships may have contributed to the creation of a positive team “ethos.” How can an ethos of respect become established in other teams and what part does unit and program management play in this?

The ability of both employers and employees to raise each other to higher levels of motivation based on a leader’s ability to envision a direction and empower staff to act toward that direction has been called transformational leadership (Burns, 1978; Marquis & Huston, 2000). In relation to nursing practice, autonomy, empowerment and professionalism are stated by Clifford (as cited in Boccino, 1991) to be crucial factors in the attainment of harmonious working environments. Autonomy implies a freedom to act without obstruction. Nurses who are empowered, act in their environment without obstacles and have easy access to essential resources. The highest level of professionalism is likely to be displayed by nurses, and other staff for that matter, who are enabled to accomplish their work without the stresses of inadequate staffing, low pay or having to undertake the work of support staff (Boccino, 1991, p. 8). The attainment of these sorts of conditions falls heavily on the shoulders of unit and program management. Ensuring that
adequate resources exist to enable staff to work unencumbered is, however, only part of the picture. Empowering leadership is also likely to require skilful management, supervision and, perhaps, coaching in relation to individual behaviours and performance. Fears of failure, inability to admit confusion, poor group skills, fierce independence and certain personal beliefs are, according to Wilson (1992), personality features that produce behaviours that may be resistant to the establishment of what many call new cultures, but are probably better described as an ethos. Similar behaviours are discussed in what Bass (1990) calls the emergence of non-functional leadership. A number of informants have already commented on the “type” of nurses who went to Janson, describing them as “the noisy ones” and being “gung-ho.” If this is a reflection of the “fierce independence” and certain ‘personal belief’ that mediate against a change in the ethos of a unit, then it is leadership skills, rather than management ability that were desperately needed post relocation at Janson.

As already highlighted by Brennan’s unit manager, clinical skill is not the crucial ingredient when empowerment or enhancement of staff capacity for professionalism is required. For the units in this study the most likely ingredient is the ability to envision a future and a patient care philosophy that all staff see as not only desirable, but attainable because their individual needs are recognised and addressed, and supportive infrastructure is lobbied for and, in most cases, seen to be provided. This sounds like a simple recipe with only 3 ingredients: vision, personnel management skills and systems building abilities. The perceptions shared by the unit manager charged with creating the new team at Janson reveal the importance of vision, or in this case, how an inability to provide and sustain a vision can be detrimental. The situation at Janson provides a case in point regarding the importance of support for middle level management, that “managers themselves may be the biggest single obstacle to the accomplishment of successful change” (Marquis & Huston, 2000, p. 91). This seems to be a particular threat when managers themselves are not supported. Referring to the needs of managers, Marquis and Huston (2001) state: “because the planning team often overlooks the needs of managers during times of transition, the needs and concerns of staff may be the focus rather than that of managers.” There may be an expectation to “take on the implementation of the new structure with no relief from other duties. There may be
no safe place for managers to question the change” (p. 92). At a symbolic level, Marquis and Huston (2000) states, “during the implementation of change the nursing manager becomes the symbol for the new order. If the nursing managers are confused, threatened by change, or uninformed about the implementation plan, then the manager as symbolic of the process will convey the same message to subordinates” (p 95). Quality patient care and low team stress are consistently related to quality leadership (Firth-Cozens & Mowbray, 2001; Hogan, Raskin, & Fazzini, 1990). Good leadership requires more than performance monitoring within a new organisation. It requires attention to staff wellbeing and “the ways in which staff are used and developed to enhance their strengths” (Firth-Cozens & Mowbray, 2001). As Firth-Cozens and Mowbray (2001, p. 6) suggest, it is this attention that will produce the “real benefits to patient care.” The responsibilities of a unit manager are many and great.

Parker (2000) provides a British view on the difficulty of being a manager during the corporatisation of the National Health Service, and gives some hint of the extra support and resources, both financial and human, that need to be considered if managers themselves are to find rewards in their positions and be good advocates for staff and patients.

Managers in the NHS could never be like managers in industry since they can never make profits to reinvest, all they can do is manipulate an increasingly inadequate amount of resources against continually rising demand – an intrinsically unrewarding occupation (p. 124).

Significant challenges exist for managers within aged psychiatry in Victoria, which to be fair, appear to be a macro level concern beyond that of even senior hospital administrators. In what Ames and Stafrace (1999, p. 783) term “naked ageism” the daily cost for a bed in aged psychiatry is $267, compared to $297 for adult services and $366 per day for child and adolescent services. As Ames and Stafrace (1999) simply observe, the fact that funding for aged psychiatric services, where patients “tend to be more disabled, have multiple co-morbid medical illness and require more assistance with activities of daily living” (p. 783) appears ludicrous.
Other research focusing on health reorganisation confirms a "disillusionment and low trust syndrome" among those working in services experiencing rationalisation or having to engage in competitive tendering (Hart, 1991). The skills of leaders in managing the disillusionment and demoralisation that is known to accompany rationalisation is of considerable importance if positive change is to be effected. Recognition of some of the unrewarding aspects of the job and consideration of the incentives required to support managers was seen by Janson's unit manager to be absent. If it is the case that unit managers are so vital to the optimal functioning of a team, and this is certainly the contention of a number of authors (Donaldson, 2001; Edelson & Lyons, 1985; Firth-Cozens & Mowbray, 2001; Kitson, 2001; Marquis & Huston, 2000; Tichen, 1998; Wilson, 1992), then ways of attracting and rewarding the efforts of good leadership and management, must be entertained, whether these incentives are financial or otherwise.

Thus far I have provided arguments, supported by field data and the literature, that establish the following: occupational engagement, which is crucial to wellbeing, and in this context, is a powerful sign of mental health, is enabled or constrained by the relationships, attitudes and level of support available to staff within aged persons' mental health units. Broader organisational factors in turn, critically affect these issues. Changes throughout the entire system are required. This system includes the local or micro level (i.e., staff routines, practices, relationships), the unit leadership level, the middle, or service management level, and the macro level. At the macro level, sufficient resources to ensure micro level change must accompany state and national policies. In the short term, changes need to focus on supporting unit managers to lead and manage. Provision of appropriate financial resources to enable the work of staff is one element of this support. Unit managers who can lead and manage will empower staff toward a change in team practices that will enable patients to be occupationally engaged while they are within the aged persons' mental health units. Investing in the social capital, the people entrusted to work with our most severely mentally ill older persons make sound financial sense. Mental health policy focusing on aged persons must also be matched with funding that enables staff empowerment. If these changes are successful, then the good practice that results, are more likely to be informing policy.
Reflecting on the findings of this study, and more specifically, the functioning of each of the units, enables consideration of the further changes required. The final chapter makes a definite shift from the presentation and analysis of micro level issues, to macro level concerns. A summary of the status of the units is presented, in addition to a number of macro level strategies that require implementation for successful investment in social capital.
CHAPTER 9

ESTABLISHING AN OCCUPATIONAL MILIEU THROUGH ENHANCING THE ORGANISATION.

In this occupational ethnography, I have used stories from interviews with staff and personal observations as a basis for describing and interpreting the everyday occupational experiences of staff and patients of three aged persons' mental health units. One of the reasons I did this, was to make a comparison of these units in terms of how occupationally engaging and/or constraining each was. Through these stories it is clear that one unit, Janson, is not operating in a manner that could be described as occupationally engaging. Brennan unit, on the other hand, provides a stark contrast. The comparatively engaging environment at Brennan provides sufficient clues as to what needs to happen to alter the custodial and restrictive environments that Port Edward (to a large extent) was, and Janson appears.

Starting with Chapter 6, a description and interpretation of the micro-level issues associated with ward staff (PSAs and Nurses) laid the foundation for understanding the habitual, 24 hour nature of the units, and the concerns associated with the largest single group of staff on the unit. At Port Edward and Janson, a strong hierarchy was evident; PSAs were subservient to nurses, were sidelined in much of the decision making on the unit, but interestingly, welded substantial power that served to perpetuate the institutional nature of Port Edward and Janson. In Chapter 7, the next organisational layer was presented, and through this the story of social workers, occupational therapists and psychiatrists was told. Not only is a strengthening hierarchy evident, for example when considering the position of doctors in relation to nurses, but so too is the growing complexity of strained inter-disciplinary relationships between, for example, the occupational therapists and nurses. These layers of complexity, built around mainly micro level concerns, are, by the time we reach Chapter 8, overlaid with increasingly macro level issues. In this case those higher order issues are associated with leadership.
This final Chapter culminates in a discussion of what are, arguably, macro level issues, and specifically, how organisational level policy, and its strategic elements must be framed and practically implemented to enable the establishment of an adaptive occupational milieu.

Current organisational status and occupational environment

In Chapter 1, I stated that my reasons for engaging in this study were to describe and analyse the ways in which staff and patients' occupations were either enabled or constrained by the occupational environment and to provide interpretations for each alternative. As the study progressed, I became more focused on the occupations, attitudes and relationships of and between staff, and it became increasingly apparent to me that these factors determined how engaged patients were in their environment. In using the term “engaged” I am referring to patients’ general level of alertness or awareness of what was going on around them, and, at an even higher level, patients’ ability to respond to what they were aware of, the activities on offer to them, and/or their ability to spontaneously engage in chosen occupations. I have also stated, as supported by other authors, that these elements may be thought of as indicators of well-being often associated with health.

I searched for evidence that the physical environment might be the crucial factor, but my field experiences and evidence from informants continued to draw me toward the social environment, the staff-patient and staff-staff interactions. One throwaway but memorable remark from one of the staff members sticks in my mind: “I don’t think it’s the environment, I reckon if you threw me and [nurse] together in a barn we could run a perfectly good unit.”

Having completed fieldwork, my “picture” of the 3 units casts Port Edward as the large institutional unit, which at times in its history provided what I would describe as an occupationally enabling environment, but within current socio-political and economic contexts could no longer be maintained. Janson and Brennan units were hoped to embody what was required from a strategic (policy) perspective: small-scale, non-institutional, non-custodial, home-like units, situated among other
everyday health care services. The two new units are certainly smaller and are situated within mainstream health facilities, however the two are starkly different. Brennan, a home-like unit, has managed to establish a non-restrictive and occupationally engaging environment, that with continued attention to service and staff development, can be maintained. At Brennan there are good foundations, and a new ethos exists. In comparing Brennan’s features with those of both Janson and the predecessor unit, Port Edward, at present Janson lacks many of the features that are required to build organisational and, in turn, occupational capacity. Janson is not an occupationally engaging milieu. Given this, it is clear that relocation/decentralisation alone does not necessarily result in enhanced occupational engagement for staff or patients. It is my contention, and that of many others (e.g., NSW Health Department, 2001; Donaldson, 2001; Paul, 1995; Pettigrew, Ferlie, & McKee, 1992) that significant organisational thought and planning is required to ensure that the hoped for gains of physical change (relocation/decentralisation) do in fact result in positive outcomes. This study has shown that physical change that omits strategic organisational capacity building is insufficient. Significant commitment, which begins with recognition that staff capacity is worth building, and must consciously be planned and invested in at multiple levels of the organisation, must accompany the actual relocation/decentralisation process. This study finds that while thought went into planning the physical move, strategic thought as to how to build on staff capacity to provide enhanced care was not as carefully considered. A number of informants in this study also reveal that consultation and engagement of staff in the change process was perhaps not as extensive as would be ideal. There are a likely to be a number of reasons for this, including the possibility that service planners/managers did not wish to burden staff with the complex strategic and operational issues associated with the change, particularly when patient care needed to be maintained throughout the process. Despite this possibility, staff empowerment through being more engaged in the occupation directly linked to change in the units appears to have been a critical need. Organisational change that will enable enhanced care and promote an occupationally engaging environment, an occupational milieu, is now required, as is thought regarding how staff will be engaged in this process.
The evidence and analyses presented regarding Janson paints the picture of a troubled unit, a unit that is operating, but in a manner that regards patients and the related work variously as “very busy and chaotic” and “cold and lonely.” At Janson the “inappropriate patients,” the “negative energy” of the ward and “managers who aren’t prepared to make a stand” or who are the program manager’s “lackey” mean that staff respond as best they can in a unit that has remained a hospital ward in more ways than one. I have presented examples of nursing and other staff practices in all three units that I have found personally inspiring, however at Janson, it appears to be less an issue of staff skill and capacity, but more the ability of the current organisational environment to recognise, organise and build on that capacity. The chapters of this thesis have highlighted examples of occupationally enabling and constraining resource allocations, relationships, routines, and leadership approaches. The history of the service reveals a gradual rise to glory, seen through the birth of a new aged persons’ mental health specialty, investment in the learning and development of staff, expansion of resources and trials of new treatment approaches, for example the Dementia Management Program at Port Edward. Recent history now reveals, for many staff, a perception of erosion of those gains, with the negative consequences being revealed in Janson unit. Pertinent questions are: How can an occupational “milieu” be created in Janson and maintained in Brennan? What organisational commitments are required to build the milieu?

From micro to macro: Building the milieu

Each Chapter of this thesis helps build the organisational picture that has emerged. At a micro level, it is clear that the work of PSAs and their relationships with others is crucial. At the increasingly macro level, it is clear that sufficient resources, respectful relationships and perceived professional support is required to enable interdisciplinary cooperation between ward staff, allied health and psychiatry. Without this cooperation and a shared vision of what is important and how it will be achieved, it is unlikely that an occupational milieu can be established or maintained. The role of leadership in enabling this is crucial. But how is good leadership enabled? What broader organisational level issues must be addressed so that the day-to-day running of the units does not result in occupational constraint, and contributes to the well-being of both staff and patients?
In this final chapter, I wish to present a framework, or more accurately, an “influence diagram” (Iles & Sutherland, 2001) that describes the interrelationships between key factors that I believe, given the findings of this study, determine whether an environment is constraining or enabling of patients’ occupations. I have called this framework “Establishing an Occupational Milieu through Organisational Capacity Building.” This framework portrays the occupational environment as being comprised of patients who depend on staff to engage in certain occupations in certain ways, if they are to engage to their ideal capacity. As this aspect of the diagram is not hierarchically organised, it simultaneously attempts to portray that patient behaviours, which may be a symptom of their illness or a response to constraint, can feedback and determine staff occupations (i.e., use of medication as a staff occupational response to patient aggression). Put simply, staff and patients influence each other. Together, they are the occupational environment. The diagram also attempts to portray that the occupational environment can be influenced, positively or negatively by certain organisational elements, such as leadership and partnerships. This aspect of the framework (see Figure 14) is informed by work commenced within the fields of health promotion relating to capacity building, and acknowledges the fact that the individuals within the system cannot be viewed as separate from the system. It also acknowledges that the organisation can contribute positively to the occupational environment through its attention to resources and staff development. At an even broader level, the organisation is depicted as being embedded within a socio-political and historic context that can impact on the organisation’s capacity to support its staff.

Included in the next few pages are findings and questions that help demonstrate why organisational level capacity building concepts are relevant at an individual occupation level. How I have structured the framework is a representation of how these theoretical concepts have helped me visualise the impact or influence of certain elements on the occupations of staff and patients. Organisational policy that addresses elements of the framework should now, as a priority, be developed.
Factoring-in organisational and occupational concepts

In order to understand this framework and its application in this case, and possibly others, we need to first explore a few core contemporary concepts. These concepts are central to the implementation of strategies which will enhance the organisation. In essence, these concepts and strategies are fundamentally related to the notion of capacity building, and it is through capacity building that the occupational milieu will be established. As outlined in Chapter 3, I began actively working from a capacity building framework as part of my work as a policy analyst for NSW Health. This work coincided with the final stages of analysis in this study. This framework, which enabled me to plan and develop projects that would identify the barriers to, and build the capacity of services to respond to drug and alcohol problems, resonated strongly with what I felt was missing in the units, and what I felt needed to be addressed within the organisation that I was formally studying.
What is Organisational development?

A crucial pre-requisite to change and growth is an organisation’s capacity to respond and learn (Senge, 1990). Systems, policies, procedures and practices that complement the organisation’s “purpose, role, values and objectives” (NSW Health Department, 2001, p. 10), will enable staff to be supported in their work, to think of new ways of working and to act strategically. If systems do not support the roles of staff or the objectives of teams, valuable skills and knowledge will be under-utilised and staff may perceive that their contribution is not valued. These staff may leave the organisation. Issues for consideration in organisational change include: identifying external factors impinging on the work of staff and the service, role clarification for staff, recognition of the supports and systems staff require to fulfil roles, and attention to the relationship and communication between groups of staff. Some of the strategies include: the development of policies and strategic plans that
support goals and roles of the institution and its employees, including ensuring funding is available to support these, legitimising activity toward valued personal and organisation goals, and roles by formally acknowledging these in job descriptions. A staff development system that starts with acknowledging what staff value, are proud of, or do well, is required in order to ensure that there is staff "buy-in" for a system that is as much about staff and what they need, as it is about the organisation and what it needs. A system that focuses on what staff do well, and what help they need to continue to do well, frames the process less from a "deficit" perspective and more from an "assets" perspective. This orientation is consistent with the belief that capacity exists and needs to be acknowledged, supported and built. It is also consistent with holistic and client-centred occupational assessment frameworks (Fearing, 2000; Law, 1998) that start with ascertaining clients' strengths rather than narrowing in on weaknesses.

Clear evidence of ongoing organisational problems exists within Janson unit. Inadequate role support and interdisciplinary relationships culminated in the resignation of the occupational therapist and unit manager within several months of the move from Port Edward. Achievement of key elements of the aged persons' mental health program "model of care" relating to the provision of a least restrictive environment, the utilisation of existing capacities, and encouragement of improved functioning was severely challenged in the absence of a well developed team wide approach to the group program and inadequate leadership development systems among all staff. Protocols formalising action toward "least restrictive practice" as expressed, for example, in the practice of PSAs and ward staff around meal times are just one visible example of the need for ongoing development to formalise practical daily staff action toward organisational values and goals. In this study, I have suggested that the organisation should formally adopt values and goals based around the notion of the "occupational milieu", a total environment approach that provides opportunities for engaging in occupations that hold meaning, and maintain or build skills that promote health and well-being. A formalised organisational orientation to this approach, with attention to other capacity building strategies such as workforce development, leadership, resource and partnership building will promote a more home-like and less restrictive environment for patients, and the sort
of learning and supportive environment for staff that will be necessary to maintain this.

Workforce development

Processes that ensure that workers have the skills and knowledge to contribute to organisational goals and values are referred to as workforce development strategies and include formal, informal and incidental learning (NSW Health Department, 2001). Apart from processes and resources to assist staff to identify and/or engage in necessary graduate and postgraduate courses, seminars, workshops, conferences and in-service programs, a whole range of on-the job-learning opportunities are required to enable people to “question, experiment, adapt and innovate on behalf of the organization” (Argyris, 1999, p. 4). Some of these opportunities include staff rotation and secondments, formal supervision, the establishment of mentoring programs, encouragement and assistance to set up peer support systems, monthly journal clubs, and pairing new or junior staff with more experienced clinicians in mentoring type arrangements. Each organisation possesses novice and expert practitioners (Dreyfus & Dreyfus, 1986; Schell & Cervero, 1993) and a wealth of combined skill and knowledge. How an organisation utilises, shares and further develops these resources within the organisation requires vision, commitment and a recognition that workforce development involves far more than formal off-site training. The loss of the Clinical Nurse Specialist position at Port Edward Unit is a specific example of an organisational change that threatened workforce development among nurses. Ongoing supervision and staff development problems highlighted by occupational therapists and social workers, where discipline staff structures do not favour the retention of highly skilled senior therapists, are other examples of how workforce development issues impact on capacity building.

Resource allocation

This dimension of capacity building includes the provision of human, and non-human resources, including “people, physical space, administrative support,
planning tools and financial support" (NSW Health Department, 2001, p. 14). A few of the many questions that could be posed in relation to enhancing occupational capacity among staff include: Are the units staffed to a level adequate for “doing and being with” patients, as opposed to merely “doing to” patients? Do appropriate resources exist to facilitate a “meeting of the minds” between staff and patients? This state, as Hasselkus (1997) tells us, is of crucial importance in the creation of occupational space and place, but, do staff have time to go there? Are staffing levels among disciplines adequate to allow all staff to be involved in unit programs focusing on occupational engagement (i.e., the group program)? Does appropriate physical space exist to engage in occupation? Do staff have ongoing access to information (best practice, literature reviews and research findings) that promotes the patient management benefits that might result from occupational engagement? Appropriate resource allocation is undoubtedly the most basic and fundamental capacity building element, a major macro level concern impacting on the quality of services for a very vulnerable health consumer. Adequate funding for aged mental health, that takes into account the co-morbid, and frequently multi-morbid nature of the population (Ames & Stafrace, 1999), must be addressed at a state and national level.

Leadership

This concept, discussed in Chapter 8, focuses on “vision” and the motivation of others toward that vision. Key elements that expand on this include the ability to think systemically and strategically and to promote creativity and innovation in others. In addition, sound leaders require skills in communication, an ability to use policy development process to influence and support the change needed to build staff and patient occupational capacity and an ability and willingness to foster a team “learning” ethos that favours dialogue and discussion (NSW Health Department, 2001).

The current Nursing Union position in Australia requires that hospital based inpatient units must be managed by personnel with a nursing background. Despite this, discussion must be commenced, with a view to broadening the requirements in relation to the background of the unit manager. This study indicates that the ingredients necessary for good leadership in a multidisciplinary environment are not restricted to the nursing profession, particularly when an associate charge nurse who
is able to take clinical leadership for the shift leads each shift. Good clinicians are not necessarily good leaders or managers (Donaldson, 2001; Schell & Cervero, 1993). Opening up the leadership of units to individuals who have proven leadership and managerial capacity, rather than proven clinical ability, requires urgent consideration by services and representative unions. An alternative strategy, and one that is recommended, is that a leadership program that develops core leadership skills in a range of unit staff be offered. As Donaldson (2001) suggests, drawing a person from the ranks when the job is difficult to fill is a haphazard way of developing leaders. As I have maintained, Donaldson also states “truly effective leadership and clinical management demands a more systematic approach” (Donaldson, 2001, p. 11).

**Partnership building**

The development of alliances, intersectoral collaboration and coalitions are all geared toward capitalising on “each organisation’s unique strengths, to work together to achieve shared or related goals that neither could achieve as well by working alone” (NSW Health Department, 2001, p. 18). Key issues regarding the integration of both the new aged mental health units exist. Challenges include how each unit will become more “mainstreamed” within their respective health care environments, so that neither unit remains an isolated psychiatric unit tacked onto, and in Janson’s case “tucked down the back of,” general health care facilities. Consultations with other on-site health services and the development of “Memoranda of Understanding” regarding the collaborative use of resources in a way that promotes the mainstreaming of all clients of the broader health facility, needs to be explored and progressed as part of each unit’s strategic plan. A need to develop partnerships within the organisation is also evident through this study. The limited nature of an interdisciplinary approach to the work of the units (for example between nurses and occupational therapists), suggests that strategies for building internal staff partnerships will be a crucial component of an overall capacity building effort.
Building Capacity

Building capacity requires attention to organisational development, workforce development, resource provision, leadership and partnership building. The addition of new managerial levels within the health sector, staffed overwhelmingly by nurses trained to work directly with patients (Donaldson, 2001), demands consideration of the personnel, preparation and support systems required to create a sustainable and empowering working environment for staff and an occupationallly engaging treatment environment for patients. Attention to systems of support that will allow the organisation to grow and to “learn” are vital to the sustainability of any positive change. As an occupational therapist, I have considered the notion of “capacity building” through my own occupational “lens”, thus while the idea of capacity building is not new, I am reframing it, bringing an occupational perspective to it. In terms of capacity building, a pertinent question, framed, or asked from an occupational perspective, might well be: What approach is required to build and maintain the capacity of the organisation to support staff and patient’ occupations? Capacity building, as an organising framework, is worthy of consideration as a guide to enabling much of the change and maintenance that is required in treatment environments such as Janson. A framework extended by NSW Health (2000) states:

capacity building occurs both within programs or more broadly within systems and leads to greater capacity of people, organisations and communities to promote health. This means that capacity building activities may be developed with individuals, groups, teams, organisations, inter-organisational coalitions, or communities. (p. 3)

The notion of capacity building in community health is far from innovative. It is a key approach promoted in the Ottawa Charter for Health Promotion (World Health Organisation, 1986). Its consideration as a framework for organisational change within acute healthcare settings, such as an in-patient mental health unit may, however, be new. In reference to health sector reform, Paul (1995) discusses capacity building in terms of expansion or upgrading the “stock” of human and institutional capabilities. Of health reforms such as decentralisation that may be likened to the changes occurring within the Portside Healthcare Network, Paul (1995) states that what is required to see the reform though is “the capability to
assess and design organizational structures, systems and processes, to create a sustainable financial framework and to motivate and manage people at differing levels" (p. 6). In recognition that context is an important element in any program or community, a capacity building approach does not attempt to prescribe particular changes that organisations can make, however, dimensions of capacity building and broad strategies can provide a guide to service change. Broad capacity building dimensions outlined by NSW Health (2000) reflect concepts similar to those outlined by Paul (1995) and include: organisational development, workforce development, resource allocation, leadership and partnership development. These strategies provide a clear guide for capacity building and are suggested to have particular utility for the Portside Aged Persons’ Mental Health units.

Establishing an Occupational Milieu through Capacity Building:

Summarising ideas.

Many of the current theoretical frameworks employed to guide the work of occupational therapists and other health workers in acute inpatient treatment environments focus on what is done “to” and “with” the patient, rather than consideration of how staff relationships and practices, mediated by the organisational environment, may be utilised. The philosophies and principles on which “milieu therapy” (Gunderson, 1978; Taft et al., 1993) is organised go some way toward this ideal. Such environments are specifically structured to draw out desired behaviours, and as Taft et al. (1993) state it is the relationships within the social environment – rather than the architecture and interior design of the physical environment that create a therapeutic milieu. Even these environments however, are at risk of failure in the absence of many of the capacity building notions discussed in this chapter. The occupational milieu demands a strong foundation that goes far beyond the skills of direct care staff. It is my contention that the environment within an in-patient unit is critically related to the current capacities of an organisation and this determines the level of occupational engagement. Described alternatively, the occupational capacity that exists within an inpatient unit is directly related to the
unit’s organisational status. In the occupational milieu that I propose, the environment is consciously structured to arouse the interests of people to engage in the sorts of meaningful activities that utilise, and develop (where possible) their underlying capacities, enabling them to experience well-being and a sense of personhood. A commitment to building the capacity of the organisation to support the occupational milieu is vital.

Occupational therapists: Supporting the maintenance of the occupational environment in collaboration with others.

A well functioning occupational milieu will require development of routines that create (optimal) occupational demands for patients. These demands should be systematically planned and formally recognised as a responsibility of the entire team. Occupational therapists have a major role to play in identifying opportunities within usual care routines that allow patients to take a more active role. With the assistance and legitimate leadership role vested in the Unit Manager, occupational therapists can model “engaging routines” as part of the daily operation of the unit, which involve other staff in an extension of their usual roles, rather than as “helpers” in an occupational therapy group. As an example, a “self-catering” breakfast routine, where 8-10 patients are enabled to make choices about, prepare and clear up after breakfast, could be established as an everyday event in the unit. In this routine, which would run alongside the usual catered breakfast in the main part of the unit, a PSA, nurse and occupational therapist or even medical registrar, would be available to enable a number of the patients to maintain a sense of independence or to gain new skills that might prepare them for discharge from the unit. The sorts of goals of such a group might include to “enable members of the multidisciplinary team to assess function”, “encourage normal breakfast conversation”, “make choices about what to have and when” and “carry out simple food preparation tasks”. The Unit Manager would be required to legitimise this unit routine among medical, nursing and PSA staff, formalising it within a roster and negotiating altered timing for the start of breakfast as necessary.
A final word on the research and its findings

As an occupational therapist and scholar with an interest in occupational science, I have explored occupational issues as they occur across a number of health sites. I have focused on ascertaining the meaning that a number of people and disciplines associate with their day-to-day occupations within an aged persons’ mental health unit, and I have used the field-based approach of ethnography, as the most suitable method of inquiry into the occupational issues related to this study. In earlier chapters, ethnography is discussed in dual terms as both process and product. As process, it is most often thought of as the inquiry process of choice for anthropologists. Clearly, I am not an anthropologist, and I have not invented a new type of ethnography. This is not an anthropological ethnography. In terms of product, I have written an “occupational ethnography”.

As a process of inquiry and a product, this occupational ethnography establishes the important role that interpretive, meaning-generating research methodologies play within discipline specific research fields such as occupational therapy and the health and human services evaluation field. While no theories have been verified, a way forward for in-patient aged mental health service policy development and practice at the organisational level has been presented. The importance of establishing an occupational milieu within this and other health and social service programs has been stated, and as a framework for engagement-oriented practice that focuses on establishing well-being, it is compatible with current policy direction associated with least-restrictive practice. In the absence of coherent organisational policy, which is, in turn, a reflection of the adequacy of state and national policy, and its associated funding, a number of the challenges highlighted through this study will remain, and the “cost” to staff and patients will continue to be felt.

This study recommends that if an occupational milieu is to be established, the organisational capacity must be built. A number of clear strategies associated with capacity building have been outlined and these relate to organisation and workforce development, leadership, resource provision and partnership building. It is recommended that individual development projects associated with each of the key capacity building areas be initiated. Evaluations relating to the outcomes of these projects, using mixed methodology, (incorporating qualitative data gathering and
quantitative measurements) would be a natural progression of this ethnographic study. Measurement of changes associated with such projects may include, care practices, level of social distance between staff and patients and the amount of occupational/social activities provided and attended. In the event that a strategic capacity building project is undertaken, as suggested through this study, a replication of this study as conducted would also be warranted. Project development and associated outcome measurement could also be readily applied in other closed ward environments catering to similar clients, for example, extended care psychogeriatric facilities (nursing homes).

Improvements directed towards staff can have a flow over effect that results in better service for patients. What is presented here has implications for a broad range of environments and should be considered in the evaluation of all kinds of service systems.
REFERENCES


APPENDICES
THE PORTSIDE AGED PERSONS' MENTAL HEALTH SERVICES PROJECT

Project Directors – Tracy Fortune and Maureen H. Fitzgerald

INFORMATION SHEET

This is a study of the places in which aged persons' mental health services are offered. It is directed by Tracy Fortune, an occupational therapist, and supervised by Dr. Maureen Fitzgerald, a medical anthropologist, from the University of Sydney, School of Occupation and Leisure Sciences.

The purpose of this study is to better understand how the places in which mental health services are offered, impact on the service that people receive while they are in them. We wish to learn about such things as how the physical environment helps people to go about their daily activities. We are also interested in learning about the ways in which the organisation and daily running of the unit help with this. As this service will be moving to a new location, we hope to explore some of the differences between this unit and the new unit. The goal of this study is to help health professionals and managers of mental health services to structure and plan services in a way that is least restrictive for people and allows them to feel less disrupted when they come into places such as an acute unit.

We feel that the best way to do this is by having people, such as patients and their families, health professionals and service planners, talk about their experiences and views about both places. By talking with many people related to both places we hope to understand their perspectives as to how these places and the things that happen in them can help or hinder them in the things that they do. Many of the conversations that Tracy has with you will be quite casual, perhaps while you are going about your everyday activities. These will be things like meetings, group or other therapy activities, getting ready for the day, or resting and recreating in the unit. Tracy also plans to interview people. For these more formal discussions she may find a quiet place and with your permission, she may wish to tape record the interview.
Other ways in which we can understand the service and how it works is by observing and participating in many of the things that occur within it everyday. Tracy may also learn more about how and why things happen by reading public documents and, in some cases, some people’s files. Finally, to help record information about the unit Tracy may use a standard or a video camera and take photographs of places and people. If these are to be used in any way other than helping Tracy to learn about the unit (for example in reports about the project), then this use will be explained to you and your permission will be sought before they are used.

Your identity and that of others will not be revealed as a result of any conversations, interviews, or observations. Even photographs and videos can be changed with computers to maintain your anonymity. You are free to withdraw from this study at any time and your withdrawal will not affect your access to any services.

All of the notes, photographs, or tapes collected during this research will be securely stored and they will be kept for at least seven years.

This study will also assist one of the project directors, Tracy Fortune, in her PhD studies. Some of the information may also be used to help in teaching health professionals as Tracy and Maureen are involved in the education and training of health professionals.

If you wish to have more information about this study, please call Tracy Fortune on 02 60 516 751 or Dr Fitzgerald at the School of Occupational Therapy on 02 9 351 9216.

Researchers or participants in research who have any concerns or complaints may write to the Chairperson of the Ethics Committee, (Portside). You may also contact the Secretary of the Human Ethics Committee, University of Sydney on 02 9 351 4811.

NOTE: The National Health and Medical research Council (NH &MRC) in the statement on Human experimentation 1992, require ethics committees to monitor approved projects principally to ensure that their conduct is not jeopardising the rights and interests of those who have consented to take part as subjects (1)

The method of monitoring required by the NH & MRC is as follows:

Until completion of the research project the Committee shall –

1. Require that at regular periods, and not less frequently than annually the principal investigators shall provide reports on matters including
- security of records
- compliance with approved consent procedures and documentation
- compliance with other special considerations

2. Require as a condition of approval of the protocol, that investigators report immediately anything, which might affect ethical acceptance of the protocol. Including:

- adverse effect on subjects
- proposed changes in the protocol
- unforeseen events that might affect continued ethical acceptability of the project

3. Establish confidential mechanisms for receiving complaints or reports on the conduct of the project (2)

(1) NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL: GUIDELINES FOR THE MONITORING OF RESEARCH BY INSTITUTIONAL ETHICS COMMITTEES, NOVEMBER 1992

(2) NH & MRC STATEMENT ON HUMAN EXPERIMENTATION, SUPPLEMENTARY NOTES, PAGE 7, NOVEMBER 1992.
BEHAVIOURAL AND PSYCHIATRIC ETHICS COMMITTEE

(Address)

CONSENT/REQUEST TO PARTICIPATE IN A RESEARCH PROJECT

TITLE OF RESEARCH PROJECT: “The Portside Aged Persons’ Mental Health Service Project”

RESEARCHER:

I, Tracy Fortune CERTIFY THAT I have fully explained the aims, risks, and procedures of the research to the PARTICIPANT/PATIENT named herein (or to the lawful guardian of such patient) and have handed to the PARTICIPANT/PATIENT (or guardian) a copy of this Consent together with a PLAIN ENGLISH STATEMENT of aims and procedures of the research and any risks to the PARTICIPANT/PATIENT.

In my opinion, the PARTICIPANT/PATIENT (or lawful guardian thereof) appears to understand and wishes to participate.

I undertake to the PARTICIPANT/PATIENT (or lawful guardian thereof) that the confidentiality and anonymity of the PARTICIPANT/PATIENT and his or her record will be preserved at all times.

In the case of a PATIENT under involuntary status (Mental Health Act) I undertake to inform the relative named in accordance with the express wish of the PATIENT as set out below.

SIGNED...........................................................................................................

DATE........................................

CONSENT OF PARTICIPANT/PATIENT OR PRIMARY CARER

The purpose of the above project has been fully explained to me and I have read and signed the attached PLAIN ENGLISH STATEMENT. I UNDERSTAND the aims and procedures of the research and any risks to myself, which are involved, and I REQUEST to participate on condition that I can withdraw my consent at any time.
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<tr>
<th>Permission</th>
<th>Yes</th>
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<td>To be interviewed</td>
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<td>For the researcher to take photographs/videos</td>
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Please note: Further consent will be obtained in the event the researcher wishes to USE any photographs or videotape footage for a purpose other than that directly related to the research (for example in publications or teaching).

**You may refuse or withdraw your permission to participate in any of the above activities at any time.**

Signed: .............................................................. Date: .................
GUARDIAN appointed under GUARDIANSHIP AND ADMINISTRATION BOARD ACT to sign.

SIGNED:

..................................................................................................................................................

(Guardian for patient)

DATE:......................................................

FOR SUBJECTS UNDER SECTION 12

I, .................................................................................................................. DO/DO NOT (cross out which does not apply) wish for my relative
.................................................................................................................. to be informed of my participation in this research.

Relative Notified:.................................................. Date:.........................

Signed...........................................................

WITNESS OF PATIENT'S SIGNATURE

I, .................................................................................................................. of
..................................................................................................................

as an independent witness confirm that the aims and procedures of the research and any risks to the Participant/Patient has been adequately explained to the PARTICIPANT/PATIENT whose signature I witness. In my opinion, he/she appears to understand and wishes to participate.

Signed:.................................................. Date:.........................
CONSENT FOR THE USE OF VIDEOTAPE FOOTAGE AND/OR PHOTOGRAPHS

TITLE OF RESEARCH PROJECT: “The Portside Aged Persons’ Mental Health Service Project

I, .......................................................................................................................... CERTIFY that I have given permission for the researcher to use:

PHOTOGRAPHS in which I am depicted yes no

VIDEOTAPE FOOTAGE in which I am depicted yes no

For the purposes of publication and teaching.

I also understand that my identity may be disguised if I wish it to be.

Please DO NOT DO (circle appropriate) disguise my identity.

SIGNED: .................................................................

DATE: ..............................................................

(This form to be distributed only to those for whom permission to use photographic or video material is sought for reasons other than those directly related to data collection and analysis)