Patient and Staff Perceptions of Medication Administration and Locked Entrance Doors at Psychiatric Wards

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Abstract

The general aim was, within psychiatric inpatient care, to explore patient and staff perceptions with regard to medication administration and locked entrance doors. In Study I, medication administration was illuminated according to a mini-ethnographic approach. Nurses and voluntarily admitted patients were observed and interviewed. Two central categories of patient and nurse experiences were identified, get control and leave control. In Study II, patients and nurses were interviewed about patient experiences of forced medication. Identified experiences were related to the disease, being forcibly medicated, and the drug. In Study III, the frequency of and reasons for locked entrance doors on Swedish psychiatric inpatient wards were investigated. Seventy three per cent of the doors were locked on a specific day. According to ward managers, doors were most often locked in order to prevent patients from escaping, provide security and safety, and because legalisation. In Study IV/V, voluntarily admitted patients/mental nurse assistants and nurses were interviewed about advantages and disadvantages about being cared for/working on a psychiatric inpatient ward with a locked entrance door. Most advantages mentioned by patients and staff were categorised as protection against "the outside", secure and efficient care, and control over patients. Most disadvantages mentioned by patients were categorised as confinement, dependence on the staff, and emotional problems for patients. Most disadvantages mentioned by staff were categorised as extra work, confinement, dependence on the staff, and a non-caring environment. In conclusion, medication administration and locked entrance doors are perceived as connected with staff’s control and restricted freedom for patients. Increased reflection among staff about how medication administration and locked entrance doors are perceived by patients would increase staff’s possibilities to prevent potential experiences of coercion due to these situations among patients in psychiatric inpatient care.

Keywords: forced medication, locked ward, medication administration, patient, perception, psychiatry, staff

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“... but psychiatry has yet another dimension”.

Lisa Ekselius
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Introduction

The thesis is focused on two complex and challenging situations within psychiatric inpatient care, medication administration and locked entrance doors. The situations imply control and restriction of freedom, and may be perceived as restraining (Ashcroft-Simpson, 1999; Hall 2004). Even though the situations have been identified as causing ethical concerns among staff (Lützén, 1998; Lind et al., 2004), as well as conflicts between patients and staff (Bowers, Simpson & Alexander, 2003), patient and staff experiences and perceptions with regard to the situations have been studied only to a very limited extent. Patients and staff - in this thesis the term staff refers to nurses and mental nursing assistants - are the ones most involved in the described situations. Therefore this thesis is focused on patients, nurses, and mental nurse assistants’ experiences and perceptions with regard to medication administration and locked entrance doors.

Laws and regulations

Health care personnel, i.e. all professions working within health care, are according to the Swedish Health and Medical Service Act (Svensk Författningssamling, 1982:763), obliged to provide secure and good quality care, promote good interpersonal contacts with patients, respect patients’ integrity, and involve patients in their care. Autonomy is a prestigious word in the Health and Medical Service Act (Svensk Författningssamling 1982:763). However, in specific cases, psychiatric inpatient care has the possibility and responsibility to constrain patients’ autonomy with the use of formal coercion. Complementary laws that regulate formal coercion are the Compulsory Mental Care Act and the Forensic Mental Care Act (Svensk Författningssamling, 1991:1128; 1991:1129). The purpose of formal coercion is to make treatment possible and to protect patients from harming themselves and/or others. Like the care of voluntary patients, the care of committed patients must always be in the best interest of the patient and safeguarding the human dignity and legal rights of the patient.
Ethics and ethic declarations

Laws regulate psychiatric care, but the individual judgement of psychiatrists and staff in determining what is correct and appropriate is also of importance. To find the optimal treatment strategies, to guarantee a patient the best available care, which also is least restrictive to a patient’s freedom, is a common ethical dilemma in psychiatric care. Therefore, there are ethical documents set out to guide the care.

The Madrid Declaration on Ethical Standards for Psychiatric Practice was approved by the World Psychiatric Association in 1996 (World Psychiatric Association, 1996) and is based on The Declaration of Hawaii (World Psychiatric Association, 1977). The declaration has been updated to reflect changing social attitudes and new medical developments. In the declaration, it is concluded that psychiatry is a medical discipline concerned with the provision of the best treatment for mental disorders, rehabilitation of individuals suffering from mental illness, and with promotion of mental health. It is also concluded that patients should be given the therapeutic interventions that are least restrictive to their freedom.

The International Code of Ethics, approved by the International Council of Nurses (1953), was adopted in 1953 and is updated at various times. The code concerns nurses in all health care specialities, psychiatric care included. It declares that nurses shall alleviate suffering, treat patients with respect and promote an environment in which patients’ human rights, values, customs, and spiritual beliefs are respected.

Psychiatric inpatient care

After the Second World War, psychiatric care strove towards increased freedom for patients and individualization of the care (Ryan, 1962). The opening of entrance doors at wards was considered as a step, as keys and locked doors were perceived to destroy the relationship between patients and staff (Cobb & Gossop, 1976). Later, several mental hospitals in many western countries closed down and acute psychiatric inpatient care was provided at general hospitals. Today, patients at psychiatric wards, even those with severe psychiatric disturbances, mostly receive short-time care. Most often the care is sub-specialised or geographically organised with both voluntary and committed patients on the wards.

Bowers (2005) has reported seven main reasons for psychiatric inpatient admission: dangerousness, assessment, medical treatment, severe mental disorder, self-care deficits, respite for relatives, and respite for the patient. Dangerousness, to oneself and others, is according to Bowers (2005) the most frequent reason for admission.
The number of beds in Swedish psychiatric care decreased from approximately 27,400 in 1964 (with a population of 7.6 million) (Ekblom, 1970) to approximately 4,500 in 2004 (with a population of 9 million) (Statistisk Årsbok för Landsting, 2005).

During six months in 2001, Sweden had 2,900 finished care episodes according to the Compulsory Mental Care Act (Socialstyrelsen, 2001a). Even though Sweden has a joint legislation, there are considerable local differences between different hospitals, with regard to the number of coercive care episodes and coercive measures (Socialstyrelsen, 2001a; Kjellin, et al., 2004).

**Staff’s working situation in psychiatric inpatient care**

Staff can be considered as the “backbone” of psychiatric inpatient wards (Berg & Hallberg, 2000; Cleary, 2004). The staff is obliged to maintain safety on the ward (Fourie et al., 2005) and maintain institutional rules and norms. Further, to observe, handle dangerous behaviour by patients (Alexander & Bowers, 2004), and sometimes carry out coercive measures. Staff is also obliged to provide basic care, interact with and develop trustful relationships with patients (Bowers, 2005). The working situation is complex, has an unpredictable character, and the staff has to balance between ideals and the reality of daily work. For example, short care periods may create stress among staff, especially when their work mainly consists of reporting on observed symptoms and controlling patients’ behaviour and less of interpersonal contact (Hummelvoll & Severinsson, 2001).

**Patient experiences with regard to being cared for in psychiatric inpatient care**

Patients’ experiences of the psychiatric inpatient care have been described in a number of studies and show that the care can be experienced in many different ways. Patients have described the following aspects as positive with regard to being cared for in psychiatric inpatient care: feeling secure (Samuelsson et al., 2000; Thomas, Shattell & Martin, 2002), protected from vulnerability and empowered to cope with daily life (Koivisto, Janhonen & Väisänen, 2004), having the possibility to talk to staff (Talseth et al., 1999; Olofsson & Jacobsson, 2001; Thomas et al., 2002), and being confirmed (Talseth et al., 1999). Patients appreciate meeting sensitive, compassionate staff, who are devoted to their work (Olofsson & Jacobsson, 2001), mediate hope, and resolve patients’ problems (Talseth et al., 1999; Samuelsson et al., 2000; Olofsson & Jacobsson, 2001). In addition, patients have described
interpersonal contacts with other patients as a beneficial aspect while being cared for in psychiatric inpatient care (Thomas et al., 2002).

Patients have described the following aspects as negative with regard to being cared for in psychiatric inpatient care: not being respected by staff (Olofsson & Jacobsson, 2001), feeling discredited and uncomfortable when staff behave like guardians and make arrangements for patients without explaining the reason, having to talk about sensitive issues with a number of persons (Samuelsson et al., 2000), being left alone, and when staff communicate hopelessness (Talseth et al., 1999). In addition, inexperienced staff, staff who lack knowledge, staff who reprimand patients for developing a close relationship with other patients, and staff who are too “strict and/or professional” have been described - by patients - as negative aspects of psychiatric inpatient care (Thomas et al., 2002).

Patients may perceive being committed to psychiatric inpatient care as balancing between opportunities and losses, e.g. being protected and cared for and being restricted in autonomy (Johansson & Lundman, 2002). However, committed patients may not always experience coercion (Kjellin, 1996; Bindman et al., 2005), whereas voluntarily admitted patients may experience coercion (Hiday et al., 1997; Poulsen & Engberg, 2001). Voluntarily admitted patients may experience being coerced when persuaded in connection with admission (Lidz et al., 2000), forced to shower, threatened to take medicines (Socialstyrelsen, 2001b), and when staying on a locked ward (Zinkler & Priebe, 2002). Why some patients experience a situation as coercive whereas others don’t, may depend on whether the patient’s integrity is violated or not (Høyer et al., 2002). In addition, it may depend on whether the patient believes he or she is mentally ill and needs treatment, if the treatment is successful or not, and whether the patient has been treated with respect (Monahan et al., 1995).

Medication administration on psychiatric inpatient wards

The use of medication treatment in psychiatric care may sometimes be troublesome for psychiatrists, staff, and patients. Patients often have to be convinced about the need of medication and may refuse to take a medicine because they fear side effects (Schwartz, Vingiano & Perez, 1988; Greenberg, Moore-Duncan & Herron, 1996). The medicines can be experienced as dangerous, even as poison (Rhodes Amarasingham, 1980). Sometimes patients may experience a lack of support to take the medicine or lack of information about reasons for taking the medicine (Svedberg, Backenroth-Ohsako & Lützén, 2003; Happell, Manias & Roper, 2004). In addition, refusal may
occur when a patient does not believe she/he is mentally ill (Greenberg et al., 1996).

**Forced medication**

Forced medication can sometimes, based on the judgement of a psychiatrist, be necessary in order to protect a patient against himself/herself or others and to restore his/her capacity to make autonomous decisions about the care (Svensk Författningssamling, 1991:1128; 1991:1129). Since 2001, all instances of forced medication in Sweden shall be reported to the Swedish National Board of Health (Socialstyrelsen, 2005) according to the following definition: injection given by holding the patient or by physical restraint. Before 2001, instances of forced medication were reported according to staff’s subjective perceptions of whether a medication was a coercive measure or not, i.e. physical force was not always involved. During six months in 2001 (Socialstyrelsen, 2001a), 17% of all Swedish involuntarily admitted patients received at least one forced medication. During 1996/1997, before the use of the current definition of forced medication, the corresponding figure was 30% (Socialstyrelsen, 2001a).

**Patient and staff experiences with regard to forced medication**

Greenberg et al. (1996) interviewed 30 forcibly medicated patients, after discharge from psychiatric inpatient care, about having been forcibly medicated. Recollecting their experiences, approximately half of the patients expressed fear of side effects and feeling angry because of the forced medication. Patients also expressed fear of addiction, objecting to others controlling them, feeling helpless and embarrassed, and that nothing was wrong with them. Some patients expressed relief. However, approximately half of the patients stated that doctors should not be allowed to force patients to take medicines. In different studies, 54–63% of patients retrospectively approved of having been forcibly medicated (Schwartz et al., 1988; Greenberg et al., 1996).

In order to make patients take the prescribed medicines and to avoid forced medication, nurses use their negotiating skills and relationship with the patient. When this does not help, forced medication may be needed, which may cause ethical concerns among staff (Olofsson et al., 1998; Olofsson et al., 1999; Lind et al., 2004; Vuckovich & Artinian, 2005) and a need to justify the action (Vuckovich & Artinian, 2005). Staff want to be seen as providers of good care (Olofsson et al., 1999) and therefore dislike actions which they believe diminish patients’ trust in them (Lützén, 1987).
Locked entrance doors at psychiatric inpatient wards

Entrance doors at psychiatric inpatient wards may, permanently or periodically, be locked (Fenton et al., 2005). A locked door is a safety and security measure when, for example, there is serious illness and suicide risk. Further, the locked entrance door is a means to regulate patients and other persons' possibilities to leave and enter the ward (Bowers, Jarrett & Clark, 1998; Adams, 2000), and may protect the community from the patients, and the patients from the community. It has also been reported that the door may be locked because of staff shortage (Cobb & Gossop, 1976; Fagin, 2001) and in order to diminish the need of close observation (Adams, 2000).

Occurrence of locked entrance doors

In a Scottish study (Smith, 1997), it was reported that eleven of fourteen psychiatric acute wards were permanently locked and in a study from London (Bowers et al., 2002) it was reported that the entrance door was permanently locked on one fourth of psychiatric wards. Bowers et al. (2002) concluded that local tradition and history of patient behaviour determined locking policies, as well as other security policies. In an investigation concerning psychiatric care in five European countries, Austria, Hungary, Romania, Slovakia, and Slovenia (Rittmannsberger et al., 2004), it was reported that on a certain day a fifth of the patients were cared for on a ward with a locked entrance door. Half of the voluntarily admitted patients in Slovakia and a fifth of the voluntarily admitted patients in Slovenia were staying on locked wards, whereas only 2 to 8% of the voluntarily admitted patients were staying on locked wards in Austria, Hungary, and Romania, respectively.

Patient and staff experiences with regard to locked entrance doors

A locked entrance door to a psychiatric inpatient ward is associated with positive as well as negative experiences for patients. A locked door may signal relief (Levy, Cooper & Elizur, 1986), safety, and security from real and imagined dangers (Adams, 2000; Hummelvoll & Severinsson, 2001). On the other hand, it has been reported that patients’ satisfaction with treatment and care may be lower on a locked than an open ward (Müller et al., 2002). The locked door may be connected to patient experiences of loss of autonomy and freedom (Hummelvoll & Severinsson, 2001), and may make the ward remind patients of a prison (Adams 2000; Zinkler & Priebe, 2002). Other findings indicate that patients may experience admission to a locked ward as a punishment or an abandonment (Pinsker, Raskin & Winston, 1981), and experience that the atmosphere on locked wards is more charged
with anger and aggression than the atmosphere on open wards (Middelboe et al., 2001).

A locked entrance door may help staff to provide safe and secure care and provide staff with a sense of control (Adams, 2000; Hummelvoll & Severinsson, 2001). However, it has been reported that a locked ward cause ethical concerns among staff, for example, about restricting patients’ autonomy (Lützén, 1998; Fagin, 2001; Lind et al., 2004) as well as concerns about their professional role. A locked door may interfere with staff’s therapeutic role (Cobb & Gossop, 1976) and may make staff feel like jailers (Bailine et al., 1982).

Why this thesis?

A literature search reveals a limited number of studies focusing on how patients and staff perceive specific situations within psychiatric inpatient care, for example, medication administration and locked entrance doors. The obligation to restrict patients’ autonomy and to use measures that may be perceived as restricting or coercive, calls for reflection among psychiatric staff (Lützén, 1998). To advance the care and further research within the area, it is of need to illuminate patient and staff perceptions of common situations, such as medication administration and locked entrance doors.
General aim

The general aim was, within psychiatric inpatient care, to explore patient and staff perceptions with regard to medication administration and locked entrance doors. An underlying aim was to explore whether patients and staff experience any coercion in connection with these situations.

Specific aims

Study I
To illuminate medication administration in psychiatric inpatient care, and to present a description of patient and nurse experiences of medication administration. An underlying aim was to study if experiences of coercion could be identified in connection with medication administration to voluntarily admitted patients.

Study II
To describe patient experiences of and nurse perceptions of a certain patient’s experiences of forced medication, patient and nurse perceptions of alternatives to the forced medication; and whether patients, according to the patients and the nurses, retrospectively approved of the forced medication.

Study III
To investigate the frequency of and the reasons for locked entrance doors at Swedish psychiatric inpatient wards; whether the frequency of locked entrance doors differs between types of psychiatric inpatient care and between the six Swedish public health service areas, and whether the frequency of patients committed to care vs voluntarily cared for differs between wards with a locked vs an open entrance door.

Study IV
To describe voluntarily admitted patients’ perceptions of advantages and disadvantages about being cared for on a psychiatric inpatient ward with a
locked entrance door. An underlying aim was to study whether voluntarily admitted patients perceive any coercion connected to being cared for on such wards.

**Study V**

To describe nurses and mental nurse assistants’ perceptions of advantages and disadvantages about working on a psychiatric inpatient ward with a locked entrance door. An underlying aim was to study whether nurses and mental nurse assistants perceive any coercion connected to the locked entrance door.
Methods

Methodological considerations

Research approaches
A mini-ethnographic approach (Leininger, 1998) was chosen in Study I in order to study medication administration to voluntarily admitted patients in psychiatric inpatient care. The approach was judged to be appropriate, as no previous published study describing general medication administration and patient and nurse experiences with regard to medication administration to voluntarily admitted patients in a psychiatric inpatient setting, could be identified in the literature. In Studies II, IV, and V a qualitative descriptive approach (Sandelowski, 2000) was chosen. In these studies, observations were considered ethically inappropriate and data was collected by interviews only. In Study III a mixed approach including a quantitative descriptive design (Kazdin, 1998) and a qualitative descriptive approach (Sandelowski, 2000) was chosen.

Samples
The samples were chosen according to what was considered appropriate according to the aims and research approaches in the respective studies.

In Study I, after selecting a ward for observations of medication administration, a purposeful sample (Patton, 2002) was chosen according to age, gender, and previous experience of being cared for/working on a psychiatric ward. Due to the limited number of nurses working on the two wards where the study was performed, all nurses working on the wards were asked about participation.

In Study II, due to the limited number of forced medications, all patients on the five wards where the study took place, who, during the study period were forcibly medicated and considered to be in a sufficient mental condition to be interviewed, were asked about participation. All nurses who had conducted the forced medications of the interviewed patients were asked about participation. If one of these nurses declined to participate, another nurse who had assisted during the forced medication was asked about participation.
In order to make it possible to conclude how many Swedish psychiatric inpatient wards that are locked, ward managers on all Swedish psychiatric inpatient wards (besides those caring for forensic patients only and private care wards) were asked about participation in Study III.

In Studies IV and V, purposeful samples (Patton, 2002) were chosen according to age, gender, ethnicity, and being cared for/working on a psychiatric ward.

Author’s experience
Before conducting the studies presented in this thesis the author (KH), had a considerable experience of working within custodial treatment, as well as forensic- and psychiatric care. This experience contributed to the interest in studying patient and staff experiences and perceptions with regard to medication administration and locked entrance doors. The same experience may have contributed to an open communication between KH and the participants during interviews and observations, and thus to detection of large parts of the investigated phenomena. KH conducted all interviews and observations, and in order to evaluate whether the interview questions were understandable and helpful in investigating the aims in Studies I, II, IV, and V, pilot interviews were conducted. Before conducting the interviews in Study II, KH had no experience of conducting research interviews. However, after performing the interviews in Study II, but before conducting the interviews in Study I, IV, and V, KH carried out several interviews with adult cancer patients and participated in analysing these data, as well as data from interviews with children with cancer, their parents and nurses, with content analysis. In order to minimise the risk that only one perspective, i.e. the author’s, should determine how data was analysed, at least one other person took part in all parts of the analysis of data in Study I, II, IV, and V, and in the analysis of the data from an open-ended questionnaire question in Study III.

Setting and participants
Study I
The study took place on two locked acute psychiatric inpatient wards during the autumn of 2001. Two additional interviews with nurses were conducted in May 2003. Patients with psychotic and mood disorders were cared for on the wards; most patients were voluntarily admitted. All voluntarily admitted patients on the wards were eligible. None of the approached patients refused being observed and fifteen of sixteen patients who were asked about participation in interviews agreed to be interviewed (the reason for not accepting to
be interviewed is not known); five of these were males and ten females, 20-80 years of age. Most had previous experiences of being cared for on a psychiatric ward. All nurses working on the wards were eligible and agreed to participate in interviews. Three males and six females, with 2-37 years experience of working within psychiatric care, were interviewed. Eight of them agreed to be observed during the medication administration (the reason for not accepting being observed is not known).

Study II
The study took place on five locked acute psychiatric inpatient wards from October 1996 to October 1997. Patients with mood, psychotic, and personality disorders were cared for on these wards. All patients on the wards who had been forcibly medicated and were in a sufficient mental condition to be interviewed and able to decline participation were eligible. Fifteen patients were asked about participation, eleven agreed to participate (the reasons for not accepting to participate are not known). Among the participating patients, eight were females and three males, 20-80 years of age, and all had a psychotic disorder at the time of the forced medication. Eight nurses had administered the eleven instances of forced medications; three of these had administered two forced medications each. The eight nurses were asked about participation; three were asked about being interviewed about two patients. Two of the nurses who each had administered one instance of forced medication did not agree to participate (the reasons for not agreeing to participate are not known). Instead two other nurses who had been present during the forced medications, administered by the two nurses who did not agree to participate, were asked about participation. These two nurses agreed to participate. Among the eight participating nurses, five were females and three males, 36-54 years of age, with a median of 18 years of experience of working in psychiatric care.

Study III
In April 2003, ward managers working on all Swedish psychiatric inpatient wards (except private care wards and wards exclusively caring for forensic psychiatric patients), N=269, were sent a questionnaire and asked about participation. The wards were identified through internet homepages, telephone calls to secretaries of the heads of the psychiatric departments, and staff at psychiatric emergency rooms. Two hundred and twelve questionnaires were returned (79%). Nineteen of these were excluded as the ward where the answering ward manager worked provided forensic care (n=10) or outpatient care only (n=6), ward managers had not been able to answer because of time off (n=2), or the ward had closed down (n=1). Questionnaires from ward
managers on 193 out of 250 possible wards (77%) were included (reasons for not accepting to participate are not known).

Study IV
The study took place on seven locked psychiatric inpatient wards from April 2003 to September 2003. All Swedish-speaking, voluntarily admitted patients on the wards were eligible. Twenty-one patients were asked about participation, one patient declined participation at the time of the interview (the reasons for not accepting to participate are not known). Among the participants, ten were males and ten females, 19-87 years of age; their current care periods varied between 7 and 210 days, and two had foreign background. The patients suffered from mood disorders, personality disorders, schizophrenia, and other psychotic disorders.

Study V
The study took place on seven locked psychiatric inpatient wards from April 2003 to September 2003. All nurses and mental nurse assistants working on the wards were eligible. Twenty nurses and twenty mental nursing assistants were asked about participation. Among the participating nurses, six were males and fourteen females, 26-63 years of age, their experiences of working within psychiatric care ranged from 3 months to 43 years, and four had foreign background. Among the participating mental nurse assistants, six were males and fourteen females, 23-62 years of age, their experiences of working within psychiatric care ranged from 2 weeks to 41 years, and six had foreign background.

Data collection
Study I
KH followed eight nurses during medication administration. The observations started in the medicine room and lasted until administration of the medicines to the patients was completed. KH repeatedly clarified her role as a student and did not explicitly interfere in the medication administration. As soon as possible, after each observation, data were recorded as field-notes focusing on when, where, and how the medication administration was conducted. Individual interviews (Hammersley & Atkinson, 1995) were conducted by KH after the observations in privacy on the wards. The interview questions concerned the patients and nurses’ experiences of medication administration, starting with the question: How do you experience to get medicines from the nurses/How do you experience to administrate medication?
The interviewer was supportive during the interviews and follow-up questions were asked in order to let the patients and nurses expound on their answers. Interviews with patients lasted 10-45 minutes, whereas interviews with nurses lasted 30-80 minutes. Demographic data were collected at the time of the interviews. Ten interviews with patients were tape-recorded. Five patients did not agree to their interview being tape-recorded; their answers were written down. All interviews but one with nurses were tape-recorded (one interview was not tape-recorded due to technical problems). The tape-recorded interviews were transcribed verbatim by KH.

Study II

Semi-structured interviews, according to an interview guide (Patton, 2002), were conducted by KH. The following questions were posed to patients: 1) What did you experience before, during, and after the forced medication? 2) Do you retrospectively approve to the forced medication? 3) What were the possible alternatives to the forced medication? The following questions were posed to nurses: 1) What do you believe the patient experienced before, during, and after the forced medication? 2) Do you think the patient retrospectively approve of the forced medication? 3) What were the possible alternatives to the forced medication? The interviewer was supportive during the interviews and follow-up questions were asked in order to let the participants expound on their answers. Interviews with patients lasted 15-45 minutes, whereas interviews with nurses lasted 15-30 minutes. Demographic data was collected at the time of the interview. The interviews were tape-recorded and transcribed verbatim by KH.

Study III

Ward managers completed a questionnaire consisting of some closed-ended questions and two open-ended questions. The closed-ended questions focused on the type of care provided on the ward, whether the entrance door to the ward was locked on the investigated day (9th of April 2003), how often the entrance door usually was locked, how many patients that were cared for on the ward on the investigated day, and how many of these that were cared for according to any of the mental health laws regulating involuntary Swedish psychiatric care: The Compulsory Mental Care Act, The Forensic Mental Care Act, and The Special Provisions Acts (Care of abusers and Care of young persons) (Svensk Författningssamling, 1988:870; 1990:52; 1991:1128; 1991:1129). In the open-ended questions, ward managers were asked about type of care on the ward and reasons for locking the entrance door.
Study IV

Semi-structured interviews, according to an interview guide (Patton, 2002), were conducted by KH. The following questions were posed: 1) What is/are, if any, the disadvantage/s with regard to being cared for on a ward with a locked entrance door? 2) What is/are, if any, the advantage/s with regard to being cared for on a ward with a locked entrance door? For each expressed disadvantage/advantage, the patient was asked: What makes this an advantage/disadvantage and to whom is it an advantage/disadvantage? The interviewer was supportive during the interviews and asked follow-up questions in order to help participants to expound on their answers. Demographic data were collected in connection with the interviews. The interviews lasted 10-60 minutes. The interviews were tape-recorded and transcribed verbatim by KH or by a secretary in the research team.

Study V

Semi-structured interviews, according to an interview guide (Patton, 2002) were conducted by KH. The following questions were posed: 1) What is/are, if any, the disadvantage/s with regard to working on a ward with a locked entrance door? 2) What is/are, if any, the advantage/s with regard to working on a ward with a locked entrance door? For each expressed disadvantage/advantage, the informant was asked: What makes this an advantage/disadvantage, and to whom is it an advantage/disadvantage? The interviewer was supportive during the interviews and asked follow-up questions in order to help participants to expound on their answers. Demographic data were collected in connection with the interviews. The interviews with nurses lasted 15-30 minutes whereas the interviews with mental nurse assistants lasted 10-40 minutes. The interviews were tape-recorded and transcribed verbatim by KH or by a secretary in the research team.

Data analysis

Study I

The data collection and analysis were conducted according to an ethnographic approach in a dialectical and interactive process (Hammersley & Atkinson, 1995). KH and an additional researcher, with experience of performing ethnographic research, reflected upon the collected data (field notes and interviews) and went back to the context (wards) for further data collection and for checking interpretations. The data from the interviews and observations was jointly analysed by KH and the additional researcher, in the following steps: 1) Repeated reading of the field notes and transcriptions of interviews to become familiar with the data. 2) Identification of specific
patterns of interest for the research focus. 3) Generating concrete and analytic categories to organise the data. 4) Generating central categories or subcategories by comparing items related to the different categories, and 5) Conducting additional data collection for respondent validation with six patients, not previously interviewed, and six nurses, three of which had been interviewed previously.

Study III

Descriptive statistics were used, to present answers to close-ended questions whereas $X^2$-tests were used to analyse differences with regard to frequency distributions between groups. Content analysis was used to analyse answers to the open-ended question about reasons for locking entrance doors. For a description of content analysis, see below (Study II, III, IV, V).

Study II, III, IV, V

Interview-data (II, IV, V) and answers to the open-ended question about reasons for locking the entrance doors at psychiatric inpatient wards (Study III) were analysed using content analysis (Weber 1990; von Essen et al., 2002). The analysis was performed in the following steps: 1) The transcribed text/answers to the open-ended question was read and re-read, and words and sentences (recording units) that contained information relevant to the question were identified (KH). 2) Recording units were grouped into mutually exclusive categories reflecting central messages. Recording units classified in the same category were presumed to have a similar meaning, either based on the precise meaning of the words or on words sharing similar connotations. 3) After a discussion (KH and at least one additional researcher) of the categorisation and the category content, the names of some of the categories were judged to be misleading and were re-labeled. 4) Category boundaries were defined and descriptions of the content of each category were developed (KH and at least one additional researcher). Even if a person mentioned a certain recording unit more than one time, it was calculated/reported once in the findings.

Much data and several categories emerged in Study III, IV, and V. In order to investigate whether generated categories were clearly distinguished from each other, were given appropriate names, and descriptions, the interrater agreement between two categorizations (one by KH and another person, and one by an additional person) was calculated. In Study III, a doctoral student/nurse without experiences of working in psychiatric care assigned all recording units to the categories and in Studies IV and V a doctoral student/nurse with experience of working in psychiatric care assigned all recording units to the categories. Thereafter the inter-rater agreement between the two categorisations was calculated by the Kappa method (Howell, 1997).
The Kappa values varied between 0.62–1.0 in Study III, 0.87-0.89 in Study IV, and 0.78-0.92 in Study V, indicating substantial to almost perfect agreement (Downe-Wamboldt 1992; Flatley Brennan & Hays 1992).

Research ethics

For all studies, ethical approval was obtained from the regional ethics committee at the Faculty of Medicine, Uppsala University. For Study III, ethical approval was also obtained from the additional five Swedish regional ethics committees. In Studies I, II, IV and V, ward managers/deputies provided potential participants with oral and written information about the studies. For Study III, written information was sent to ward managers and doctors in charge. Potential participants in Studies I-V were informed that participation was voluntary, that confidentiality was guaranteed, and that they could withdraw from the study at any time without any consequences. Patients were informed that neither participation nor non-participation would affect their care. Special consideration was taken to patients’ dignity, integrity, and vulnerability during interviews and observations according the Northern Nurses’ Federation (1920), based on The Declaration of Helsinki (World Medical Association, 1964) and The Madrid Declaration on Ethical Standards for Psychiatric Practice (World Psychiatric Association, 1996).
Results

Study I: Medication administration in inpatient psychiatric care – get control and leave control

Interviews, observations, and field notes revealed two central categories of patient and nurse experiences with regard to medication administration to voluntarily admitted patients: get control and leave control, and two sub categories: interpersonal contact and nurses’ knowledge.

Medicines were most typically administered to the patients, as they were sitting in the dining or sitting rooms and the nurses decided, from time to time, when, where, and how to give the medicine to a certain patient. Sometimes nurses waited to give a patient a medicine, for example when perceiveing a risk for a discussion or an aggressive reaction from a patient. While waiting for a patient to put the medicine in his/her mouth, the nurses often talked in a friendly manner to the patient and offered her/him water.

Get control

Nurses had control over prescriptions and medicines, whether the right medicine was given to the right patient, whether the patient put the medicine into his/her mouth, and seemed to swallow it. Medication administration provided nurses with an opportunity to get control over the patients’ total care, this was especially important when coming back from leisure time and when meeting new patients. Checking on prescriptions provided the nurses with information about the patients’ health problems and possible effects and side effects of medication.

Leave control

Patients did not have access to the prescribed medicines and the nurses administrated every pill to them. Most patients were grateful for the opportunity to leave the control over the medication to the nurses. The patients were of the opinion that the nurses knew best and trusted them. Some patients counted the pills and asked questions about changes of prescriptions. When interviewed, patients mentioned that they disliked being controlled when taking their medicines, however, they also mentioned that they understood the routine as it, according to the patients, was enacted in their best interest.
Patients mentioned that the nurses ought to have even better control of the situation, as it was easy for patients to hide a pill or to spit it out. The patients would have appreciated information about the routine. No patient mentioned anything about this routine during the observations.

Interpersonal contact
Whether the medicines were administered in the common rooms or in privacy, patients and nurses appreciated spending some time together during the medication administration. It appeared as if the interpersonal contact made it easier for the nurses to make the patients take the medicines. Part of the contact comprised questions and information about the medicines. The nurses underscored the importance of honesty; covert administration of medicines was unthinkable. Not having an interpersonal contact with the patients during medication administration might result in nurses feeling like a “pill machine”. During interviews, patients mentioned that they disliked being given medicines in the presence of other patients. However, no patient mentioned anything about this during the observations.

Nurses’ knowledge
Knowledge about the effects and side effects of the medicines, made it easier for nurses to get control over the medication administration and easier for patients to trust the nurses. The nurses described having a feeling of knowing how to act in challenging situations, such as when patients hesitated to take the medicines or wanted more medicines than prescribed. Nurses’ choice of how to act in these situations was dependent on whether the nurse knew the patient from previous admissions, and/or had previous and similar experiences with patients with similar health problems.

Study II: Forced medication in psychiatric care: patient experiences and nurse perceptions
Forced medication evoked a number of experiences for the patients according to patients and nurses. A content analysis of interviews revealed fifteen categories related to three targets: the disease, being forcibly medicated, and the drug. Most patient answers were categorised as psychological discomfort with regard to being medicated, violation of integrity with regard to being medicated, and psychological and physical discomfort with regard to the drug. Most nurse answers were categorised as violation of integrity with regard to being medicated, changed behaviour with regard to the disease,
disapproval with regard to being medicated, and improvement of health due to the drug. See Table 1 for a presentation of the categories.

Three patients retrospectively approved the forced medication. A fourth patient gave a vague retrospective approval. The remaining patients did not perceive the forced medication as being of any help. According to the nurses, seven patients retrospectively approved of the forced medication.

All patients mentioned at least one alternative to forced medication. Six patients mentioned more dialogue with the psychiatrist and staff, more explanation of the health condition and the medicine, and to coax as alternatives. Other patients mentioned alternatives such as to wait, to not prescribe the medicine, at least not psychotropics, and to give the medicine in a form other than by injection. None of the nurses mentioned any alternative to forced medication, some mentioned that alternatives would have been a short-term solution only.
Table 1. Patient experiences and nurse perceptions of a certain patient’s experiences of forced medication. Categories, category content, and number of recording units included in categories.

<table>
<thead>
<tr>
<th>Target</th>
<th>Category⁴ and category content</th>
<th>Before</th>
<th>During</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>P⁵</td>
<td>N⁶</td>
<td>P⁵</td>
</tr>
<tr>
<td>Disease</td>
<td>Awareness: Statements referring to patients being aware of having a problem/disease.</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Changed behaviour: Statements about patients demonstrating a changed behaviour because of the problem/disease.</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fear: Statements about patients fearing having a psychiatric disease and being afraid of the symptoms.</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being forcibly medicated</td>
<td>Acceptance: Statements about the importance for patients to have a certain nurse administrating the drug.</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Disapproval: Statements about patients disapproving of the forced medication.</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Do not remember: Statements about patients not remembering anything from the time before, during, or after the forced medication.</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No reaction: Statements about patients not demonstrating any special reactions.</td>
<td>1</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Non acceptance: Statements about patients experiencing being unfairly subjected to forced medication.</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Psychological discomfort: Statements about patients feeling anger, agitation, frustration, irritation, sadness, and panic due to the forced medication and experiencing the forced medication as a punishment.</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Resignation: Statements about patients feeling resignation.</td>
<td>4</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Violation of integrity: Statements about patients experiencing being subjected to physical and psychological force and pressure as well as lack of legal rights, respect, freedom, autonomy, and choice.</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Drug</td>
<td>Difficulty to manage troublesome situations: Statements about patients experiencing difficulties because of the drug.</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fear: Statements about patients experiencing fear as they do not know what drug they get, and being afraid of dying, or getting ill because of the drug.</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improvement of health: Statements about patients experiencing some improvement of health e.g. relief, peace, tranquillity, and being able to sleep because of the drug.</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Psychological and physical discomfort: Statements about patients experiencing physical and psychological discomfort because of the drug.</td>
<td>7</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

⁴Categories are presented in alphabetic order within targets. ⁵P=patient, N=nurse.
Study III: Locked entrance doors at psychiatric wards. Occurrence and reasons

Seventy three per cent of Swedish psychiatric inpatient wards (besides those caring for forensic patients only and private care wards) were locked on the day of the investigation, 9th of April 2003. Sixty six per cent of the wards were locked always or most of the time. Twenty five per cent of the patients (N=2073) staying on the wards were committed to care according to one of the acts: Compulsory Mental Care Act, Forensic Mental Care Act or The Special Provision Acts (Care of abusers and Care of young persons) (Svensk Författningssamling, 1988:870; 1990:52; 1991:1128; 1991:1129). Nineteen per cent of the wards with a locked entrance door were locked without any committed patient being cared for on the ward and on nineteen per cent of the wards with an open entrance door was at least one patient committed to care. There was significantly more often at least one patient committed to care staying on wards with a locked vs an open entrance door (X²=65.5, df 1, p<.0001). Less entrance doors were locked on wards providing care to children and adolescents (35%) than on wards providing gero-psychiatric care (87%), wards for substance misuse (86%), and wards providing general psychiatric care (75%) (X²=17.7, df 3, p<.0005). See Table 2 for a presentation of the type of care provided on wards, number of wards with a locked/open entrance door and with at least one patient committed/not committed to care on the day of the investigation.

The frequency of locked entrance doors varied between the six Swedish public health service areas: the North region (57%), the Uppsala-Örebro region (69%), the Stockholm region (76%), the West region (77%), the South East region (57%), and the South region (88%) (X²=11.7, df 5, p<.05). There was a higher frequency of locked doors in areas surrounding Sweden’s three largest cities: Stockholm (Stockholm region), Göteborg (West region), and Malmö (South region) (82%) as compared to the rest of Sweden (63%) (X²=8.3, df 1, p<.005).
Table 2. Type of care provided on wards (N=193), number of wards with a locked/open entrance door and with at least one patient committed/not committed to care on the 9th of April 2003.

<table>
<thead>
<tr>
<th>Type of care</th>
<th>N</th>
<th>Locked entrance door on the 9th of April 2003 (n=140)</th>
<th>Open entrance door on the 9th of April 2003 (n=53)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>At least one patient committed to care on the ward</td>
<td>No patient committed to care on the ward</td>
</tr>
<tr>
<td></td>
<td></td>
<td>At least one patient committed to care on the ward</td>
<td>No patient committed to care on the ward</td>
</tr>
<tr>
<td>General psychiatry</td>
<td>137</td>
<td>91</td>
<td>11</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>21</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Child and adolescent psychiatry</td>
<td>20</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Gero-psychiatry</td>
<td>15</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>193</td>
<td>114</td>
<td>26</td>
</tr>
</tbody>
</table>

Reasons for locking entrance doors were explored by an open-ended question, answered by 175 ward managers. A content analysis of the answers revealed 14 categories of reasons. Most reasons were categorised as: prevent patients from escaping, legislation, provide patients and others with security and safety, prevent import and unwelcome visits, and staff’s need of control. See Table 3 for a presentation of categories.
Table 3. Reasons for locking entrance doors at inpatient psychiatric wards according to ward managers. Categories, category content, and number of recording units included in categories.

<table>
<thead>
<tr>
<th>Category and category content</th>
<th>Number of recording units and percentage of ward managers (N=175) mentioning a reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent patients from escaping: To prevent patients from escaping from the ward because of problems related to their psychiatric diagnosis and/or psychological problems.</td>
<td>170 (97%)</td>
</tr>
<tr>
<td>Legislation: Patients cared for according to any of the mental health laws: The Compulsory Mental Care Act, The Forensic Mental Care Act, The Special Provision Acts (Care of abusers and Care of young persons).</td>
<td>95 (54%)</td>
</tr>
<tr>
<td>Provide patients and others with security and safety: To provide patients who are a danger for themselves or others with protection and security and to provide significant others and the surrounding with protection and safety.</td>
<td>84 (48%)</td>
</tr>
<tr>
<td>Prevent import and unwelcome visits: To prevent import of alcohol, drugs, and dangerous objects to the ward and visits of unwanted persons.</td>
<td>54 (31%)</td>
</tr>
<tr>
<td>Staff's need of control: To help staff to control which patients and other persons that are on the ward.</td>
<td>27 (15%)</td>
</tr>
<tr>
<td>Prescribed special observation: Prescribed observation/surveillance.</td>
<td>17 (10%)</td>
</tr>
<tr>
<td>Staffing: Staff shortage - with a locked door the number of needed staff personnel decreases.</td>
<td>12 (7%)</td>
</tr>
<tr>
<td>Work environment: To create a safe work environment for the staff.</td>
<td>12 (7%)</td>
</tr>
<tr>
<td>Local tradition: Local tradition and routine.</td>
<td>11 (6%)</td>
</tr>
<tr>
<td>Local decision: The staff has decided to keep the entrance door locked.</td>
<td>8 (5%)</td>
</tr>
<tr>
<td>The ward’s design: The ward’s design or size.</td>
<td>7 (4%)</td>
</tr>
<tr>
<td>Lack of staff competence: Staff incompetence or inexperience with regard to treating patients as accountable individuals.</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>The door lock: The door is automatically locked.</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>Patients’ wishes: Patients wish to keep the door locked.</td>
<td>2 (1%)</td>
</tr>
</tbody>
</table>
Study IV: Locked entrance doors at psychiatric wards - Advantages and disadvantages according to voluntarily admitted patients

A content analysis of interviews with the patients revealed six categories of advantages and eleven categories of disadvantages about being cared for on a psychiatric ward with a locked entrance door. The most mentioned advantages were categorised as protection against “the outside”, control over patients, and secure and efficient care. The most mentioned disadvantages were categorised as confinement, dependence, and feeling worse emotionally. See tables 4 and 5 for a presentation of categories.

Study V: Psychiatric wards with locked doors – Advantages and disadvantages according to nurses and mental nurse assistants

A content analysis of interviews with mental nurse assistants and nurses revealed eight categories of advantages and eighteen categories of disadvantages about working on a psychiatric ward with a locked entrance door. The most mentioned advantages were categorised as control over patients, secure and efficient care, and protection against “the outside”. The most mentioned disadvantages were categorised as extra work, confinement, and non-caring environment. See tables 4 and 5 for a presentation of categories.
Table 4. Advantages with regard to being cared for/working on a psychiatric inpatient ward with a locked entrance door according to patients, mental nurse assistants, and nurses. Categories, category content, and number of recording units included in categories.

<table>
<thead>
<tr>
<th>Category and category content</th>
<th>P²</th>
<th>Mna³</th>
<th>RN³</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact with visitors and patients:</strong> When a staff member opens the door, he/she may get an opportunity to talk to those coming or leaving.</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Control over patients:</strong> The locked door may provide staff with a possibility to control patients, which implies calmness and safety for staff and patients.</td>
<td>9</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td><strong>Less discussions:</strong> If the door is locked all the time, it may imply less discussions about why it is locked.</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Less staff is needed:</strong> A locked door may imply that less staff members are needed.</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>More time for patients:</strong> Staff gets the possibility to spend more time with patients, as they do not have to check whether patients leave the ward without consent.</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Protection against &quot;the outside&quot;:</strong> The locked door may protect patients and staff against unwanted visitors, stealing and alcohol/drugs.</td>
<td>10</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td><strong>Relief for significant others/relatives:</strong> A locked door may be relieving for significant others, knowing that patients are cared for and unable to abscond.</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Safety:</strong> The locked door may make patients experience the ward as a calm sanctuary.</td>
<td>7</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td><strong>Secure and efficient care:</strong> The locked door may help staff to create a structured environment and a structured, efficient care that e.g. helps patients to not get in trouble and/or harm themselves or others.</td>
<td>9</td>
<td>16</td>
<td>13</td>
</tr>
</tbody>
</table>

²Categories are presented in alphabetic order. ³P=patient, Mna=mental nurse assistant, RN=registered nurse.
Table 5. Disadvantages with regard to being cared for/working on a psychiatric inpatient ward with a locked entrance door according to patients, mental nurse assistants, and nurses. Categories, category content, and number of recording units included in categories.

<table>
<thead>
<tr>
<th>Category and category content</th>
<th>P</th>
<th>Mna</th>
<th>RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptation to other patients’ needs: The environment is worked out for seriously ill patients, some patients are forced to stay behind a locked door in spite of not needing to be locked in.</td>
<td>1</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Concerns for visitors: The locked door may make visitors feel unwelcome, insecure, and fearful.</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Concern for visitors’ reactions: Patients may worry about visitors’ thoughts about why a patient is admitted to a locked ward.</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Confinement: The locked door may make patients experience a decreased self-confidence and responsibility.</td>
<td>12</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>Dependence: Patients may feel dependent on the staff and/or that they disturb the staff when they ask for and wait for the door to be opened.</td>
<td>10</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Double job roles: The locked door may make staff experience having double job roles, being both a carer and a guard.</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Emotional problems for patients/Feeling worse emotionally: The locked door may make patients feel depressed, nervous, fearful, and struck by panic.</td>
<td>7</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Extra effort explaining why the door is locked: Staff has to explain why the door is locked. This may cause conflicts and confrontations between staff and patients.</td>
<td>0</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Extra work for staff: Opening the locked door is a time-consuming and uncomfortable task for staff, which may interrupt ongoing duties or contacts with patients.</td>
<td>5</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>Frustration for patients: The locked door may make patients feel frustrated and aggressive.</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Frustration for staff: The staff may dislike keeping the door keys and may be influenced by the patients’ reactions about the door being locked.</td>
<td>0</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Hindrance in emergency situations: The locked door may be a hindrance, e.g. for the intensive care team in an emergency situation.</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Locked in and/or unsafe: Even though the staff has keys and actually can unlock the door, they may feel locked in and unsafe.</td>
<td>0</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Non-caring environment: The locked door and the keys may remind patients and staff of a place more like a jail, an asylum or a cave, than a hospital.</td>
<td>4</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Passiveness: The locked door may make it difficult for patients to leave the ward. As a consequence they may avoid outdoor activities and become unnecessarily passive.</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Problems with hygiene: Door keys may not be washed up which may cause infections.</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Special clothes: Because of the keys staff may need to wear special clothes and these may, because of the keys, wear out quickly.</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Staff’s power: The locked door and the keys are signs of staff’s power and may thus signal a difference between patients and staff.</td>
<td>3</td>
<td>8</td>
<td>5</td>
</tr>
</tbody>
</table>

*Categories are presented in alphabetic order. P=patient, Mna=mental nurse assistant, RN=registered nurse.*
Discussion

The goal with the work presented in this thesis was to explore and describe patient and staff perceptions with regard to medication administration and locked entrance doors within psychiatric inpatient care.

Discussion of methods

Credibility

Different steps were taken to achieve credibility (Lincoln & Guba, 1985). First, a purposeful sample (Patton, 2002) was used in Study I, IV, and V in order to detect as much as possible of the investigated phenomena. As relatively few patients are forcibly medicated it was considered impossible to use the same sample procedure in Study II. Second, when considered possible (Study I), different methods of data collection, interviews, observations, and field-notes were used. Third, at least two persons (KH and an additional person) took part in the analysis of data from interviews, observations, and an open-ended question. The fact that KH has extensive experience of working within psychiatric care may strengthen as well as threaten the credibility of the results. It can be assumed that the work experience made it easier for KH to formulate and ask relevant questions and follow-up questions, which may have helped informants to broadly illuminate the investigated phenomena. On the other hand, it can be speculated whether the same experience interfered with the collection and analysis of data. However, the data analysis was performed by at least one additional person besides KH, which supports the credibility of the findings.

Observer bias

The observations were focused on medication administration during a short period of time. The observer (KH) did not interfere in the medication administration and clarified her role as a student. It should however be kept in mind that a participant observer always, to a certain extent, interferes with what is observed and thus may have an impact on the observed persons (Hammersly & Atkinson, 1995). However, as the presence of nursing students was common on the wards where the observations took place, it can be
assumed that the presence of KH did not have an impact on how patients and nurses behaved during the observations.

The place and time of the interview
Interviews were conducted on the wards where the patients were cared for and where the staff worked. This circumstance may have restricted the participants’ willingness to talk freely about their experiences. However, the fact that the interviews were conducted by KH, who was not involved in the care of the patients, may have diminished this risk. The alternative would have been to interview patients after discharge from hospital, which may have increased the risk of dropouts and may have made it difficult for patients to recollect and talk about their experiences and perceptions. An advantage with interviewing patients when cared for on the ward, was the possibility for them to get support from the staff in case the interview made them upset.

General discussion
Medication administration to voluntarily admitted patients
The findings illustrate that medication administration, as demonstrated in previous studies (Wolf, 1988; Cheek, 1997), is a complex task. Two central categories of patient and nurse experiences with regard to medication administration: get control and leave control and two subcategories: interpersonal contact and nurses’ knowledge were identified. The observations gave the impression that the medication administration was enacted without problems. However, a slightly different picture emerged through interviews with patients. Some patients mentioned that receiving medicines in the presence of others, and nurses controlling whether they swallowed the medicines or not, at least to some degree, was experienced as a violation of their integrity. Patients did however understand the importance of nurses controlling whether they swallowed the medicines or not. It has earlier been reported that patients in psychiatric care understand and respect staff’s work (Olofsson & Jacobsson, 2001). Staff is expected to enact control (Sullivan, 1998; Cleary, 2003) which may explain why the patients did not object to the unpleasant routines. The nurses did not mention that administering medicines in the presence of other patients or controlling whether the patients swallowed their medicines or not, could be experienced in a negative way by the patients. The findings indicate that the nurses could have respected the patients’ integrity to a greater degree during the medication administration.
Patients and nurses appreciated the interpersonal contact, which could emerge during the medication administration. For the nurses, the contact resulted in gained knowledge about the patients, their problems, and the effects of medicines. The knowledge increased the nurses’ possibility to keep control over the patients’ care. For the patients, the contact contributed to their willingness to leave the control over the medication administration to the nurses, which may increase their compliance to take prescribed medicines. The importance of the interpersonal contact between patients and nurses in order to increase patients’ compliance with regard to taking medicines has been described in previous studies (Marland & Sharkey, 1999).

Forced medication

Fifteen categories of patient experiences and nurse perceptions were identified with regard to forced medication. Patients and nurses mentioned a range of negative experiences for patients. Most of these were categorized as violation of integrity and psychological discomfort, e.g. anger, panic, and sadness. The findings support previous findings indicating that patients with psychiatric problems fear taking medicines (Rhodes Amarasingham, 1980; Schwartz et al. 1988; Greenberg et al., 1996). A number of patients mentioned resignation in connection to the forced medication and that refusal would be futile as staff’s control and power was total. Few nurses mentioned these aspects. Few patients - less than nurses thought - retrospectively approved of the forced medication. Previous findings (Schwartz et al., 1988; Greenberg et al. 1996) indicate that a small majority of patients retrospectively approve of having been forcibly medicated. The patients in the study by Schwartz et al. were interviewed at discharge and in the study by Greenberg, et al. (1996), approximately one month after discharge. It is possible that more patients in the study, presented in the thesis, would have approved to the forced medication if the interviews had been conducted later. In a future study, it would be interesting to identify patients’ experiences of forced medication with interviews, for example, one year after being forcibly medicated.

Patients’ approval to coercive measures may depend on previous experiences of coercive measures, and how the coercive measure is conducted (Høyer et al., 2002). In the present study, one woman mentioned that she approved of the forced medication as the staff, during the forced medication, treated her with respect. Other patients approved of the forced medication as it was conducted by a certain nurse, and as they experienced increased mental health as a consequence of the medication. Some of the findings agree with previous results by Olofsson and Norberg (2001), demonstrating that closeness with and attention from nurses and physicians may decrease patients’ feelings of discomfort and increase patients’ feelings of security when subjected to coercion.
Patients and nurses were asked about possible alternatives to the forced medication. Patients mentioned several alternatives; most of these were concerned with having a dialogue with psychiatrists and staff and receiving more information about the medicine and the health condition. Staff waiting to give the medicine, staff using more persuasion, and medicines in another form than injections were mentioned as other alternatives. The nurses did not mention any alternatives to the forced medication they were interviewed about. The findings correspond with earlier results illustrating that nurses do not perceive any useful alternatives to coercive measures (Olofsson et al., 1998; Marangos-Frost & Wells, 2000). The finding may be explained by the fact that there are no alternatives or may reflect that nurses try to justify their use of forced medication, which has been reported by others (Vuckovich & Artinian, 2005).

Locked entrance doors

Occurrence

Seventy three per cent of Swedish psychiatric inpatient wards (excluding those caring for forensic patients only, and private care wards) were locked on the day of investigation. When compared to the number of locked psychiatric acute wards in London (Bowers et al., 2002) the number appears high. The number appears even higher when compared to the conditions in Austria, Hungary, and Romania, but low when compared to the conditions in Slovenia and Slovakia (Rittmannsberger et al., 2004). An explanation to the high number of locked wards in Sweden may be that only nine wards were labeled as psychiatric intensive care units and that patients with a variety of mental health problems are often cared for on one and the same ward in Sweden.

There were regional differences with regard to the frequency of locked entrance doors between the Swedish health care areas. Entrance doors were more often locked in the areas surrounding the three largest cities than in the remaining areas. The difference might be explained by the fact that areas surrounding large cities often are more exposed, than other areas, to drugs and crimes, which may pose a threat to patients and staff.

Twenty six of 140 locked wards were locked on the day of investigation, though no committed patient was cared for on the ward. It can be questioned why these 26 wards were locked and it can be argued, in accordance with Bowers et al. (2002), that some may perceive this fact as an illegal detention of voluntarily admitted patients. On the other hand, ten wards were open, though committed patients were staying on the wards. Swedish mental health laws (Svensk Författningssamling 1991:1128; 1991:1129) do not say that entrance doors must be locked on wards where committed patients are cared for, only that patients can be prevented to leave the ward or hospital area.
Reasons
According to ward managers, entrance doors on psychiatric wards are most often locked in order to: prevent patients from escaping, legalisation, provide patients and others with security and safety, prevent import and unwelcome visits, and staff’ need of control. These results support previous findings (Bowers et al., 2002). A number of ward managers mentioned other reasons, for example prescribed special observation, this finding seems to disagree with previous results (Adams, 2000) demonstrating a decreased need of special observation when a ward is locked. An explanation to the, at first sight, contradictory findings may be different definitions of special observation. A confusion with regard to how special observation is defined has previously been reported (Bowers & Park, 2001). Special observation may imply that staff checks a patient every fifteen minutes, but it can also mean that a member of the staff shadows a certain patient all the time. Staff shortage was another identified reason for locking the entrance door; the result supports previous findings (Cobb & Gossop, 1976; Fagin, 2001). Whether staff shortage is a legitimate reason for locking the entrance door should be questioned, especially if used as a permanent solution.

Local tradition and local decision were mentioned as other reasons for locking the ward. Local tradition has previously been reported (Bowers et al., 2002) as a reason for locking wards, the reason indicates a lack of reflection about why the door is locked. Local decision, however, indicates some kind of reflection on the matter. According to a small number of answers, entrance doors were sometimes locked as a consequence of automatic door locks and the ward’s design. These answers indicate that staff lacks influence on whether the entrance door is kept open or not.

Advantages and disadvantages
Locked entrance doors at psychiatric wards are experienced in positive as well as negative ways. Almost every patient, mental nurse assistant, and nurse mentioned advantages as well as disadvantages with locked entrance doors. Nine categories of advantages, as against nineteen categories of disadvantages, were derived from the answers. Besides mentioning advantages and disadvantages for themselves (their own group), patients mentioned advantages and disadvantages for staff and visitors, and staff mentioned advantages and disadvantages for patients and visitors. Five of the nine categories of advantages included answers from all groups whereas ten of the nineteen categories of disadvantages included answers from all groups.

The most often mentioned (by both patients and staff) advantages with a locked entrance door were categorized as control over patients, protection against “the outside”, and secure and efficient care. The findings illustrate that the (by ward managers) most frequently mentioned reasons for locking entrance doors, to a large extent correspond with the most often mentioned
(by patients and staff) advantages with locked entrance doors. Staff keeping control over patients, implying safeness and calmness, protecting patients and staff from unwanted visitors, stealing and import of alcohol and drugs, and providing patients with a structured environment and care are perceived as advantages by patients as well as staff. The importance for patients within psychiatric care to feel secure has previously been reported (Samuelsson et al., 2000). Providing patients with safe and secure care are main tasks for staff working within psychiatric care (Cleary, 2003; Alexander & Bowers, 2004; Hall, 2004; Fourie et al., 2005), and the findings indicate that a locked entrance door may help staff to reach these goals.

The most often mentioned (by patients) disadvantages with a locked entrance door were categorized as confinement, dependence, and feeling worse emotionally. Mental nurse assistants most often mentioned disadvantages categorised as extra work (for staff), confinement, and emotional problems for patients whereas nurses most often mentioned disadvantages categorised as confinement, extra work (for staff), and non-caring environment. The findings illustrate that the patients and the staff to a larger extent share their experiences with regard to advantages than disadvantages with a locked entrance door. The majority of the patients, mental nurse assistants as well as nurses mentioned confinement, causing patients to experience decreased self-confidence and responsibility, as a disadvantage connected to locked entrance doors. Half of the patients and a majority of the nurses mentioned dependence, i.e. patients feeling dependent on the staff as a disadvantage. Voluntarily admitted patients can usually not be stopped from leaving the ward, however having to ask staff about opening the door may, at least for some patients, decrease the likelihood of leaving the ward and thus of taking part in activities outside the ward.

One of the, by mental nurse assistants and nurses, most often mentioned disadvantage with locked entrance doors was categorised as extra work; some patients mentioned this aspect. Staff experienced opening the door as a time-consuming and uncomfortable task, which may interrupt ongoing duties or contacts with patients. Opening the door also implied an extra effort having to explain why the door is locked, which may result in discussions causing conflicts between patients and staff. On the other hand, staff mentioned that opening the door may result in extra opportunities to talk with patients and visitors. It can be discussed whether opening the entrance door should be considered as extra work or as part of staff’s regular work on locked psychiatric wards. If staff consider opening the door as a regular and important task of their work the patients may also do so, which may imply less experiences of confinement, dependence, and emotional problems connected to the locked door.

In future studies it would be interesting to investigate the potential impact of the identified disadvantages and advantages with a locked entrance door.
on patient and staff behaviours, as well as to explore which individual and situational factors that may be related to how the locked door is experienced.

Perceived coercion

Medication administration and locked entrance doors are to some degree connected with experiences of restricted freedom for patients. In Study I, IV, and V, an underlying aim was to explore whether staff and voluntarily admitted patients experience any coercion in connection to medication administration and locked entrance doors, respectively. Neither patients nor staff explicitly mentioned the word “coercion”. Patients did, however – among other things – say that they had to adapt to staff routines during medication administration and mentioned decreased emotional function, confinement, dependence on staff, having to adapt to other patients’ needs, and feeling like being in a prison, as consequences of locked entrance doors. Such experiences may be considered as coercion and may counteract the purpose of the care as well as make staff’s work harder. However, it should be kept in mind, that even in case the patients did experience coercion, they may not have mentioned it because of their mental condition (Lützén, 1998) or because of feeling stigmatized (Goffman, 1990) as being cared for at a locked psychiatric ward.

Both patients and staff used the word “jail” and similar words to describe the environment caused by the locked entrance door. However, not as many patients as staff mentioned that the locked door made the ward appear like a non-caring environment or that the locked door implied double job roles for staff or made staff appear as guardians. Some staff expressed frustration about their power becoming so obvious as a consequence of the locked door. The fact that few patients mentioned staff’s power, may illustrate that staff did not signal power and/or that the patients understood and respected staff’s work. Another explanation may be that patients agree to be treated with a certain degree of paternalism (Elander & Hermerén, 1989), and appreciate that staff has control over them and their care.

Patients and staff often mentioned the word “control”. The voluntarily admitted patients seemed to accept and appreciate handing over the medication administration to the staff as well as staff’s possibilities to keep control over patients and “the outside”. On the other hand, some patients disliked staff’s control during medication administration, and many patients experienced confinement and dependence as consequences of locked entrance doors.

Tännö (1999) has drawn a distinction between modest and meddlesome coercion in connection to the physical care of patients suffering from dementia or mental retardation. Modest coercion is enacted in the patient’s best interest only, and meddlesome coercion is enacted in the interest of the caregivers. Taken together, the findings of this thesis indicate that staff’s control
in connection to medication administration and locked entrance doors mostly is enacted in the patients’ best interest and thus can be considered as modest. However, increased reflection among staff, about how medication administration and locked entrance doors are perceived by patients, would increase staff’s possibilities to prevent potential experiences of coercion due to these situations among patients in psychiatric inpatient care.

Summary of results
Medication administration within psychiatric inpatient care
- Medication administration was described by the nurses as a complex task with an importance beyond giving the right pill to the right patient.
- Medication administration provided the nurses with an opportunity to get control over the patients’ total care.
- Medication administration provided the patients and nurses with an opportunity to communicate. Lack of an interpersonal contact during medication administration could cause frustration for the patients and nurses.
- The patients and nurses did not fully share the same perceptions about what patients experience when subjected to forced medication.
- Most of the patients experienced violation of integrity and psychological discomfort with regard to forced medication.
- All patients mentioned alternatives to forced medication. The nurses did not mention any alternatives.
- Only a minority of the patients, less than the nurses thought, retrospectively approved to forced medication.

Locked wards within psychiatric inpatient care
- Three fourths of Swedish psychiatric inpatient wards were locked, a high number compared to some European countries.
- Approximately a fifth of the wards were locked without any committed patient on the ward.
- Ten wards were open, in spite committed patients on the ward.
- Less wards where children and adolescents were cared for, than wards where adults and old people were cared for, were locked.
- More wards in the areas of Sweden’s three largest cities, than in the rest of the country, were locked.
- Entrance doors were, according to the ward managers, most often locked in order to prevent patients from escaping, legislation, provide patients and others with safety and security, prevent import and unwelcome visits, and because of staff’s need of control.
• The patients perceived a variety of advantages and disadvantages, for themselves, visitors, and staff, connected to locked entrance doors at psychiatric wards. Most advantages concerned control over patients, protection against “the outside”, and secure and efficient care. Most disadvantages concerned confinement, dependence, and emotional problems for patients.

• The nurses and mental nurse assistants perceived a variety of advantages and disadvantages for themselves, patients, and visitors, connected to locked entrance doors at psychiatric wards. Most advantages concerned control over patients, protection against “the outside”, and secure and efficient care. Most disadvantages mentioned by the nurses concerned confinement, extra work, and non-caring environment. Most disadvantages mentioned by the mental nurse assistants concerned extra work, confinement, and emotional problems for patients.
Conclusions and implications for psychiatric inpatient care

- In order to maintain patients’ integrity, nurses should administer medicines in privacy and inform patients that they routinely will check whether the patients swallow their medicines or not.
- Whether a patient approves or not of being forcibly medicated may depend on how the patient is treated during the medication and who performs the medication.
- In order to cause least possible psychological discomfort and to maintain patients’ integrity, staff should validate their perceptions about how patients experience forced medication, with the patients.
- Staff should discuss and try to identify potential alternatives to forced medication.
- Staff should be aware that locked entrance doors are connected with negative as well as positive experiences for patients as well as staff.
- Staff should reflect upon and articulate reasons for and decisions about locking or opening entrance doors, with the limitation of patients’ freedom in mind.
- Staff should consider opening and locking entrance doors as an important duty.
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