

Duty stations and the regulation of space in mental health wards: A South Australian Case Study

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Abstract

This paper reports on a cross-disciplinary pilot study that examined the relationship between architecture and mental health. Drawing upon ethnographic data collected within a purpose-built mental health ward in South Australia, the paper focuses upon the role and use of the duty station in relation to both staff and clients. The findings indicate that duty stations often functioned in problematic ways in terms of surveillance and administration. Specifically, the findings question whether mental health wards can truly promote psychological wellbeing if duty stations solely serve to reinforce power differentials between clients and staff in ways that contribute to the physical gap between these two groups. As such, the findings pave the way towards a clearer understanding of the design needs of mental health clients and clinicians. The paper concludes with suggestions to address the issues raised by the findings.

Keywords: ethnography; health care administration; mental health; relationships, patient-provider

It has been increasingly recognized over the past decade that the design of any given space can either promote the wellbeing of those who use it, or contribute to existing problems (or indeed create new ones, for example, see Huffcut, 2010; Stichler, 2008). Perhaps nowhere is this more so the case than in mental health facilities, where research continues to find marked differences in outcomes for clients who are housed in traditional, as opposed to reconstructed, facilities. Specifically, and in their review of evidence based healthcare design published to date, Ulrich and colleagues (2008) found that factors such as single-bed rooms, softer lighting, windows that provide views of the world outside, welcoming spaces for family to visit, and finishings that reduce the impact of harsh or jarring noises upon clients all contribute to positive mental health outcomes for clients. This review, and the research it draws upon, clearly indicates the merits of designing spaces with the mental health of clients in mind, and government departments across the western world are gradually beginning to draw upon notions of evidence based healthcare design when engaging in the reconstruction of mental health facilities. Despite these gradual changes, there remains a relative paucity in research on the specific aspects of such facilities that might still impact negatively upon clients, and as such, ongoing attention must be paid to the impact of design and architecture on clients within such wards

One aspect of mental health facilities that is beginning to receive more attention, and which we would argue is central to any facility, is that of the duty or nurses'/nursing station. Whilst clients are obviously at the heart of any mental health facility (that is, the facility would not exist if there was not a demand for it), facilities can only function through the work of professionals whose role it is to care for clients. This would therefore suggest that the location of the duty station, the relationships it facilitates or inhibits between staff and clients, and the

practice ethos that drives these first two factors (for example, whether it is seen that the role of staff is to work *with* or work *on* clients) warrants close attention. One site in which this may be the case is in the context of mental health wards, where staff are charged with the dual function of monitoring clients to prevent harm, but also working with clients to facilitate their recovery.

The research presented in this article reports upon an observational ethnographic pilot study aimed at examining how both clients and staff move in and respond to the design features of one purpose-built mental health ward located in a public hospital in Adelaide, South Australia. Our interest in conducting this research was to examine how those who use the mental health ward in question relate to the space around them, and in particular to consider the implications of specific aspects of the site that potentially impact upon site users, with a particular focus on the duty station. Our research question, therefore, centered around how clients and staff used the duty station, and in this paper we report on our findings concerning this usage, and extrapolate from these to examine the implications of the design and positioning of duty stations within mental health units. As such, the project takes up Halford and Leonard's (2003) suggestion that "Not only do people make spaces, but spaces may be used to make people" (p. 202), because in the context of mental health units there is a tendency to believe that there has been a paradigm shift away from the types of units identified in the work of Foucault (2006) or Goffman (1961), and towards units that recognize the rights and dignity of clients as human beings. Our findings, however, suggest that as with any paradigm shift, in reality there are overlaps between what went before and what occurs in the present. Specifically, and as noted by Foucault, whilst the particular ways in which surveillance is enacted may change, surveillance is still considered the norm when it comes to the provision of services to clients in mental health facilities.

Before outlining our project and the findings as they pertain to the duty stations, we first

outline the research published to date that has focused on the impact of the design of duty stations upon both clients and staff, focusing on work which has considered the duty station in any form. It should be noted that the reason for our use of the term ‘duty station’ as opposed to the more traditional ‘nurses’ station’ or ‘nursing station’ is simply that in the facility that was the focus of our study the name displayed over each such station was ‘duty station’. Despite the fact that some staff or clients may have referred to the stations by other terms, we have chosen to opt for the official title allocated within the unit. In doing so, however, we are mindful of Jarrell and Shattell’s (2010) insightful discussion of the implications of the terms used to refer to stations, and the important semantic and procedural differences between the term ‘nurses’ station’ (which is the province and possession solely of staff) and the term ‘nursing station’ (which implies a task orientation that is more clearly directed towards the role of nursing and thus also clients).

Duty Stations and Previous Research

The small body of research that has focused on the mental health implications of the use and placement of duty stations has emphasized two factors: the effects of surveillance upon both staff and clients as individual cohorts, and the effects of the distancing and separation that arises from the position and function of duty stations upon the relationship between staff and clients.

In relation to surveillance more generally within mental health units, it is important to note, as do Andes and Shattell (2006), that entering into any mental health unit requires a relinquishment of control, and this relinquishment may be welcomed by many clients. However, Andes and Shattell also note that the injunction to relinquish control - and the corollary uptake of control by staff on behalf of clients - must be balanced against the need to work *with* clients to

achieve a return to normal functioning, or at least an approximation of it. Monitoring clients is an essential part of the role of staff in mental health units, and must be done so as to create spaces that do not exacerbate or perpetuate the possible factors that instigated the client presenting at the service in the first place. Further, research suggests that despite a duty station providing some degree of staff-only space which ensures that staff can speak privately about clients or indeed take a break from clients, clients often have no similar private space of their own (Halford and Leonard, 2003; Thomas, Shattell, and Martin, 2002). In this sense, the duty station serves as a signifier of surveillance: that staff are in the position to watch, and that clients are always already in a position of being the object of such watching. We are of course mindful that observation is a central part of mental health units. Our concern, however, and one that is shared by researchers such as Andes and Shattell (2006), are the ways in which duty stations may only or primarily serve a *solely* regulatory role, rather than also serving a role in rehabilitation. Indeed, this point was noted by nursing staff in recent research by Novotna, Urbanoski and Rush (2011), who discussed the tension between ensuring patient safety through the use of the observational function of a duty station whilst also encouraging an effective therapeutic relationship.

These tensions found in results from the above research brings us to the second area that the literature has focused on in relation to duty stations; namely the potential for duty stations to have a distancing effect rather than a therapeutic one. For clients, and as noted by Cleary and Edwards (1999), presenting to a duty station for assistance is often no guarantee that assistance will be provided, and some research has noted that clients may exhibit nervousness in approaching the duty station to request assistance (Novotna, Urbanoski and Rush, 2011). In contrast, Andes and Shattell (2006) note; “psychiatric patients are generally expected to interrupt what they are doing if a nurse requests their attention. Nurses thus have the power to decide

when to engage in contact with patients, but patients often do not have a choice” (p. 702). Duty stations function as a clear barrier between staff and clients, one that is marked by a complex set of power relations in which clients are unlikely to feel empowered to engage with staff, and which potentially position clients as a ‘demanding object’ upon staff.

Indeed, research conducted by Tyson, Lambert and Beattie (2002) found that when the unit they observed was redesigned to provide staff with a dedicated private space, clients spent less time milling around or approaching the duty station, as it was made clear that when staff were in their space it was to do administrative work, whilst when they were outside the unit they could be freely approached. Andes and Shattall (2006) note an opposing possibility, namely that duty stations could be open spaces that clients can move freely in and out of, albeit with respect for staff and the work they are required to complete. However, findings from other research suggests that this would place a considerable pressure upon staff, who would effectively then have no ‘down time’, as well as no place from which they can combine administrative duties with client care (Novotna, Urbanoski and Rush, 2011). Further, we also suggest that such a model may place pressure upon clients who, in a potentially already vulnerable psychological state, would be charged with the requirement to adequately read and respond to the cues of others, rather than having access to a structured mode of requesting assistance.

In summary, previous research that has included a focus on the impact of duty stations upon either clients or staff, indicates that duty stations, even in reconstructed facilities, still function primarily in a regulatory role, and moreover that this does little to move beyond the level of surveillance required to encompass a consideration of a more therapeutic model of care embedded within the design of the ward and the duty station. Further, it would appear that duty stations continue to operate in ways that separate clients from staff, and which reinforce power

differentials between the two groups, although a tension exists in relation to, on the one hand, the need for staff to have a space of their own, and on the other, the need to breakdown power imbalances produced by duty stations..

Method

Setting

The study was conducted in the mental health unit of a large public hospital in South Australia. As mentioned previously, the aim of the project was to examine the use of this space by both staff and clients, in terms of movement within the spaces provided to clients in both the secure and open wards. The buildings in which the mental health unit was located were completed in stages between 2009 and 2010. The secure ward had a total of 6 beds that were all single rooms, and three bathrooms with one disabled bathroom. The open ward contained 20 beds, and 10 bathrooms with one disabled bathroom and one assisted bathroom. Both of these wards were typically fully occupied throughout the time the study was undertaken. Staff entered both wards through the emergency admission as they would enter any other ward within the hospital. Clients who were considered to pose a risk to themselves or others were initially placed within the HDU (High Dependency Unit) for more rigid surveillance, and were often admitted with the presence of security guards. Clients were moved from the HDU into the open ward after a period of approximately two weeks, although this varied greatly depending on the needs of the client in question and instructions from the psychiatrists involved. Conversely, on one occasion during observations, a client was moved from the open ward into the HDU after behaving in a

threatening way towards clients and staff.

Ethics and Participants

Ethics approval was granted from both the University of South Australia's Human Research Ethics Committee and from the Ethics Committee of the hospital involved in the study. Clients, staff and visitors at the hospital were informed of the study through information sheets that were placed around the ward. Staff interacting with the second and third author were assured that anything they said would remain strictly confidential, and the information sheet stated that no identifying information would be used in any publications that arose from the study. We informed all users of the ward of the times that the observations would take place (typically one day a week for a three hour time slot). The movements of clients, staff and visitors were observed throughout the ethnographic observations.

Procedure

The second author carried out ethnographic observations on ten occasions for three hours each, a total of 30 hours of observations. These observations were conducted during both the morning and afternoon over a ten-week time-period, to ensure rigour in the observations in terms of consistency of space-use, and the time was split evenly between both the secure ward and the open ward. In the open ward, the second author spent time both within and outside the duty station, however in the secure ward the majority of time was spent observing from within the duty station for security and ethical reasons. Brief notes were taken during observations, but in

order to reduce the amount of time spent note-taking during observations the majority of the field notes were written immediately after leaving the hospital premises. In addition to these 30 hours, the third author also conducted four hours of ethnographic observations entirely from within the wards, including the secure ward. These observations were conducted in order to examine the use of spaces within the wards by clients and staff, including the use of the duty station. The notes concerning duty station use form the data set for this paper. Both the second and third authors remained neutral during these times, rarely asking questions of staff unless wishing to gain clarification in relation to a particular procedure or space. Where clients or staff asked either author what they were doing, both of the authors who undertook observations replied that they were observing the use of space and the architecture within the ward.

Ethnography was chosen as the methodology for this study since the literature has identified it to be an appropriate method for use in healthcare settings (Johansson, Skärsäter and Danielson, 2006; Savage, 2000; Sinding, 2010). In particular, ethnographic observations are typically unobtrusive and allow the researcher to develop a flexible approach to both understanding an environment, and to gaining insight into the relationships between that environment and the behavior of the people within it in a naturalized setting. Rigour within the study design was maintained through the fact that two of the researchers independently conducted observations and familiarized themselves with the ward, meaning that their field notes could be compared for consistency in terms of observations around the use of duty stations (and see Gobo, 2011 for further discussion of consistency in ethnographic research). However we acknowledge that, as a pilot study, the data collection process was conducted on a relatively short-time frame for ethnography and only within one site, and thus we do not claim generalizability for our results.

Analytic Approach

On completion of the observations, the field notes were analyzed using thematic analysis, following the approach laid out by Braun and Clarke (2006)., Braun and Clarke (2006) provide rigorous guidelines for conducting thematic analysis in qualitative research within the broad study of psychology and these guidelines were followed in each stage of the analysis of the field note data. Initial analysis of the entire corpus revealed a primary theme surrounding the use of the duty station by both staff and clients, and the corresponding extracts from the data concerning the duty station were further analyzed in order to reveal the patterns of use of this space. Themes were then cross-checked by all authors to ensure reliability at the analysis stage of the project. The results of this analysis are presented in the following section.

Results

As discussed, a primary concern in relation to the design of mental health units is that of the location and use of the duty station. In the current study, the duty station emerged as a primary point of interest during the ethnographic observations, and thus constituted a theme arising from the data. In the analysis that follows we examine the use of the duty station in both the High Dependency Unit (HDU - the locked ward) and the open ward. Our ethnographic research noted both similarities and differences between the use of the stations in these two spaces, which we discuss in detail.

The Duty Station in the HDU

The duty station in the HDU is made up of large panes of glass that wrap around the whole of the station, separating the duty station itself from the ward. At the centre of this wall of glass is one large pane of glass that is not open to the ward (i.e., it cannot be opened like a window) but which has a ledge extending into the ward (see figure 1). To the right of this pane of glass and around the corner - from the point of view of clients inside the ward - is the door to the station, which contains a large window in the top half of the door which also could not be opened.

Figure 1: Photograph of Duty Station in HDU



During the observation periods clients were seen interacting with staff at the HDU duty station in two distinct ways: by coming to the large pane of glass, in which case clients tended to talk 'at' staff through this window, and secondly by approaching the door and either waiting or making some motion to gain the attention of staff, in which case the clients tended to be seeking to have their requests fulfilled. Indeed, it was the door to the duty station in the HDU rather than the large glass pane that clients tended to approach. At the conclusion of the first day of observations it was noted that:

Overall the door to the duty station in the locked ward appears to be a central part of interaction between staff and clients – also worth noting that it is the door and not the window. People rarely seem to go to the window in the locked ward.

This is of particular interest given the functions of continuity and flow of light and space that glass is supposed to perform. In the HDU, by contrast, it appeared that the large pane of glass acted more as a barrier, and instead it was the door – through which people could actually move and sound could travel more easily – that clients preferred to make their requests through. This attraction to the duty station window is illustrated in the next extract:

Patients come up to the [HDU] duty station a lot with requests. These are often for cigarettes. One female client within the ward is manic and staff restrict her to coming every 1/2 hour as otherwise she is coming all the time. Another young male client comes out of his room late and comes to ask for a hot dog at the door. Clients also come to the

door to ask to call parents/ask about mail/ask for glue/ask for medication (one man comes to ask for something to calm him down as he feels agitated).

However, clients did not always have their needs met through approaching either the large glass pane or the door, as can be seen in the following extract:

Another staff member comes into duty station and two staff members taking blood from a client in the ward call for him and he goes into the ward where he chats to a client for a bit. The staff member then comes back into the duty station and the client he had been chatting to comes up to the station window and elbows it aggressively. Other staff then come back inside having finished up with another client. The client who has elbowed the window comes up now to the door and punches it and staff say 'get away' and he walks away.

This extract is notable for the illustration it provides of the lack of functionality of any of the physical points of connection between staff and clients. Whilst both the large pane of glass and the door ostensibly invite interaction, the interaction is always already moderated by the wishes of the staff. Yet despite this, clients continued to attempt to engage with staff at these points of contact, which was clearly illustrated when the hospital in which the HDU was located changed its policy on smoking.

During the later weeks of the observation the policy changed from allowing smoking outside to a total ban on smoking on hospital premises. For clients inside the HDU – who only had access to a small courtyard space located within hospital grounds – this meant that cigarettes

became off limits and alternative therapies including inhalers, lozenges and patches were made available. This change was anticipated with concern by staff since smoking was previously a common practice for many clients in the HDU, and indeed requesting a cigarette was one of the most common reasons for approaching the duty station in this unit. Given the number of times clients were observed approaching the station to request cigarettes prior to this change in policy, it is noteworthy that clients were not observed approaching the station any less on the days that ethnographic observations were conducted subsequent to the change in policy. The below extract is taken from day 10 of observations, approximately two weeks after the change in smoking policy:

A female client comes to window to ask to speak to her mum, then wanders off. Have noticed people coming to window more today to ask for various items, although the clients still tend to approach the door more frequently – man comes up to window asking for some sticky tape. Again he taps on the ledge to get attention. He has some paper in his hand that he wants to fix up (it is ripped). Nurse gets him some sticky tape.

It appeared that clients continued to approach the station with the same or indeed greater frequency despite that they were no longer able to request cigarettes. This would therefore suggest that it is potentially the approach and response that serves a purpose for clients in the HDU, rather than the purported reason for the approach itself. However, when the design of the point of contact such as the duty station hinders the approach *and* the psychological benefit to be gained from it through human interaction, the rehabilitative function of staff/client interactions may be minimized. Part of this may be explained, we would suggest, by the fact that the large

pane of glass has a ledge attached to it, yet the ledge does not function as it otherwise might in a bar or café through the provision of somewhere to interact, but instead simply provides another barrier between staff and clients.

The findings therefore suggest that the design of the duty station in the HDU was potentially not orientated primarily to the needs of the clients, but more to the needs of the staff. Previous research has indicated that duty stations are important spaces for staff to be able to discuss confidential matters or to take some space from clients. The observations conducted for the present research also suggest a further function of the particular design of the duty station, namely one of controlling clients. As discussed in the introduction, previous literature has highlighted the role of the duty station in terms of surveillance. In the present study the HDU duty station represented a site that allowed staff to regulate the movements and actions of clients within the ward. For example, staff were observed on a number of occasions restricting the frequency with which clients were able to approach the station with requests.,.

Furthermore, staff were also able to monitor requests for items such as cigarettes (when these were still available), clothing that was kept in the store room, and other services such as access to food and drink (a sink with a jug of water was located in the ward, however other drinks and items of food had to be requested from staff) via the duty station. Thus the station acted as a conduit between staff and clients in terms of communication, however it arguably also acted as a barrier between staff and clients, and one that reinforced the power of staff to maintain control over clients' lives through areas such as determining what resources clients had access to. This was exacerbated by the fact that staff were only rarely observed within the HDU itself unless there was a specific reason for them to be there – such as conducting name counts, administering medications or performing general check-ups. Instead, staff spent the majority of

their time separated from HDU clients in the duty station, meaning that if clients needed access to anything (such as clean clothes), they were required to approach the duty station to make such a request. Of course, we again recognize that such issues are also related to security, particularly in relation to the HDU where items may need to be withheld due to concerns such as suicidality, however we feel that such practices need to be scrutinized to ensure that interactions between staff and clients revolve around a principle of therapeutic relationships where possible rather than issues of control.

We would argue that the utility of the duty station in the HDU in terms of serving a rehabilitative function for clients is thus questionable, particularly because the communication that occurred frequently appeared to be one-way. That is, it was observed on a number of occasions that clients would approach the window and talk ‘at’ staff who were sitting on the other side of the glass working at the bench directly behind the window. Such interactions, however, were frequently not reciprocated – a point noted by the second author in terms of her own responses to clients presenting at the HDU duty station window:

At first I feel uncomfortable ‘ignoring’ the client or anyone else when they come up to the station and chatter away, but this is what other staff do and I realize I am starting to get used to it and there are times when if I am taking notes I also start to forget someone is there talking.

This extract highlights the regulatory effects of the design of the duty station in the HDU upon both clients *and* staff. Not only would we argue that the station interface does little to ‘prepare’ clients for a life outside of the ward where ‘performing’ in front of inattentive others is

typically frowned upon, but the interface also potentially encourages staff to adopt a position in which they are alienated from clients. This is even more pronounced where structures such as the duty station appear to inhibit staff from engaging in meaningful interaction such as a conversation sitting on a couch or at a table, and instead encourage interaction which is only conducted on the terms of staff through a window or a door. Of course the practice of remaining primarily behind the duty station window is one which may be related to the security concerns of staff, and this was a point that staff did make to the authors during the observations. However, it was noted that security practices such as ensuring that while a staff member was inside the HDU they carried a personal alarm, and that that another staff member was present observing from the HDU would go some way to ensuring that security for staff can be maintained while also encouraging staff to leave the duty station to interact with clients, particularly if the duty station were designed in such a way as to further facilitate the flow of movement. This point about the effects of the HDU duty station upon staff is one we turn to later, but first we now examine the role of the duty station in the open ward, and the differences between the open ward and the HDU.

Open Ward

In comparison to the HDU, the duty station in the open ward is larger and contains several panes of glass wrapping around the entire station. This includes two windows that can be opened by both staff and clients, that is from the inside or the outside, as well as two doors into the station located at either side of the windows (as seen in figure 2).

The use of these potential points of interaction between clients and staff is outlined in the following extract:

In the open ward the duty station has a window which lifts up, and clients can lift it up too. This window appears to be a more central part of communication than the door(s), although clients appear to come up to the duty station much less in this ward than in the locked one.

Figure 2: Photograph of Duty Station in Open Ward



This extract highlights one of the main differences between the duty station in the HDU and the open ward – namely the number of times that clients approached the duty station in both wards. There could be a variety of reasons for this difference, most obviously that clients in the open ward had greater access to their possessions and other amenities and hence did not require permission from staff to use them. For example, in this ward clients were regularly observed talking on their own mobile phones, therefore reducing the need for clients to request to make phone calls, and clients had access to a fridge and tea and coffee making facilities. Most clients were also free to wander around the hospital grounds, meaning that they could also access a number of food outlets, and clients were able to carry their cigarettes or tobacco with them in this ward, thereby reducing the need to request cigarettes from staff.

It is also worth noting that nursing staff spent a much greater amount of time in the ward itself than they did in the HDU. Whilst it is acknowledged that there are security concerns in the HDU, we would also suggest that the differences observed in the behavior of staff in relation to leaving the duty station could also be attributed to the different designs of these two stations. As mentioned previously – and as can be seen in Figure 1 above - the duty station in the HDU appeared to operate much more in terms of enabling the surveillance of clients by staff rather than to ensure that communication between staff and clients was facilitated. In contrast, the duty station in the open ward appeared to be set up in a more interactive manner, enabling a greater ‘flow’ between the space inside and outside the duty station. Such a flow could arguably also account for the increased ease of movement of staff between these two spaces.

When clients did approach the station, however, it seemed to take longer in the open ward than in the HDU for them to gain the attention of staff. This is discussed in the extract below:

Lots of staff hang around the duty station chatting about various issues and clients do seem to hang around a bit without getting attention from staff – some end up knocking on the windows to get attention. There are two windows to this duty station, and two doors. The design seems to mean that clients come to windows rather than to the door as they do in the locked ward. Once clients have the attention of a staff member the latter often seem to go outside the duty station to see them, though sometimes they do talk to them through the window after lifting it up.

This extract highlights that, much like in the HDU, the open ward duty station operated not only as a conduit for communication (as it is arguably designed to do), but also as a barrier between staff and clients, and a space in which staff were able to exercise power over clients by making them wait before giving them attention. This differential power relationship between staff and clients was clearly seen in the actions of clients in relation to the duty station space in the open ward. For example, although the windows to the station could be opened by clients on the outside of the station, a client was only observed on one occasion to open the window himself. Similarly, even when the station windows were open, clients rarely attempted to attract attention to themselves beyond simply standing at the window and waiting, as demonstrated in the following extract:

A female client comes up to the duty station where the window is still open and just stands there for a while until someone looks up – then asks to see a nurse and is told she is busy. The client says wants someone to explain blood test results to her. She is quite

agitated. Nurse tries to explain but the client isn't happy with what she says. Nurse says that she really needs to speak to her doctor. Client stands for a bit at the window whilst the nurse returns to what she was doing inside the station and ignores her. Client stands for a bit just at the station window and then wanders off and finds another nurse to ask who is wandering around inside the ward. When this nurse comes back into the station they close the station window and begin to discuss the client.

As such, despite being agitated and wanting assistance, this client did not actively attempt to attract the attention of the staff working inside the duty station. Instead, she stood and waited until the staff member looked up, and then remained standing and waiting after the staff member resumed her work inside the station. Conversely, when a staff member walked past her inside the ward the client actively intercepted them to ask a question. This is suggestive that the station acted as a barrier to communication between the client and the nurse by ensuring that the nurse retained her position of power and control over the interaction and was able to resume her work without resistance from the client on the other side of the glass. On the other hand, the client was much more in a position of control over the staff member inside the ward where she was able to also regulate the communication. Issues pertaining to staff use of the duty station are discussed in the next section.

Staff use of the Duty Station

As outlined thus far, one of the main observations of the stations were the differences in staff behavior between the HDU and the open ward; that is, staff were much less likely to leave the

station in the HDU than they were in the open ward. Part of the reason for this difference is likely to be security concerns relating to some of the clients detained within the HDU, however we argue that this difference can at least in part be attributed to the different design of these two spaces. That is, the station in the open ward facilitated the movement of staff into the ward to a much greater extent than did the design of the station in the closed ward.

It must of course be noted that the greater degree of movement by staff in the open ward may have been because not all of the ward could be seen from the duty station (as it was a larger space – see figure 3), and therefore that staff had to ‘patrol’ the open ward to a greater degree. However, this reason is mitigated by the fact that security cameras were installed in all sections of both wards and were actively monitored by staff. Further, we would note that the staff presence in the open ward included staff engaging in interactions with clients or participating in activities. As such, ‘patrolling’ of the open ward is likely to account for a relatively small proportion of the reasons why staff were more likely to venture out of the duty station in the open ward compared to the HDU.

Figure 3: Map of Ward

The limited and highly visible use of the duty station as a space for staff to undertake the administrative side of patient care has a number of implications in terms of their role as professionals. For example, it meant that nursing staff had to update notes and perform other tasks while sitting at a desk behind the window, and nursing staff and doctors were frequently observed discussing clients in the nursing station. This meant that staff were frequently busy when clients approached the station, and clients were often told to wait before their concerns were addressed, or were even ignored completely. The below extract illustrates this, taken from observations in the open ward:

...another female client comes up to the other station window which is closed, and stands for a while, then approaches a nurse who is walking into the ward – then comes back to the duty station and stands for a while again. Nurse in station is doing work and doesn't look up but then client knocks on the window and the nurse does look up. Again I think people tend to approach the station less in this (open) ward than in the secure ward. Also it appears to be difficult sometimes to get the attention of staff at the station via the window, particularly if the windows are down. I have only rarely noticed clients opening the windows themselves.

Thus it appeared that even in the open ward the station was viewed primarily in terms of the function it served nurses rather than the function it served clients. That is, the station appeared to be primarily seen by staff as a place to do work and staff were even occasionally observed to be annoyed if interrupted by clients. The multiple uses of the duty station clearly

presented issues for all users of the space inside the wards particularly in relation to the observation that the windows in the duty station in the open ward were generally kept closed, thereby acting as a barrier between the station and the clients – a barrier that was rarely actively removed by clients themselves. The observation noted above in relation to the client being required to wait before being noticed by staff was a common occurrence and highlights the difficulties and ambiguities of the station for both clients and staff.

The function of the duty station as a space for work by staff also presented other problems, outlined clearly in the next extract:

A client in the open ward goes down to the bedrooms, then comes up to the station window and asks a staff member to look for her pink jumper as if she gets day leave tomorrow to see her son she wants to wear it. She says she 'only has daggy clothes here and wants to look nice'. She walks off and sits at a table. Staff chat about this request as they think she isn't up for day leave as she is too paranoid. The client approaches again and asks when her doctor is coming. Staff say 'soon' and she goes and sits back at the table and chairs and watches as doctor comes into duty station. Doctor and staff chat – the client wants leave to go to her son's sports day but staff think it is too early. They are shaking heads, etc and the client is watching closely. At one stage she says 'you're kidding me' and starts to cry.

It is clear that the lack of private space in which the nursing staff and the doctor in charge of this particular client could discuss this issue had a negative impact on the client herself. Furthermore, the need for staff to discuss clients in full view of the clients themselves arguably

perpetuates the power relationships between staff (as regulators of the movement of clients) and clients. The female client in this extract is unable to participate in the conversation between the nurses and her doctor, but is able to observe this conversation taking place. As such, the station operates in this instance to render her helpless and powerless – an obstacle she attempts to overcome when she approaches the station several times to speak with staff prior to her doctor coming in and cries out at one stage in the conversation.

In the following discussion we examine the implications of the findings we have presented and consider some possible ways of addressing the concerns we have raised.

Discussion

As noted throughout our findings, a hallmark of the duty station in the facility in which we undertook our observations was the fact that it appeared to do very little to facilitate positive relationships between staff and clients. This primarily appeared to be the case because of the design of the stations in both the HDU and the open ward, which both provided no private space for staff, and were structured to suggest that an approach to the station was possible, but that there was little guarantee that the approach would be successful due to the nature of the design of the stations.

It seems possible that a large part of the reason for the failure of the duty stations to function in ways that facilitate positive relations is the positioning within the two wards in ways that appeared to centre upon surveillance. This was a product both of their orientation into the wards (which involved large panels of glass directly facing the remainder of the wards), as well as their position within the wards (which were located at the entry point to both wards). We are,

of course, appreciative of the security concerns relating to stations in locked units. Nonetheless, we would argue that where the duty station operates *primarily* in terms of surveillance, the ability for clients to have their needs met and to develop healthy relationships with nursing staff is restricted. As such, there is a role for arguably less intrusive security features or design, such as closed circuit television (CCTV) monitoring. Security features such as CCTV are likely to ensure that both staff and clients are able to be kept safe – and indeed to feel safe – but are less likely to promote differential power relationships between staff and clients in the way that the duty stations appeared to do. Although previous literature is unclear in terms of which security features are effective in particular areas (such as preventing clients self-harming), research does suggest that properly-implemented surveillance features such as CCTV can facilitate the reduction of violent incidents (Duxbury 2002; Meehan et al. 2006). The effectiveness of CCTV specifically, and particularly in terms of replacing a duty station, is an area which could be the focus of future research (Desai 2010).

In relation to freedom and movement, it is also important to point out that while clients in the open ward could move out of the ward and indeed the hospital, the centrality of the duty station and its role as a focal point may well override any sense of freedom of movement for clients in this ward. In the HDU, these issues of movement are compounded by the fact that the contact point at the HDU duty station is relatively large in comparison to the size of the HDU itself. This design is aimed at ensuring maximum observation of those at highest risk of harm (observation that may well be welcomed by some clients), but the disparity between these spaces may nonetheless impact negatively upon clients in the HDU if they feel over scrutinized.

We now turn to some possible ideas for how the concerns raised by our findings might be addressed. First, it would seem important that the space in which nurses undertake

administrative work is separate from the space in which they provide direct care to clients. Clearly, such an arrangement would mean that staff would need to be single-duty focused, and in an age of economic rationalism this is unlikely to be welcomed by healthcare administrators. Yet we suggest that the benefits are obvious: staff who are rostered to undertake administrative work can do so without interruption and staff in general can have space away from the unit itself and the eyes of clients. Having a dedicated staff-only space that is not open to clients would also mean that those staff rostered for direct client work can be in the ward and thus available to clients, or minimally at some form of open duty station where they may still be able to take notes or other light duties but can be primarily focused upon clients and their presenting needs.

Furthermore, having a separate staff administration/retreat area that is located in the periphery of the ward, and then having an open duty station that is located within the ward but not necessarily in a central position (which would avoid it appearing as a form of panopticon), may help to facilitate a sense of space in which the entire ward is not centered around surveillance. Indeed, it seems anomalous, in the age of technology, that the primary work of surveillance could not be undertaken via cameras in a room accessible only to staff. Of course, any use of surveillance must bear in mind some of the ethical concerns around using surveillance in terms of control, as well as areas where surveillance technologies such as CCTV might be problematic, such as the potential for issues in use with clients who are psychotic (see Desai, 2010).

Further, surveillance must not be used as a substitute for human interaction and thus, ward staff could still maintain monitoring of clients as part of their role. But the fact that ward staff would primarily be charged to work *with* clients would help to positively connect any forms of surveillance with actual human contact aimed at supporting clients and facilitating their

recovery. This might go some way towards addressing McMahon's (1994) question as what a 'non-institutional institution (p. 343) might look like. Our suggestion is that such a space, and specifically as pertaining to duty stations, would both incorporate the administrative and protective functions that are required, but do so in ways that facilitate the client-staff relationship. Indeed, the relationship between nursing staff and their clients is acknowledged by early career registered nurses as one of the primary elements of high-quality nursing (Cline, Rosenberg, Kovner & Brewer, 2011), and thus structuring space in such a way that best enables the development of such relationships is critically important. We acknowledge that such an approach will not entirely avoid the dual roles of the mental health ward, as both health care facility and home. But perhaps this is precisely the point: clients for the large part do not enter mental health facilities looking for somewhere to live. Instead, they enter (or are forced to enter) under the premise that their admission will facilitate greater functioning so that they can return to or find a home.

Of course, as discussed earlier, this study is limited in relation to its generalizability to other mental health wards given the specific details concerning the duty station which impact upon the findings presented here. Nevertheless, these findings contain important points concerning the design and placement of duty stations that can be considered within a range of mental health care units. Further, as a pilot study, our results are preliminary. However, they provide an important base from which further research can build in relation to how staff and clients use duty stations, how they affect interactions between staff and clients, and in turn, how their design may have an impact on wellbeing and recovery for clients within mental health wards.

To conclude, mental health wards must be both welcoming and a place in which healing

can occur, but not a place in which most clients are expected to reside for the remainder of their lives. This disparity presents a difficult challenge to designers and health practitioners. Straddling the line between being therapeutic (and thus not primarily homely) and being welcoming and inclusive (and thus in some forms homely), requires an approach to the orientation of space that does not seek to mask the therapeutic aspects of admission to a mental health ward, including surveillance, which some clients may experience as vital. However, the role of surveillance must be teamed with opportunities to build therapeutic relationships with clients outside the role of surveillance or control that staff must sometimes take on. Jarrell and Shattell's (2010) comment about the semantics of 'nurses' station' versus 'nursing station', having both a separate, private staff area as well as an open station/area through which clients can interact with staff may help to facilitate the building of such relationships.

References

- Andes, M., & Shattell, M. M. (2006). An exploration of the meanings of space and place in acute psychiatric care. *Issues in Mental Health Nursing, 27*, 699-707.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.
- Cline, D. D., Rosenberg, M., Kovner, C. T., & Brewer, C. (2011). Early career RN's perceptions of quality care in the hospital setting. *Qualitative Health Research, 21*(5), 673-682.
- Desai, S. (2010). Violence and surveillance: Some unintended consequences of CCTV monitoring within mental health hospital wards. *Surveillance & Society, 8*(1), 85-92.
- Duxbury, J. (2002). An evaluation of staff and patient views of strategies employed to manage inpatient aggression and violence on one mental health unit: A pluralistic design. *Journal of Psychiatric and Mental Health Nursing, 9*, 325-337.
- Foucault, M. (2006). *The history of madness*. New York: Routledge.
- Gobo, G. (2011). Ethnography. In Silverman, D. (Ed.) *Qualitative Research*. London: Sage Publications.
- Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. New York: Doubleday.
- Halford, S., & Leonard, P. (2003). Space and place in the construction and performance of gendered nursing identities. *Journal of Advanced Nursing, 42*, 201-208.
- Huffcut, J. C. (2010). Can design promote healing? *Behavioural Healthcare, 30*, 33-35.
- Jarrell, A. D., & Shattell, M. M. (2010). 'Nurses station' or 'nursing station'? How to appropriately describe our work space in acute care? *Issues in Mental Health Nursing, 31*, 237-238

- Johansson, I. M., Skärsäter, I., & Danielson, E. (2006). The health-care environment on a locked psychiatric ward: An ethnographic study. *International Journal of Mental Health Nursing, 15*, 242-250.
- McMahon, B. (1994). The functions of space. *Journal of Advanced Nursing, 19*, 362-366
- Meehan, J., Kapur, N., Hunt, I., Turnbull, P., Robinson, J., Bickley, H., Parsons, R., Flynn, S., Burns, J., Amos, T., Shaw, J., & L. Appleby. (2006). Suicide in mental health in-patients and within 3 months of discharge. *The British Journal of Psychiatry, 188*, 129-134.
- Novotna, G., Urbanoski, K., & Rush, B. (2011). Client-centered design of residential addiction and mental health care facilities: Staff perceptions of their work environment. *Qualitative Health Research, 21*, 1527-1528
- Savage, J. (2000). Ethnography and health care. *BMJ, 32*(1), 1400
- Shattell, M. M., Andes, M., & Thomas, S. P. (2008). How patients and nurses experience the acute care psychiatric environment. *Nursing Inquiry, 15*, 242-250.
- Sinding, C. (2010). Using institutional ethnography to understand the production of health care disparities. *Qualitative Health Research, 20*(12), 1656-1633.
- Stichler, J. F. (2008). Healing by design. *Journal of Nursing Administration, 38*, 505.
- Thomas, S. P., Shattell, M., & Martin, T. (2002). What's therapeutic about The therapeutic milieu? *Archives of Mental Health Nursing, 16*, 99-107.
- Tyson, G. A., Lambert, G., & Beattie, L. (2002). The impact of ward design on the behaviour, occupational satisfaction and well-being of psychiatric nurses. *International Journal of Mental Health Nursing, 11*, 94-102.
- Ulrich, R., Zimring, C., Zhu, X., DuBose, J., Seo, H., Choi, Y. S., Quan, X. & Joseph, A. (2008). A review of the research literature on evidence-based healthcare design.

Health Environments Research and Design Journal, 1, 61-125.