Title

The influence of psychiatric inpatient environments on ethical decision making of psychiatric nurses

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Publication Date

1985

Peer reviewed|Thesis/dissertation

THE INFLUENCE OF PSYCHIATRIC INPATIENT ENVIRONMENTS ON ETHICAL DECISION MAKING OF PSYCHIATRIC NURSES

by

Susan Hunn Garritson

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF NURSING SCIENCE

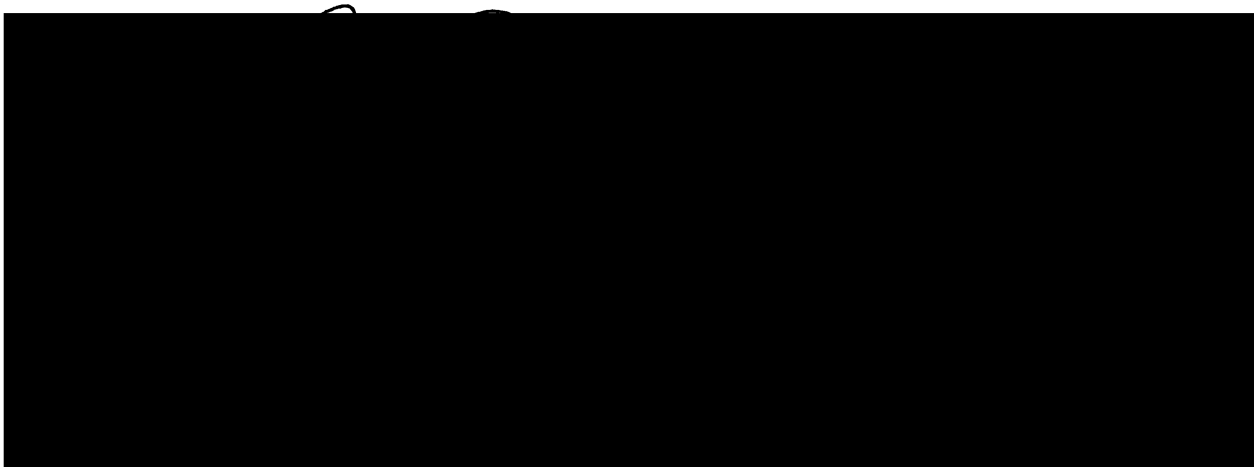
in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA

San Francisco



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ACKNOWLEDGMENTS

My decision to study the concept of restrictiveness was an obvious conclusion arrived at from two unrelated circumstances. First, I had been hearing nursing colleagues question the meaning of documentation of "the failure of the least restrictive intervention" required prior to seclusion of patients by accreditation standards. Second, my efforts to identify factors influencing staffing acuity in psychiatric settings were frustrated by my perception that staffing levels depended on the setting's tolerance for varying degrees of restrictiveness. When a journal article coincidentally appeared defining restrictiveness and the least restrictive alternative, I knew immediately what would be my future direction of study. I have never regretted my decision and am grateful to my colleagues at Langley Porter Psychiatric Institute and faculty at the School of Nursing, University of California, San Francisco for creating the unique set of events that resulted in my conceptualization.

I specifically wish to thank Dr. Anne Davis, Sponsor and Chair of the Dissertation Committee, for her guidance throughout my doctoral education. Her enabling and supportive style has reduced many obstacles to insignificance. Her particular contributions to my study of the ethical perspective of the least restrictive alternative were pivotal. Dr. Davis co-authored the article, "Least restrictive alternative:

Ethical considerations", Journal of Psychosocial Nursing and Mental Health Services, December 1983. Committee members Dr. William Holzemer and Dr. Holly Wilson provided excellent critique based on their knowledge and clinical and research experience, and I am particularly appreciative of their professional style and collegial manner.

I am grateful to Don Chambers for his consultation in data analysis and computer techniques. I also wish to thank Cheyney Johansen for her skillful and knowledgeable manuscript preparation.

The literature review of this dissertation (portions of Chapter II) is a reprint of two manuscripts as they appear in Journal of Psychosocial Nursing and Mental Health Services, 21 (12), December 1983. Permission to reproduce this material has been received from Slack, Inc., 6900 Grove Road, Thorofare, NJ 08086.

Partial funding for this research was gratefully received from UCSF Patent Funds, UCSF Instructional Use of Computer Funds, Alpha Eta Chapter of Sigma Theta Tau, and School of Nursing Opportunity Funds. National Institute of Mental Health Traineeship 5 T01 MH16122-04 and a Graduate Opportunity Fellowship assisted me during my educational program.

My husband, Bruce Garritson, has consistently encouraged my educational endeavors and has generously provided moral support, practical assistance, and thoughtful perspectives. My son, Paul, is a constant reminder of the special relationship between the autonomous human spirit and human needs for nurturing. This dissertation is dedicated to my husband, son, and parents, Richard and Berniece Hunn, who have each contributed their stimulation and inspiration to the circumstances that resulted in this project.

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ABSTRACT

This study examined the relationship of inpatient psychiatric treatment environments and ethical decision making in psychiatric nursing practice. The psychiatric treatment environment was defined by six restrictiveness dimensions: structure, institutional policy, enforcement, treatment, patient demographic characteristics, and staff characteristics. Ethical decision making was depicted by items representing the principles of beneficence, autonomy, and distributive justice.

A conceptual framework based on a human/environment interaction model and the prima facie principles of beneficence, distributive justice, and autonomy formed the basis for three study questions: 1) What are the restrictiveness qualities of psychiatric inpatient units? 2) How are the ethical principles of beneficence, autonomy, and distributive justice represented in clinical decisions by psychiatric nurses? 3) Is there a relationship between the restrictiveness of psychiatric inpatient environments and ethical principles of beneficence, autonomy, and distributive justice in psychiatric nursing practice?

The convenience sample consisted of 177 registered nurses from 29 units representing private, county, university, and veterans administration psychiatric inpatient settings. No statistically significant differences between nurse demographic categories for staff from locked and unlocked units were noted.

Data were gathered for nurse subjects and the psychiatric units using the following eight instruments: Inventory of Structural and Treatment Restrictiveness, Opinions about Mental Illness, Resident Control and Tolerance for Deviance subscales of the Multiphasic Environmental Assessment Program, Staff Demographic Characteristics, Patient Demographic Characteristics, Case Vignettes, and the Nursing Philosophy Statement.

Inpatient units were distinguished by their locked or unlocked security status. These two types of units were also differentiated by patient demographic characteristics and policies for patient decision making. Minimal differences were noted between the two types of units for treatment and enforcement variables.

Frequency results for the ethical principles indicated that beneficence-based items were consistently ranked first choice; however, nurses' decisions were also guided by nonmoral goals of professional responsibility, patient limitations, maintenance of bodily and social safety, and improvement in the patient's quality of life. The lack of a clear mandate for one ethical perspective indicates a situational approach to nursing ethical decision making.

Susan Hunn Garritson

Susan Hunn Garritson, Author

CHAPTER I

PURPOSE OF THE STUDY

Introduction

Nursing's ideological perspective incorporates social, historical, and philosophical traditions that have evolved from their unique origins to create a context for integrating new ideas and for identifying practical problems. Psychiatric nursing's ideology has been influenced by the philosophy of kindness and caring based in the moral therapy movement and by government paternalism during the custodial care era. The upsurge of the western liberal philosophy in the 1960s emphasizing concepts of individual self-determinism, equality, and liberty confronted psychiatry's benevolent position. This liberal political tradition is the basis for the concept of "the least restrictive alternative" and underlies issues such as deinstitutionalization, rights to receive and refuse treatment, and informed consent. These issues have significantly influenced patterns of care for the mentally ill for the past twenty-five years and have posed practical and philosophical challenges to psychiatric nursing. The discipline is beginning to examine its behavior control techniques and deterministic theoretical views to recognize patient self-control. Additionally, least restrictiveness extends nursing's relationship to the community through

identification of alternative health care delivery systems. Thus least restrictiveness is a symbol of the moral balance between the just distribution of resources, respect for autonomy, and provision of care. The operationalization of least restrictiveness in nursing practice represents the discipline's implementation of the social mandate to change delivery of care to the mentally ill. Least restrictiveness concomitantly shapes the profession's identity by influencing the moral codes guiding nursing practice. This process of philosophical and technical change provides multiple research opportunities and is the basis for this study of restrictiveness and ethical decision making in psychiatric nursing practice.

Purpose

This study proposed to examine the relationship between inpatient psychiatric treatment environments and ethical decision making in nursing practice. In order to accomplish this goal, the study also proposed to describe restrictiveness qualities of psychiatric treatment environments and ethical principles in clinical decision making. Psychiatric treatment environments were described using six variables noted to contribute to restrictiveness: structure, institutional policy, enforcement, treatment, patient demographic characteristics, and staff characteristics (attitudes and demographic items). Ethical decision making was depicted by the selection of interventions/ statements representing the principles of beneficence, autonomy, and distributive justice.

Background

The Therapeutic State

The "therapeutic state" has resulted from the merger of a deterministic view of man, which negates the concept of free will and individual responsibility for behavior, with the state's traditional right to exercise parens patriae and police power (Kittrie, 1971). Parens patriae is defined as "the interest of the state in caring for, protecting, or treating persons who are unable to care for or treat themselves. Police power includes the rights of the state to protect its citizens from potential harm or danger resulting from the action or inaction of others" (Roth, 1980, p. 386). Thus the therapeutic state provides for social protection and defense through intervention to change behavior perceived as threatening or needing care.

The application of scientific principles of cause and effect to human behavior has resulted in the belief that the human condition can be altered. The American liberalism movement in the early 20th century expanded the boundaries of political intervention by attending to human needs and social injustice. Intervention was based on an attitude of benevolence and the assumption that all treatment was good. This has led to the belief that the ill, injured, and disabled are helpless and must be helped by others (Szasz, 1974). In psychiatric practice, positivism, pragmatism, and interventionism has combined with the parens patriae philosophy to result in public policy of minimal regulation over professional treatment of individual patients. The primary focus of care is the identification of the individual's needs in order to help

him realize his capacities. The patient has the "right" to imposed treatment (Winslade, 1980).

Critics of "benevolent intervention" charge the state with infringement on the individual's guaranteed rights to due process. The legal language of this challenge to the state is consistent with the American acceptance of law as a legitimate symbol and with the assumption that through litigation courts declare rights, these rights can be realized, and this realization is equivalent to social change (Scheingold, 1974, p. 5). Rights-oriented lawyers have increasingly turned to adjudication as a more promising route to social change than other government forums.

Doctrine of Least Restrictive Alternative

The doctrine of the least restrictive alternative (also referred to as least drastic alternative and reasonable alternative) has stood for the perspective that government actions should be those that least interfere with individual liberties. The doctrine has been used in cases of competing governmental and constitutional issues when the court determines it is critical to protect both interests (Chambers, 1972, p. 1150). Constitutional interests are the individual's civil rights. Governmental interests are regulation of activity for the social good.

The least restrictive principle has been frequently applied when government regulations are so vaguely worded or are so broadly applied that constitutionally protected rights and liberties are infringed upon. However, the least restrictive doctrine has not been applied consistently due to the lack of a priori standards on types of protected expression or forbidden regulations (Keker, 1969). Thus the Supreme

Court failed to apply the least restrictive doctrine to the case of the State v. Sanchez (1968) in which Mr. Sanchez was committed to a mental institution for inability to care for himself. This commitment occurred despite the willingness of Mr. Sanchez's niece to care for him in her home. This case was similar to Lake v. Cameron (1966) in which the doctrine was first applied. Without specific standards, the court must consider each case on an individual basis. Since the court lacks competency in evaluating many less restrictive alternatives (i.e. in terms of assessing costs or effectiveness), the least drastic means test may not always be a predictable decision-making tool.

Effectiveness is a critical component of the least drastic alternative. If effectiveness of the alternative is not considered, then the least drastic alternative becomes no interference at all and the concept is no longer useful to achieve a balance between competing interests. Governmental regulation is reduced to no intervention and individual rights are elevated to an absolute status and cannot be infringed upon. While there are some pragmatic advantages to including the concept of effectiveness when considering alternatives, there is some precedent in a transportation case to interpret the doctrine very broadly and to accept a less effective alternative (Chambers, 1972, p. 1185). Exclusion of effectiveness allows the court to give greater weight to protection of individual rights. Ascribing absolute protection to individual liberty by denying competing interests is one mechanism used by the courts to disentangle itself from dilemmas when less drastic alternatives have not been obvious. Other mechanisms include questioning the state's intent, creating its own interpretation

of political necessity, and determining that first amendment liberties do not apply to the particular case (Keker, 1969, p. 1473).

The doctrine of the reasonable alternative has been primarily applied to cases involving the first amendment. For example, in conflicts between the government's interest to restrict obscene material in an effort to protect its citizens versus the citizen's right to have access to reading material of his choice, the least restrictive alternative supports the citizen's right to access. In the case of Shelton v. Tucker (1960) in which Arkansas teachers were required to list all organizations they had been involved with in the preceding five years, the court ruled that such a broad request may identify organizational relationships irrelevant to a teacher's competency, thus stifling personal liberty. The court ruled that determination of competency could be more narrowly achieved (Wormuth & Mirkin, 1969, p. 285). The Shelton case is an example of the alternative being less satisfactory than the legislature's original regulation. In this case, the individual's right to association outweighed the government's interest (Chambers, 1972, p. 1186).

Several court cases have been influential in establishing and extending patient rights to least restrictive alternatives to treatment. The least restrictive alternative was first applied to mental health care in the landmark case of Lake v. Cameron (1966). Mrs. Lake was a 61-year-old woman with arteriosclerotic brain disease who had episodes of confusion and memory loss and was unable to care for herself. Though not a danger to others, she did have a tendency to wander. She was involuntarily committed to St. Elizabeth's Hospital. Her commitment was challenged on the argument that she did not require inpatient

psychiatric supervision and that some less restrictive form of attention (i.e. nursing home or even simply carrying an identification card) would be more suitable. The state was required to demonstrate that no other care was suitable. Mrs. Lake won her case, though she eventually died at St. Elizabeth's because no other facilities were available for her placement.

The least restrictive decision was extended to "life within the confines of the hospital" in Covington v. Harris (1969) and in Wyatt v. Stickney (1972) (Wexler, 1973, p. 81). Wyatt v. Stickney was originally initiated by a group of mental health professionals in Alabama dismissed following budgetary cuts. They claimed that their dismissal would lead to deteriorated care in an already understaffed system. Patients had a right to treatment that consequently could not be provided. The case proceeded in several phases. First the U.S. district court affirmed the right to treatment and ordered the state to produce an adequate treatment program. The state produced an indefensibly vague program that was found inadequate by the court. The court ultimately adopted detailed criteria for the physical environment (Schwartz, 1974, pp. 461-462) and the doctrine of least restrictiveness was applied to these criteria.

Least restrictiveness was applied in Dixon v. Weinberger (1975) to require states to develop alternative facilities regardless of available resources for development (Schwarz, 1981, p. 204). Finally, in the second Rennie v. Klein case (1979), the doctrine of least restrictiveness was extended to the nature of treatment itself. The court ruled that antidepressant and antimanic medications are less restrictive than antipsychotic medications (Leeman, 1980, p. 231).

Between 1966 and 1979 the court's application of the least restrictive alternative became increasingly specific, including location of treatment, environment in which treatment occurs, development of alternative facilities, and ranking of treatments. This judicial involvement, with its emphasis on patients' rights to privacy, free choice, self-determination, and autonomy, has severely challenged the dominance of psychiatry with its focus on patient needs. The extent of the judiciary's influence on nursing care and philosophy is less clear.

Therapeutic Environment

Significance attributed to the external environment has varied according to the prevailing models of mental illness and notions about the individual. Preliterate cultural belief that humans were continuous with their surroundings supported treatments based on magic and symbolic substitutions. During the Greek and Roman eras a balance between internal and external forces was achieved by treatments such as purging. Madness was attributed to the animal nature of man during the 1600s, and this belief justified brutality and human confinement in stakes, irons, and dungeons. The moral, humanistic, and psychological emphasis of the 1700s was derived from rationalism and interpretations of madness as a matter of volition. The emphasis on the influence of the social and physical environment on behavior resulted in construction of proper facilities for care of the mentally ill. However, quality of care and successful outcomes eventually subsided as efforts to provide corrective experiences through the therapeutic environment resulted in an expansion of buildings and types of patients accepted for treatment. Custodial care replaced active therapeutic approaches. By the middle of the 20th

century, expanded medical knowledge, public pressure for asylum reform, and resurgence of the individual/environment interactional framework underlay renewed attention to the therapeutic environment. Thus while the external environment has not always been employed for therapeutic purposes, it has played a significant role both conceptually and practically in the management throughout history of the mentally ill.

Recent conceptualizations of the hospital organization and environment have been influenced by psychodynamic perspectives (Sharaf & Levinson, 1957), interpersonal and structural interpretations of organizational theory (Etzioni, 1960), and sociological models emphasizing professional, institutional, cultural, and public influences on psychiatric practice (Schatzman & Strauss, 1966). Personal accounts, case histories, and descriptive studies have identified such environmental influences as staff disagreements and miscommunications (Stanton & Schwartz, 1954; Caudill, Redlich, Gilmore, & Brody, 1976), controlling rules, procedures, and staff practices (Goffman, 1961; Gruenberg, 1974; Wing & Brown, 1970), and the restrictive nature of the institution's physical environment (Goffman, 1961). Other studies have characterized the ideological aspects of the treatment environment as somatotherapeutic, psychotherapeutic, sociotherapeutic (Sharaf & Levinson, 1957; Strauss, Schatzman, Bucher, Ehrlich, & Sabshin, 1981), custodial, and humanistic (Gilbert & Levinson, 1957). The concept of restrictiveness appears in these early studies of treatment environment, though it generally implied dehumanizing qualities of the setting. Later studies and theoretical formulations also used the concept of

restrictiveness, but the influence of the legal perspective becomes more obvious.

A variety of research studies have aimed to evaluate the relationship between treatment environment and patient outcome (Alden, 1978; Bursten, Fontana, Dowds, & Geach, 1980; Bursten & Geach, 1976; Kellam et al., 1966; Main & Masterson, 1981; Moos, 1972; Moos & Schwartz, 1972; Moos, Shelton, & Petty, 1973; Segal & Moyles, 1979). The significant impact of environmental factors on nurses' actions and thoughts has been proposed, though only a limited number of studies have actually assessed this relationship (Ashley, 1976; Crisham, 1981; Davis, Kramer, & Strauss, 1975; DiFabio, 1981; Whaley & Ramirez, 1980). Findings indicate that situational factors have a critical influence on decision making and that nurses experience conflicts between personal values, professional values, and clinical practice (Crisham, 1981; DiFabio, 1981). The need for greater knowledge of the interacting milieu effects and practitioners' moral judgments has been recommended (Crisham, 1981).

Significance

This study makes significant contributions to nursing's practice knowledge through examination of restrictive environmental characteristics. Since nurses are the bulk of staff in institutions, are responsible for setting the tone of the milieu, and administer treatments and management techniques, they have the opportunity for unlimited encounters with restrictive or potentially restrictive situations. While the application of this concept in this study is to

psychiatric settings, the understanding of environmental interferences with individuals' rights and liberties is meaningful for all nursing specialities.

Numerous bioethical readings apply normative theories and principles to nursing care examples which represent moral dilemmas in practice. Knowledge of ethical theory is identified as an essential component of nursing knowledge, directing decisions on what ought to be done (Beckstrand, 1978; Carper, 1978). The descriptive ethics perspective has been rejected by philosophers and incorporated into the domains of other disciplines. Nursing has, in turn, applied this knowledge to its phenomena. For example, Kohlberg's theory of moral development is psychology's description of the individual's stages of moral growth. Nurse researchers have utilized this theory to describe the moral development of nurse clinicians. Less attention has been focused on ethical description of existing nursing practices. This may result from failure to admit the limitations of science or from fear of repercussions from controversial decisions. "Science" is frequently presented as a value-free activity, yet the choice of scientific questions and certainly the application of results reflect value judgments. In nursing's efforts to attain status of a discipline, description of moral practice dilemmas has barely been addressed. This study takes advantage of the unique perspective gained from descriptive ethics to understand the actual dilemmas experienced by psychiatric nurse clinicians.

The most noteworthy contribution of this study is the exploration of nursing's stance on the principles of distributive justice, beneficence, and autonomy. Nursing has traditionally ascribed to the

principle of beneficence through its practice of providing care and meeting needs. Yet in the past 25 years social events have emphasized individual rights. While nursing has attempted to incorporate some rights perspective through delineation of the patient advocate role and through acknowledgment of patient rights, nurses at best become "double agents". The nurse frequently has allegiances to both the patient and the institution and is not free to wholeheartedly promote individual rights. Additionally, the nurse, by virtue of his/her unique role in behavior control, consistently confronts the "dilemma of how to maintain personal liberty in situations where its suppression can be rationalized by both the common welfare and by the individual's happiness" (Davis, 1978, p. 3). Identification of the issues, concepts, and historical events inherent in this dilemma, as it is illustrated by the movement toward least restrictive psychiatric treatment, posits the discipline's moral relationship to patients and society and clarifies the assumptions of nursing's "contract" with society.

Dissertation Organization

This dissertation presents the process of conducting a study of the relationship between psychiatric treatment environments and ethical decision making in nursing practice. Current knowledge, methodology, findings, and discussion are organized in Chapters II through V. A review of clinical literature and a proposal of six dimensions of the restrictiveness concept - structure, institutional policy, enforcement, treatment, staff characteristics, and patient characteristics - are presented in Chapter II. Ethical concepts related to restrictiveness

are also explored. A conceptual framework based on the interaction of the individual and environment and based on the prima facie principles of beneficence, autonomy, and distributive justice organizes the clinical and ethical literature review. Study questions and definitions of terms are also provided in this chapter.

The survey design approach to answer the study questions is discussed in Chapter III. Purposive and convenience sampling techniques, sample selection criteria, study instruments, and procedures are presented.

Study findings are described in Chapter IV. Data analysis procedures are first explained and findings are presented according to the following categories: 1) descriptive and comparative findings for restrictive qualities of psychiatric inpatient units, 2) descriptive, comparative, and qualitative findings for ethical decision making, and 3) findings related to the relationship between psychiatric inpatient environments and nurses' ethical decision making.

Chapter V begins with an overview of the study's purpose, questions, and theoretical framework. Findings are discussed in light of this overview and in light of current knowledge and controversies. Study limitations, implications, and suggestions for future research conclude the chapter.

Summary

The focus of this study, general background, and significance were presented in this chapter. Legal connotations of least restrictiveness and the legal challenge to the "therapeutic state" were discussed. The

relationship between individual rights and liberties and nursing care activities was established as a significant area for study. The organization for the remainder of the study was presented.

CHAPTER II

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Six dimensions of the restrictiveness concept are presented in this chapter. Ethical issues derived from the perspectives of human rights and human needs are explored. A conceptual framework based on the structural, psychological, and social dimensions of the environment and on the prima facie principles of beneficence, autonomy, and distributive justice organizes this information.

Literature Review

Dimensions of Restrictiveness

Structural dimension. Least restrictiveness most frequently refers to type of treatment setting (Bachrach, 1980; Krauss & Slavinsky, 1982). This usage is derived from the case of Lake v. Cameron (1967) in which Judge Bazelon ruled that Mrs. Lake had the right to be treated in a setting less restrictive than a state mental hospital. Degree of restrictiveness has been used to rank treatment settings with the following results: total institutions (most restrictive), nearly total institutions (i.e. nursing homes), institutions with partially independent inmates (i.e. half way houses), institutions with independent, but isolated, inmates (i.e. single room occupancy hotels),

family of origin, friends, and other relatives, and family of orientation (least restrictive).

The general notion of limitations on physical freedom is closely linked to type of facility. Limitations on physical freedom are defined as "ways in which treatment can interfere with an individual's freedom of movement and choice of activities. It includes alternatives such as locked or unlocked facility, open setting, seclusion, or independent living" (Ransohoff, Zachary, Gaynor, & Hargreaves, 1982, p. 363). Additional physical factors in a milieu that impinge on the patient's "adult status" include locked bedroom and lavatory doors prohibiting patient use without assistance and toilet stalls or showers without doors or curtains. These impediments to privacy, enforced regardless of the patient's need for supervision, interfere with the patient's personal autonomy, sense of individuality, and control over what information is communicated to others (Proshansky, Ittelson, & Rivlin, 1970, p. 176). Setting and objective means of physical restraint or limitation are components of a structural dimension of restrictiveness.

Institutional policy dimension. An institutional policy dimension of restrictiveness is composed of the rules, procedures, and regulations for operating the institution. Restrictiveness is influenced by the extent of an organized daily routine. The organization is particularly restrictive when it is supervised and predetermined by staff or when patient involvement in planning is limited (Goffman, 1961; Krauss & Slavinsky, 1982; Segal & Moyles, 1979). Other staff-controlled aspects of a ward that interfere with the patient's "adult status" include timed or supervised showers, smoking regulations, silver count, required nap period or bedtime, censored mail, intake bath, confiscation of property

at intake, and staff regulation of facilities such as telephone, television, or stove (Kellam, Shmelzer, & Berman, 1966). The overall degree of autonomy accorded patients, and the degree of patient involvement in treatment (i.e. self- medications), responsibilities for food, clothing, and shelter, or control over resources (i.e. money) also compose the institutional policy dimension. Thus settings with staff-determined and enforced rules, with required, pre-arranged activities, and with limited patient responsibility for daily living needs are considered more restrictive than autonomy-producing environments. Environments that produce autonomy are characterized by a patient government whose suggestions are attended to by staff, and by encouragement of patient independence by staff for program responsibility, self-determined dress, and self-determined activities and scheduling (Moos, 1974).

Enforcement dimension. The enforcement dimension of restrictiveness, characterized by staff-determined consequences of rule-breaking or inability of the patient to leave the setting, overlaps in some aspects with the previous institutional policy section. However, the differences in dimensions are sufficient to warrant a separate category. In the policy dimension, staff exert control through organizing, scheduling, and supervising patient activities while in this category, staff carry out regulations through punishment, transfer or discharge of the patient (Moos, 1974; Segal & Moyles, 1979). Restrictiveness is equated with coerciveness, particularly on units utilizing privilege systems where the privileges to be earned or lost are actually rights in wider American society. Restrictiveness may be

used to enforce socially acceptable behavior beyond what is necessary to guarantee safety when a patient is dangerous.

Restrictiveness has been related to intrusiveness where control is achieved through punishment, threat of punishment, deprivation of positive reinforcement, use of positive reinforcement in a barren environment, or where reinforcers are so strong that compliance is very likely (Stolz, 1978). The tenor of staff control in this enforcement dimension is more aggressive than staff control in the policy dimension. Staff do more here than make rules. They may coerce, intrude, or punish in order to achieve cooperation. Lack of consideration for patient autonomy seems to prevail in this enforcement category. Since the patient may be held involuntarily, he/she has no option to leave the setting. While there may be encouragement to dress in one's own clothes or participate in program-planning, involuntary status alters the treatment atmosphere by eliminating the right to give informed consent to treatment. A setting need not be involuntary, however, to be characterized as coercive and intrusive.

Treatment dimension. Belief in mind/body dualism and pain infliction to cleanse the spirit has influenced psychiatric treatment (London, 1969). Symptom control, achieved with lobotomy, shock therapy, sterilization, and medications, creates an illusion of scientific precision, but psychiatric treatment often lacks specificity (Schragg, 1978). Psychotherapy and education are less effective behavior control techniques. All of these technologies presume that human behavior can be predicted and controlled and that the environment can be manipulated to produce desired human functioning. These ideas contrast with the

legal emphasis on rights to privacy, choice, autonomy, and self-determination.

Thus the treatment dimension of restrictiveness includes the use and level of antipsychotic medications and the use of other somatic treatments such as electroconvulsive therapy or psychosurgery (Ransohoff et al., 1982). Because restrictiveness is considered less with reversible and short-term treatments, medications may be less restrictive than psychosurgery and an oral medication may be less restrictive than a long-acting, injectable antipsychotic medication. Presence of a rehabilitation effort, clarity of program goals, and defined, limited treatment goals are also aspects of this dimension.

Staff characteristics dimension. The psychosocial atmosphere created by staff characteristics has received limited attention in recent discussions of restrictiveness. One criterion that approaches this notion is that "restrictiveness of the environment is proportional to the status difference between patients and staff" (Kloss, 1980, p. 422). Coercion and restrictiveness are also equated with degrees of staff authoritarianism. A social restrictiveness scale in the Opinions About Mental Illness tool "emphasizes the desire to restrict mental patients both during and after hospitalization for the protection of society, particularly the family unit" (Cohen & Struening, 1962, p. 354). Items include prohibitions against marriage, voting, and child bearing, negative attitude toward the possibility of recovery or future capacity to be trusted, and the belief that mental patients have negative feelings about themselves and their appearance.

Patient characteristics dimension. Inclusion of patient characteristics in the concept of restrictiveness is controversial. The

assumption that the quality of restrictiveness resides outside the patient in the environment is questioned by many clinicians. The patient's ability to manage his own care, influenced by the severity of his disorder, may also have a restrictive impact on the patient's life. Least restrictiveness then becomes an acknowledgement of the patient's individuality by planning care appropriate to his needs (Bachrach, 1980; Schwarz, 1981). It is argued, however, that factors such as impediments to freedom imposed by the patient's psychiatric condition, effectiveness of treatment, or match between individual patient needs and their treatment should be considered part of treatment context. Illness factors and benefits of treatment are excluded by some writers in an effort to avoid too broad an interpretation of restrictiveness.

It is premature to eliminate patient characteristics from the concept of restrictiveness. Patient characteristics impacting on the social environment may actually contribute to an atmosphere of restrictiveness. Additionally, the patient's perspective of being treated in a restrictive environment suggests an experiential dimension of the concept. It is reasonable to eliminate the assumption that a predictable relationship exists between the patient's level of functioning and type of restrictive environment. Further research is needed to determine the degree of restrictiveness routinely experienced by patients with varying symptomatology. It is also reasonable to eliminate the restrictiveness imposed on the patient by his illness. That usage loses the significance of environment for limiting individual freedom and rights. Some theoretical assumptions provide a solution to the problem of including patient characteristics as a dimension of restrictiveness. The assumption that restrictiveness is an objective

characteristic of a setting, independent of unique features of the context, eliminates both the patient characteristic dimension and the staff characteristic dimension. The assumption that restrictiveness is a quality resulting from the interaction of environment, staff, and patient characteristics supports a broader interpretation of this concept. Continued development of both perspectives will add to a body of knowledge about the concept.

In this study, restrictiveness is conceptualized as having six overlapping dimensions - structure, treatment, institutional policy, enforcement, staff characteristics, and patient characteristics - and is defined as the degree of limitation or threat of limitation imposed on an individual's independent thought and decision making, physical activity, and sense of self. The least restrictive alternative necessary for treatment is the imposition of the least amount of limitation or threat of limitation necessary to provide care. Care may include both active treatment and custodial care.

Ethical Issues

Rights. The application of the least restrictive alternative principle to mental health cases has been justified according to such rights as right to due process, right to travel or association, and right to liberty. The Constitution guarantees equal protection under the law, yet frequently mentally ill persons have been unduly denied their rights. Paradoxically, the widespread recent demand for rights poses a risk of minimizing the significance and provision of rights. Least restrictiveness, for the purpose of promoting rights, and

restrictiveness, for the purpose of meeting needs, represent negative and positive rights.

Option rights are those rights involving notions of freedom and choice (Golding, 1978). Derived from 17th- and 18th-century philosophers, option rights permit the individual to act unhindered by others. This right to freedom from influence of others is also referred to as a negative right, negative liberty, and negative freedom. Conceptually, "right", "liberty", and "freedom" are not entirely synonymous, but the notion of the sovereignty of one's domain (body, life, property, privacy) is important in each (Bandman, 1978). The concept of interference is critical to the notion of negative liberty. Being laughed at, talked about, or eavesdropped upon may be intrusions but do not necessarily interfere with liberty (McCloskey, 1974). Rather, "the paradigm cases of interference with liberty have been those of coercion, and the analytical task is to offer an account of why certain ways of getting a person to do something other than he originally intended . . . do not count as interference, whereas others do infringe upon freedom" (Dworkin, 1976, p. 25). Noninfringing interference includes incentives, information, and argument, whereas threats and physical force interfere through infringement. Coercive interference may, however, be too narrow a perspective since absence of coercion does not necessarily result in freedom. Freedom requires some opportunities for choice and self-determination (McCloskey, 1980).

Those individuals not capable of exercising choice and therefore of having option rights (infants, the senile, the mentally ill) still have welfare rights or positive rights, which are rights to certain benefits or goods (Golding, 1978). A positive right is the "right to another

person's positive action" (Beauchamp & Childress, 1979, p. 50). For every positive right claimed, someone else has a duty to act. Critics of welfare rights describe them as mandatory rights since they are not based on choice or the capacity to freely exercise them (Bandman, 1978).

The principle of least restrictiveness sets limits on interference with an individual, thus promoting negative rights. It gives priority to the right to be left unhindered, not to the positive rights for care and services.

Paternalism. The clinical and legal concepts of least restrictive alternative are linked by the notion of paternalism. Least restrictiveness places limits on the government's role as parent in caring for its citizens and limits the traditional parent-like role of health care providers in care for their patients. Both health care providers and the government have met their obligations according to standards not necessarily centered in the rights of the individual. For example, the government may care for individuals in order to maintain the overall integrity of the social order. Health care providers may give care according to the discipline's perspective of what the patient needs. The imposition of the government's or the care provider's perspective onto the individual to help or benefit him can result in paternalism. Paternalism is an action that restricts a person's liberty, justified exclusively by consideration for that person's own good or welfare and carried out either against his present will or his prior commitment (Arneson, 1980). "Paternalism uses coercion to achieve a good not recognized as such by those persons for whom the good is intended" (Dworkin, 1980, p. 233).

The extreme antipaternalists find paternalistic interference unacceptable. Paternalistic actions interfere with negative liberty or the right to act unhindered. Deception and coercion, the most common types of paternalistic interventions, include nondisclosure of information, violation of confidentiality, forcible invasion of the person's body, refusal to carry out the person's request, and provision of unwanted services (Childress, 1982). There are similarities between these interventions and the dimensions of restrictiveness. For example, provision of unwanted services and forcible invasion of the body may correspond to the treatment dimension. The general concept of coercion, identified as being restrictive, was conceptualized in the enforcement dimension. Refusal to carry out a person's request could occur in situations of high staff control and authoritarianism and thus corresponds to dimensions of policy and procedure or staff characteristics. Failure to disclose information might also fall into either of these two categories. Thus restrictive interventions are, at least in part, synonymous with paternalistic interventions.

Paternalistic interference is sometimes ethically justified by the principle of beneficence, which promises good through enhancement of the individual's interests, skills, and abilities when risk to ourselves is minimal. One perspective of "good" is the notion of self-determination. In fact, the goal of beneficence has been identified as "relieving dependencies, deficiencies, and impediments that inhibit one's self-reliance" (Shelp, 1982, p. 203). Beneficent acts can prevent harm or remove harmful conditions (Beauchamp & Childress, 1979). Positive rights, the right to certain benefits or goods, are based on the principle of beneficence.

Beneficence provides a basis for exceptions to a strong anti-paternalistic stance. The most well-known exception is that interference with another person is justified only for self-protection or to prevent harm to others. Thus some restrictive techniques are justified since they prevent harm or injury to others. Another exception is that interference with free choice is justified to promote long-term free choice. For example, interference with a person's choice to sell himself into slavery is acceptable since this interference maximizes freedom in the long run. This freedom maximizing principle has also been extended to notions of autonomy. That is, interference is justified in order to promote autonomy in the long run. The notion of "most therapeutic alternative" proposed by many clinicians as a substitute for the least restrictive alternative illustrates this perspective. The most therapeutic alternative is based on the belief that effective, intense treatment leaves patients with greater ability to exercise their liberty (Guthiel & Appelbaum, 1982). Dworkin (1980) suggested a third case in which paternalism might be acceptable: If the individual were fully rational, he would agree to paternalistic interference. He identified two situations in which an individual might act in a nonrational fashion: 1) he attaches incorrect weights to some of his values and 2) he neglects to act in accordance with his actual preferences and desires. Interference in the second instance may be more easily justified since our version of good is not really imposed on the person. Interference in the first instance is more difficult to justify since another's priorities have been determined to be incorrect.

Yet individuals cannot always be assumed to act in their own best interest and may even cause themselves irreversible harm, a situation

further complicated by issues of competency. When an individual's priorities are questioned, paternalism can be justified as a sort of social insurance policy that allows the individual to reconsider his actions (Dworkin, 1980). Interference with the nonrational person whose actions are deemed nonautonomous or nonvoluntary is called weak paternalism. This contrasts with strong paternalism or the interference with a person's liberty justified to protect or benefit him even when his actions are informed and voluntary. Weak paternalism can be ethically justified, while it is difficult and perhaps impossible to justify strong paternalism.

Regardless of our ability to justify paternalistic intervention, opportunities for interference must be granted with extreme caution. One criterion for interference is the principle of the least restrictive alternative. "If there is an alternate way of accomplishing the desired end without restricting liberty although it may involve great expense, inconvenience, et cetera, the society must adopt it" (Dworkin, 1980, p. 239).

While there may be justifiable instances for paternalism, it should not be resorted to without careful consideration and even inconvenience in order to preserve individual liberties. The least restrictive alternative principle derives from the general notion of respect for persons, which requires truthfulness, noncoercion, and the degree of respect compatible with the patient's condition. "It would be a form of disrespect and insult to use more force or deception than is necessary to realize the ends in question" (Childress, 1982, pp. 113-114). Thus the respect-for-persons principle limits paternalistic (albeit well

intentioned) interventions, and this limit is the least restrictive alternative principle.

Autonomy. Civil libertarians have frequently used anti-paternalistic arguments drawn from J.S. Mill to criticize interference with the mentally ill. Interestingly, Mill did not extend his arguments to this group. Anti-paternalism applied only to human beings in the maturity of their faculties, not to children or to those requiring care and protection from others (Mill, 1956, p. 13). While Mill did not use the term "autonomy", his phrase "the individual in maturity of his faculties" serves that purpose. Because of the significance Mill and others gave to noninterference with the autonomous person and their arguments justifying interference with the nonautonomous person, some perspectives on autonomy are necessary. In addition, the possibility of extending the capacity for autonomous behavior to the mentally ill needs exploration.

Autonomy, the self-directed capacity to determine and carry out one's life plans, contains two features: independence and totality (Tassi, 1977). Independence is the ability to take responsibility for one's life by acting on the surrounding influences. Action is taken according to some overall plans and results in life displaying a totality.

Autonomy is associated with a "family of ideas": freedom of choice, choosing for oneself, creating one's own moral position, and accepting responsibility for one's moral views (Beauchamp & Childress, 1979). The capacity to be an autonomous person may be developed or underdeveloped in each individual and the expression of autonomy is not automatically achieved. Autonomy relies on several capacities:

language, self-consciousness, memory, logical relations, empirical reasoning about beliefs and their validity, and the ability to make plans and take actions according to rational choice (Richards, 1981).

The capacity for autonomy is considered inherent in all individuals, yet the principle of autonomy applies only to the individual capable of autonomous action. Thus children have the capacity to become autonomous as their abilities to think and reason develop. As noted previously, Mill also did not extend the principle of autonomy to the mentally ill. Their need for care and supervision stemming from their incapacity to make rational choices limits their ability to be autonomous. However, it can be argued that rationality is a value judgment that cannot be justifiably imposed on the individual. With this in mind, autonomy has been defined as consisting of the natural property and assets of one's body, sentiment, and labor and is not associated with the capacity for free and rational choice (Richards, 1981). The mentally ill might be considered autonomous given this distinction.

This first perspective of autonomy as requiring some rational evaluation and decision-making ability assumes the individual is competent to perform these skills. The second perspective does not require competence. In practice, an individual may be competent in some areas, such as to vote, while incompetent in other, such as informed consent. A person is competent if and only if that person can make decisions based on rational reasons (Beauchamp & Childress, 1979). Five tests for competence have been identified: 1) ability to evidence a choice, 2) ability to produce a reasonable choice, 3) ability to reach a choice based on rational reasons, 4) ability to understand the decision-

making process, and 5) actual understanding of the whole process (Appelbaum & Bateman, 1979).

While it is acknowledged that competency is difficult to define and operationalize, according to these criteria a test for competency may also be a test for autonomy. Intervention into the well-being of a nonautonomous or incompetent patient is ethically justified according to the principle of weak paternalism and in order to promote his positive rights and liberties. The "natural property of one's body" perspective does not require consideration of competency, so any intervention for the individual's well-being would be paternalistic, a negation of autonomy, and an affront to the negative right to be left alone.

The President's Commission on Mental Health of 1978 endorsed the concept of the least restrictive environment as promoting the objective of maintaining the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of mind, body, and spirit for individuals while they participate in treatment or receive services (Bachrach, 1980). If autonomy is defined as the assets and natural property of one's body, then involuntary receipt of services by the incompetent patient remains an invasion of autonomy. If the involuntary but competent patient has services forced upon him or her, autonomy (from whatever definition) has been negated by such a strong paternalistic action.* The involuntary and incompetent patient (who does not meet criteria as an autonomous agent with capacity to make reasonable decisions) may experience slightly less intrusion with less restrictive interventions.

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* While the incidence of involuntary hospitalization of competent patients has decreased, it may still occasionally occur.

The situation is not necessarily less complicated for a voluntary patient. To date, the court cases imposing the least restrictive alternative have not been specifically aimed at the voluntary patient population. Yet the standard of competency is often not applied to patients willing to voluntarily enter a psychiatric hospital. This may actually deprive the incompetent though voluntary patient of the right to automatic judicial review, legal assistance, and periodic reassessment (Appelbaum & Bateman, 1979). It may also deprive the patient of the right to treatment in a less restrictive environment since he or she voluntarily and presumably knowingly accepts the conditions of treatment regardless of their restrictiveness. Since competency is usually not carefully evaluated unless the patient disagrees with treatment, the least restrictive treatment principle may currently be applied in only a limited range of cases. Thus least restrictiveness does not seem to be a completely satisfactory method for assuring autonomy. Voluntary patients, both competent and incompetent, may not have recourse to it. Competent involuntary patients have their autonomy infringed upon through strong paternalistic interference. The autonomy of incompetent and involuntary patients remains infringed upon by weakly paternalistic interference, though this interference is slightly more justifiable when the least restrictive alternative is used.

The least restrictive environment is also claimed to promote freedom and self-determination. The least restrictive environment may provide some greater degree of freedom within the individual's capacity to exercise it. For example, if one criterion for less restrictiveness is for patients to have some input into decisions or rules affecting

their living environment, such as bed time or television schedule, then an individual's self-determination is enhanced when the least restrictive environment promotes the exercise of these capacities.

The least restrictive alternative has not been operationalized according to the individual's capacity to exercise autonomy. Because financial resources necessary to develop least restrictive environments did not follow from either court decisions or the deinstitutionalization process, few suitable living arrangements are available in the community. Klerman (1977) charged that patients living under conditions of minimal supervision wander the streets, are at the mercy of youth gangs and criminals, and are subject to beatings, robberies, and abuse. Some believe that to "push severly impaired patients out of hospitals into unsafe living arrangements is to abandon them" (Gruenberg & Archer, 1979, p. 503). Many chronically ill have been returned to welfare hotels and transient neighborhoods to become victims of exploitation and their own self-neglect.

Needs. The health care professional's solution to this issue has been to recommend that patient characteristics be included in the concept of least restrictiveness in order to better match patients to settings. From their perspective of doing good (benevolence) and not doing harm (nonmaleficence), the condition of many chronically mentally ill in the community is untenable. Doing good is primarily accomplished by identifying patients' needs, objectively or subjectively defined, and acting to decrease or resolve them. Subjective needs are susceptible to definition according to the individual's preference or desire, while objective needs are externally-defined criteria of well-being. Thus

intervention based on objective needs without individual consent is paternalistic interference.

Health care needs are those things we need in order to maintain, restore, or provide functional equivalents (where possible) to normal species functioning and can be divided into 1) adequate nutrition and shelter, 2) sanitary, safe, unpolluted living and working conditions, 3) exercise, rest, and other features of healthy life-styles, 4) preventive, curative, and rehabilitative personal medical services, and 5) nonmedical personal (and social) support services (Daniels, 1981). Illness is generally the basis of need for medical care. Psychiatry has been criticized for "medicalizing" or defining as illness socially unacceptable or controversial behaviors in an effort to expand their professional territory. Defining and then undefining homosexuality as an illness has been a well-known controversy.

Specifying the nursing perspective of patient needs has been a focus in nursing theory. The breadth of the nursing perspective of need is illustrated in theories by Wiedenbach and Orem. Wiedenbach (1964) defined need as "anything the individual requires to maintain or sustain himself in his situation"(p. 117). Individuals are assumed to vary in their psychological resources, and successful adaptation depends on available resources, including assistance from the nurse. Orem (1980) defined needs more specifically as self-care deficits. When these deficits relate to the health state, they indicate a need for nursing (Coleman, 1980). The perspective on patient needs provides boundaries for a professional domain while the formulation of needs sets limits on the duty of beneficence in the provider/client relationship by identifying the claims for professional responsibility and obligation.

Thus many chronically mentally ill in the community are needy, whether from a nursing, medical, or general health care perspective. The principle of double effects allows evaluation of whether the harm resulting from unmet needs is ethically justifiable. The principle of double effects is based on four conditions:

1. The action in itself must be good or at least morally indifferent.
2. The agent must intend only the good effect and not the evil effect.
3. The evil effect cannot be a means to the good effect.
4. There must be a proportionality between the good and evil effects of the action. (Beauchamp & Childress, 1979)

The action of meeting people's needs is good according to the duty of beneficence. Providers intend only good effects. However, in cases in which the patient's rights must be infringed upon in order to do good (i.e. involuntary treatment), the evil effect becomes a means to the good. Thus infringement on individual rights, even to meet their needs, is generally unacceptable. Further consideration of each individual case would be based on proportionality between good and evil effects of the intervention.

The principle of double effects does provide justification for the side effects of unmet needs if rights are promoted. The action of caring for patients according to least restrictiveness (which may include independent living) is morally good since it promotes autonomy and self-determination. Only this positive effect is intended. While some individuals may have difficulty functioning with less restrictive care, their difficulties are not intended or sought. Their difficulties

are certainly not a means to promote autonomy and freedom. The good effect of promoting a right as important as that of autonomy generally outweighs the negative effects of the least restrictive intervention. The primacy accorded to the right to autonomy and personal freedom are not always compatible with attempts to provide care. It can be appropriate and even mandatory to accept less effective means in order to respect moral rules (Childress, 1982). The conflict between rights and needs may be difficult to resolve since care providers are not accustomed to purposefully intervening with less effective techniques.

The emphasis on the primacy of patient rights over provider duties represents a shift in social values, and the least restrictive alternative is one outcome of this shift. This shift in primacy from provider to patient has been dated to the 1960s. The decline of psychiatric discretion and the rise of patient autonomy is exemplified by decisions supporting patients' rights to refuse treatment, requirements for informed consent, shifts in standards for involuntary commitment, and identification of treatment alternatives (Winslade, 1980).

Distribution of resources. To this point, restrictiveness has been discussed as it relates to the patient's best interest, that is, beneficent intervention to promote the patient's well-being and limitations on paternalistic interference to promote individual dignity. These perspectives of moral obligation and responsibility hold the patient's best interest as primary, yet ethical considerations derived from restrictiveness also impact on third party obligations. The service distribution implications of restrictiveness are discussed from the beneficence and autonomy perspectives and from obligations to third parties.

Options rights or negative rights to be left unhindered are one basis of distribution under the entitlement theory. The natural lottery of life endows each individual with various assets, and there is no prior obligation to share these with the human community. Distribution of goods occurs, if at all, according to free promises and contracts (Veatch, 1981). This entitlement perspective is one model of a least restrictive approach to health care distribution; individual assets have absolute priority and are not subject to interference.

A positive rights interpretation of the entitlement theory recognizes health care as a natural right existing prior to any social order (McCullough, 1981). A predominant theme during the French Revolution and stemming from the Catholic tradition of charity, a right to health care is not accepted by all. At best, any right to health care is probably limited to some decent, minimum level of care (McCullough, 1981).

Distribution according to the greatest good for the greatest number requires determination of what constitutes "goodness" for the social order (McCullough, 1981). A value-based social order appeals to virtues and character as constituents of a decent and humane society (McCullough, 1981). Moral conduct may be expressed through the provider/patient relationship, which reflects kindness and caring, benevolence, and sympathy. The patient's right to care emerges as a result of this relationship. Since the provision of care is the provider's moral obligation, some decent minimum level is probably guaranteed, but the limits of this obligation are not so easily identified (McCullough, 1981). If restrictiveness is equated with

services to promote the patient's well-being, least restrictiveness again represents some minimal level of service.

Finally, a right to health care may emerge as a characteristic of a good and just society. In the last example, social goodness was expressed in a virtuous provider/patient relationship while in this case social goodness is expressed through just resource allocation. Distributive justice refers to the distribution and allocation of social benefits and burdens when conditions of scarcity exist. Scarcity results from limits of natural resources that are never sufficient to meet all needs for all people. Criteria for distribution of resources include: 1) to each person an equal share, 2) to each person according to need, 3) to each person according to individual effort, 4) to each person according to societal contribution, and 5) to each person according to merit (Beauchamp & Childress, 1979).

Merit, contribution, and effort are meritarian conceptualizations and may be ill-suited as criteria for health care distribution (Outka, 1983). Social productivity is an inappropriate criterion if each individual is valued as an end in him/herself. It may be particularly difficult to distribute services to the mentally ill according to assets such as perceived effort, contribution, and merit of this class. While specific individuals may be noted to have unusual creativity or talents, the chronically mentally ill are frequently distinguished by their lack of social functioning.

Need better recognizes the inviolability of the individual, but is complicated by interpretations which range from basic and essential needs to frivolous desires. Needs-based distribution may attempt to produce a highest possible level of health care and may not account for

the possibility of benefit to some at the expense of harm to others. In a situation of limited resources, needs-based care might be impossible to provide or its provision would greatly interfere with others' option rights. The chronically mentally ill have seemingly unlimited needs, and the health care system does not have sufficient resources to correct all deficiencies.

An egalitarian model provides similar treatment for similar cases. This model is criticized, however, for being compatible with no positive treatment as long as all are treated equally as well as active treatment for equal cases (Outka, 1983). Additional criticisms include the problem of defining equal characteristics of diseases, resources, and individuals and the problem of providing equal services regardless of unequal need. Promotion of equality at the expense of unique individuality is an affront to autonomy and, like meritarian approaches, fails to recognize the value of the individual as an end in him/herself.

Equal access is proposed as a prima facie right and as a means for distributing a scarce resource. Since a just society will have other values (such as concern for a member's well-being and individuality) besides equality, it is reasonable, as far as possible, for society to provide equal conditions for members to achieve the best in their lives that they are able (Frankena, 1983).

Expanded availability of health care services to the population as a whole or to identified groups has been the major issue in health policy debate since at least the early days of the New Deal (Vladeck, 1981). This issue culminated in the enactment of Medicare and Medicaid and in government initiatives to expand the supply of hospitals, other health facilities, and health personnel. In the mental health arena,

equality of access culminated in the Community Mental Health Centers Act of 1963. This act marked an unprecedented public commitment to provide comprehensive mental health services to all citizens without regard to race, creed, or ability to pay (Chu & Trotter, 1974). Thus factors supposedly extraneous to the delivery of services would not interfere with receipt of services. The least restrictive alternative first applied to mental health care in 1966, just three years after the Community Mental Health Centers Act, has consistently supported the perspective of care outside the state mental hospitals. The timing of its application and the content of its requirements link it firmly to the equality of access philosophy of the 1960s.

Equal access must be considered in relationship to availability since it does no good to have access if the services are unavailable. While "least restrictiveness" court decisions required community development of additional facilities, these decisions have never been financed, implemented, or enforced. Equal access and service availability are further complicated by geographical differences since minimum standards for what services should be available in a given region have not been developed. Rapid technological advances and the desire of more affluent regions to purchase progressive services create a spiraling rise that may be impossible to equalize. Limiting access of the more affluent to certain services in an effort to maintain equality may result in an infringement on patients' rights or perhaps even on their specific needs. The appropriateness of demands for equal access to health care when other inequities related to wealth and income exist throughout the American system has been questioned.

The prima facie principle of equal access still conflicts with de facto supply limitations and maldistribution. Recently the pendulum of health policy concern has shifted away from equality of access to cost containment (Vladeck, 1981). Some recommend that health policy must be based on the propositions that health is but one of many goals, that access should be channeled through a hierarchy of services, and that services should meet a criterion of "good enough" instead of "best" (Brown, 1979). This minimally decent notion is consistent with the positive rights, the virtuous provider, and the essential needs models. Least restrictiveness incorporates the philosophy of minimally decent care channeled through a hierarchy of services. Least restrictiveness reflects respect for a positive right to health service and provides a socially sanctioned means to distribute and limit a provider's obligation to give care. By providing a decent minimum, least restrictiveness offers an approach to allocating scarce resources without interference with the purchase of more than minimum services by those who are able.

This perspective seems to be the basis of MediCal and Medicare reimbursement for psychiatric care. MediCal and Medicare reimbursement is restricted to hospital care that meets specific criteria and limitations. Patients must be acutely and severely mentally ill with symptoms such as suicidal or assaultive behavior, self-mutilative behavior, hallucinations, confusion, delirium tremens, seizures, and regressed, bizarre, or delusional behavior. Treatment must be "intense" and include intramuscular or intravenous medications or chemotherapeutic medications. Seclusion or restraint may be necessary. However, diagnostic or therapeutic planning requiring hourly vital signs, rounds

every thirty minutes, or one-to-one observation that can be provided in a less restrictive, nonmedical setting may require special review if it is the only criterion of treatment.

Although least restrictiveness is not specifically associated in ethics literature with the problem of service distribution, respect for persons is linked to distribution and least restrictiveness is derived from respect for persons. Since social goodness is characterized by multiple and potentially conflicting values, overriding principles must incorporate and balance numerous perspectives. Respect for persons, operationalized through least restrictive interventions and programs, is such a primary principle.

Conceptual Framework

Environment

Environment exists in a totality, yet is described in terms of theoretical component parts. Physical, psychological, and social dimensions are only different perspectives of the same situation, and each derives meaning in relation to the other aspects (Ittelson, Proshansky, Rivlin, & Winkel, 1974). The physical environment is the geographic and design properties, external to the inhabitants, such as length, size, or shape. Environmental assessment is frequently limited to objective, physical features only for conceptual clarity and ease of classification of characteristics. Yet confining assessment only to physical items limits consideration of the range of stimuli impacting on the individual since less tangible social and psychological stimuli are ignored. While physical attributes influence behavior and use of

geographic space, individuals also contribute to the psychological environment via their unique characteristics such as personality, education, values, and beliefs, all evidenced in their behavior. Social norms also create behavioral rules such as expected functioning in a role or prescribed relationships to others.

While restrictiveness has been most simplistically conceptualized as entailing only physical aspects of the environment that limit individual freedom, the literature review for this study identifies multiple interpretations of this concept. The dimensions of restrictiveness can be viewed as aspects of the physical, psychological, and social environment. For example, the structural dimension of restrictiveness, composed of architecture and type of setting and limitations imposed by locked doors or seclusion, is equivalent to the physical environment. Staff characteristics including attitudes, values, and beliefs as well as behavior and background of the patients contribute to the psychological climate. The institutional organization, enforcement, and treatment dimensions are components of the social environment. The organizational and enforcement dimensions reflect the autonomy-inhibiting or self-development-promoting rules and regulations that govern a setting. The treatment dimension of restrictiveness is linked to this social environment category since treatments are the profession's standard (and therefore the society's norm) for managing patient behavior.

Individual-Environment Relationship

The individual interprets and responds to environmental conditions according to his/her unique cognitive-perceptual skills, experiences,

values, beliefs, and coping skills. These personality characteristics influence the transaction between person and environment by directing the individual's appraisal of the meaning of encounters and by guiding the individual into or away from situations that may be threatening, beneficial, or harmful. By heightening and shaping sensitivity to environmental cues, values guide the determination of what is relevant and significant about a situation and thereby integrate the individual into the world. Beliefs operate as an interpretive system for reappraising a completed event and as a resource for coping with events that cannot be reinterpreted. Beliefs regulate emotions by offering reassurance or comfort. Values and beliefs are the basis for determining the meaning of situational encounters in relation to oneself (Wrubel, Benner & Lazarus, 1981).

These situational encounters are suggested to have a more powerful influence on moral behavior than personality characteristics (Rosenhan, Moore, & Underwood, 1976). By enabling reinterpretation of an event or regulating emotional response, values and beliefs may actually allow the individual to rationalize or justify his/her behavior when situational variables influence the individual to act differently from his/her usual stated beliefs.

Situational pressures and the individual's decision-making combine to generate actions that take on moral overtones. For example, Strauss and colleagues (1981) noted that approaches to patient care reflect the implementation of therapeutic philosophy under certain institutional conditions. Individuals' styles of implementation and professional perspectives contribute to unique variations in philosophical approach as do various environmental conditions. These approaches take on a

fundamental sense of "rightness" about how patients should be helped and what is harmful to patients. Nurses, lacking in a specific or nonconflicting professional moral direction, may experience substantial pressure from situational variables for determining their sense of what is the "right" approach to patient care.

Value Systems in Nursing

Varied ethical theories offer direction in decision-making by creating priorities of moral principles. For example, a utilitarian perspective aims to promote the greatest possible balance of good over evil, though it is limited by potential disagreement over definition of good and by lack of consideration of the just distribution of this good (Frankena, 1973). The deontological perspective aims to identify rules for guiding judgements of obligation. Rule-based judgements may be hindered by the lack of criteria for identifying moral rules in contrast to other social or legal rules. Nursing literature frequently refers to both deontologic and utilitarian perspectives when critiquing morally problematic practice issues. In this study, moral approaches to care are limited to the prima facie principles of beneficence, autonomy, and distributive justice.

Prima facie duties, as distinguished from actual duties, are binding at all times unless they conflict with stronger duties. "One's actual duty in the situation is determined by an examination of the weight of all the competing prima facie duties" (Beauchamp & Childress, 1979, p. 45). These prima facie principles have no priorities and the potential for conflict between principles is not solved. Each situation

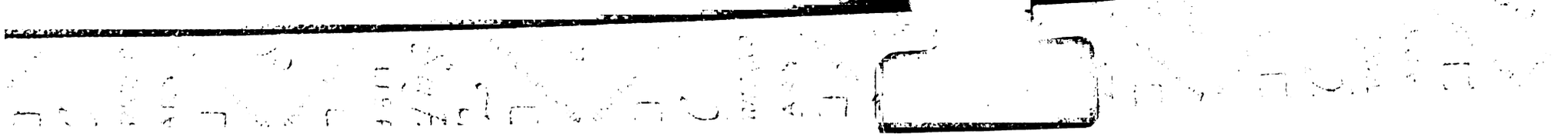
must be carefully considered with decision-making guided by weighing each principle.

The principle of beneficence involves promoting good through enhancement of the individual's interests, skills, and abilities when risk to ourselves is minimal. Some ethicists also include the notion of preventing harm or removing harmful conditions in the principle of beneficence, thereby limiting nonmaleficence to the noninfliction of harm.

The principle of autonomy entails the freedom of will, action, and choice to govern oneself regardless of the assessment by others of the risk or seriousness of one's intended actions. Usually the principle of autonomy applies only to persons competent and capable of making autonomous decisions. However, some writers argue that autonomy applies to the primacy of one's physical being and is not associated with rational decision-making.

The principle of distributive justice refers to the distribution and allocation of social benefits and burdens when conditions of scarcity exist. Scarcity results from limits to natural resources. Criteria for distribution of resources include equal shares, need, individual effort, societal contribution, and merit.

Restrictiveness has previously been presented as a morally problematic concept. When an individual's actions are nonvoluntary, restrictive care is considered weakly paternalistic and may be ethically justified by the principle of beneficence. When the individual's actions are voluntary, restrictive care is considered strongly paternalistic and may be impossible to justify. Strong paternalism fails to recognize and uphold individual rights. Providing care



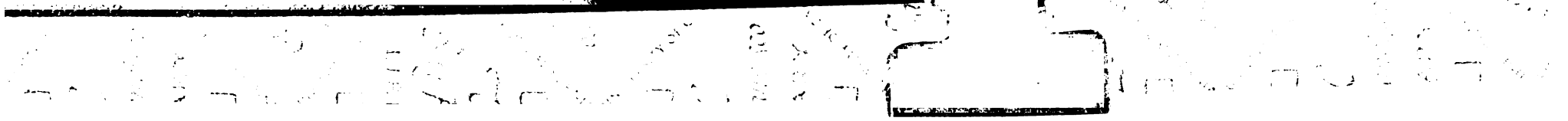
(whether paternalistic or autonomy-supporting) is also a tremendous drain on scarce resources and limits on service must be set at some point. Determining this point may result in conflict between beneficence and distributive justice.

Thus ethical knowledge directing nursing's moral obligation is not clear-cut or without controversy. This ambiguity reflects the impact of culture and traditions on the discipline and nursing's responsibility to provide services congruent with social values however contradictory these values may seem.

Assumptions

The following assumptions conclude this framework:

1. A human being is a dynamic, open system interacting with the dynamic and open environmental system.
2. A human being's cognitive, perceptual, and goal-oriented skills involve him/her in interactions with the environment.
3. Values and beliefs influence sensitivity to and interpretation of environmental cues.
4. The environment includes physical components and also social and individual behaviors that occur within it. In this sense, it is a process defined by its participants and the nature of their interactions (Ittelson et al., 1974, p. 95).
5. The individual's vantage point and role will uniquely affect his/her behavior vis-a-vis the setting (Ittelson et al., 1974, p. 96).
6. However open they may be as social systems, environments have physical limits. Behavior in the total environmental context



will always be affected by the physical opportunities that exist for expressing a desired behavior (Ittelson et al., 1974, p. 96).

Study Questions

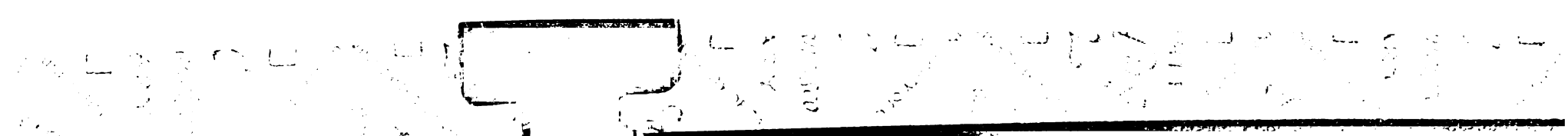
This study addressed three questions:

1. What are the restrictiveness qualities of psychiatric inpatient units?
2. How are the ethical principles of beneficence, autonomy, and distributive justice represented in clinical decisions by psychiatric nurses?
3. Is there a relationship between the restrictiveness of psychiatric inpatient environments and ethical principles of beneficence, autonomy, and distributive justice in psychiatric nursing practice?

Definition of Terms

Restrictiveness - The degree of limitation or threat of limitation imposed on an individual's independent thought and decision-making, physical activity, and sense of self. Restrictiveness is composed of six overlapping dimensions: structure, institutional policy, enforcement, staff characteristics, treatment, and patient characteristics. Each of these dimensions is defined and measured as follows:

Structure - Description of type of psychiatric treatment setting such as total institution or open community



setting and objective means of physical restraint or limitation such as locked doors, seclusion and restraint, or toilet stalls and showers without doors or curtains, elicited through nurses' completion of the Inventory of Structural and Treatment Restrictiveness (Garritson, 1983a).

Institutional policy - Rules, procedures, and regulations for operating the institution as measured by Resident Control subscale of the Multiphasic Environmental Assessment Procedure (Moos & Lemke, 1979).

Enforcement - Staff-determined consequences of rule-breaking which may include punishment, transfer, or discharge of the patient or inability of the patient to leave the setting due to involuntary confinement as measured by patient's legal status and Tolerance for Deviance subscale of the Multiphasic Environmental Assessment Procedure (Moos & Lemke, 1979).

Treatment - Use and level of antipsychotic medications, other somatic treatments such as electroconvulsive therapy or psychosurgery, and presence of treatment goals elicited through nurses' completion of the Inventory of Structural and Treatment Restrictiveness (Garritson, 1983a).

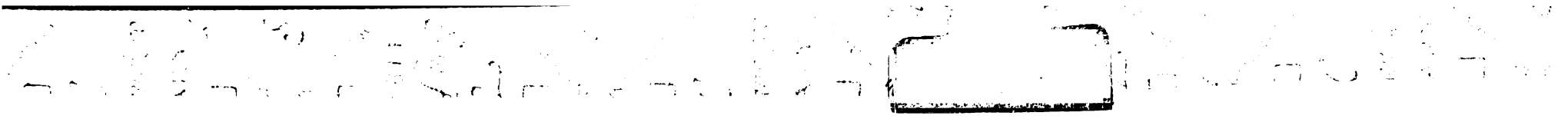
Patient characteristics - Average demographic characteristics, levels of functioning, severity of illness, legal status, and census elicited through the

nurse's completion of the Patient Demographic Characteristics form (Garritson, 1983d).

Staff characteristics - Demographic items such as age, education, psychiatric nursing experience, religious identification and participation, and employment status elicited through nurse's completion of the Staff Demographic Characteristics form (Garritson, 1983c). Also, staff's beliefs and ideas about mentally ill patients and treatment techniques for mental illness including authoritarian, prohibitive-controlling, or humanitarian notions as measured by the Opinions About Mental Illness Tool (Cohen & Struening, 1962).

Ethical Decision-making - The justification of nursing interventions according to ethical principles. Ethical decision-making in this study is limited to consideration of the principles of distributive justice, autonomy, and beneficence.

Distributive justice - Allocation of social burdens and benefits (Beauchamp & Childress, 1979). In this study, equality of treatment is the basic standard of distributive justice. While not all men have equal capacities, equal treatment is a prima facie duty to make proportionally the same contribution to goodness in their lives once a certain minimum has been achieved by all (Frankena, 1973). This reflects the cultural significance of the equal intrinsic dignity or value of the individual. Distributive justice is measured through



the nurse's response to case vignettes and the Nursing Philosophy Statement (Garritson, 1983b, 1983e).

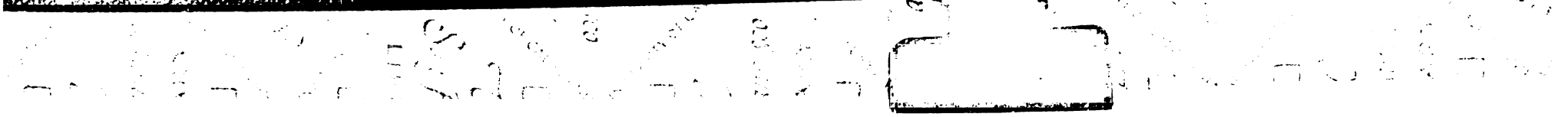
Autonomy - The self-directed capacity to determine and carry out one's life plans. Autonomy is associated with freedom of will, freedom of action, and freedom of choice. It is measured through the nurse's response to case vignettes and the Nursing Philosophy Statement (Garritson, 1983).

Beneficence - Promotion of the greatest possible good over evil through enhancement of the individual's interests, skills, and abilities when risk to ourselves is minimal. Beneficence include's preventing harm or removing harmful conditions (Beauchamp & Childress, 1979). Beneficence is measured through nurse's response to case vignettes and the Nursing Philosophy Statement (Garritson, 1983b, 1983e).

Nursing Care - The process of assessing, planning, implementing, and evaluating nursing care and measured by the choice of one of three possible interventions to a patient care problem.

Summary

The human/environment interaction, conceptualized as a unified total system, is divided for the purposes of investigation into the physical environment, the psychological environment, and the social environment. These categories are consistent with dimensions of restrictiveness identified through literature review. Cognitive-



perceptual skills and motivating values and beliefs link the individual and environment. Nursing's moral knowledge directs the discipline's duty and obligation in its service. Three prima facie principles - beneficence, distributive justice, and autonomy - are theorized as influencing nursing's moral decision-making, allowing the discipline to claim to respect client rights and self-determination while providing care. This moral position is not without conflict, however, and little information is known about nurses' interpretations and experiences of ethical dilemmas within specified environmental conditions. Therefore this study explores the relationship between restrictiveness of psychiatric treatment environments, defined as the structural, organizational policy, enforcement processes, treatment, staff characteristics, and patient characteristics, and the moral principles of beneficence, distributive justice, and autonomy in nursing practice.

CHAPTER III

METHODOLOGY

The study design, sample selection process, and data collection instruments are described and critiqued in this chapter. The procedures for obtaining entrance to research sites and for obtaining subjects' consent to participate are explained.

Design

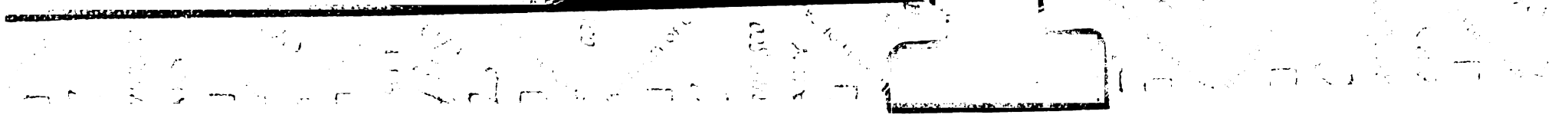
A survey design was chosen for this study for its suitability in gathering descriptive, exploratory, and explanatory data (Babbie, 1973). Both restrictive characteristics of selected psychiatric inpatient units and patterns of nurses' ethical reasoning in specific patient care cases are described. Relationships between restrictiveness variables are explored and the impact of the restrictiveness of psychiatric treatment environments on the ethical principles of beneficence, distributive justice, and autonomy in nursing practice is explained.

No variables were experimentally manipulated in this study. It was not practical to manipulate restrictiveness related to unit operation and nurses' restrictive attitudes were not manipulable variables. Manipulation of restrictiveness variables also poses potential ethical

problems. Variables were controlled through their natural occurrence and the sampling process.

The restrictiveness variables of structure, institutional policy, enforcement, treatment, staff characteristics, and patient characteristics provided data at two levels of analysis: the psychiatric inpatient unit and the nurse subject. Data on structural and treatment restrictiveness and patient characteristics were gathered for each unit. Institutional policy and enforcement items, staff characteristics, and data related to nurses' ethical reasoning were gathered from each nurse subject. These data provided a cross-sectional view of restrictive conditions and ethical reasoning for nurses in the selected psychiatric inpatient settings. Understanding of change over time in attitude and ethical reasoning was approached through analysis using some staff demographic variables such as age, years of psychiatric nursing experience, and years worked on the current psychiatric unit. Thus these variables provided both a cross-sectional view of subjects as well as an approximation of a longitudinal perspective.

The two levels of analysis (nurse subject and unit subject) provided a contextual dimension to this design. Nurse responses were assessed according to characteristics of the unit on which they worked. Additionally, these two levels of analysis provided flexibility in defining the independent and dependent variables. The relationship between structural restrictiveness (theoretically the most significant restrictiveness characteristic) and the other categories of restrictiveness could be analyzed. The restrictiveness variables could also be considered as independent variables impacting on the dependent variable of ethical decision making.



While the survey approach was justified by the need to discover relationships among variables, this technique is limited due to its inability to specify causality. However, since the restrictiveness literature is primarily composed of theoretical discussions of relationships between variables, the survey design was a reasonable approach to the study. Results would provide groundwork for a more rigorous hypothesis-testing design.

Sample

Two types of sampling techniques were used to obtain subjects for this study. Purposive sampling was used to select acute care inpatient psychiatric treatment facilities in the San Francisco Bay Area that could be classified as Veterans Administration, Private, Community Mental Health Centers, and University. While these categories of facilities were originally selected in order to test theoretical assumptions about the restrictiveness construct, an adequate representation from each facility was not available to make statistical comparisons. In addition to these Bay Area facilities, two private hospitals located outside the geographic area were included. While these various types of settings provide an "impressionistic modal instance" (Cook & Campbell, 1979, p. 77) of mental health care treatment facilities, this remains the least powerful model for generalizing results. There is no guarantee that the selected settings are representative of psychiatric treatment units in general.

The convenience sampling of nurse participants is likely to have resulted in further sampling bias since there is no assurance that these

nurses were representative of either all nurses on a given unit or the broader population of psychiatric nurses. Nurses who did agree to participate may have been those willing to expose their beliefs and practices about an emotionally-laden topic to the researcher's scrutiny. Nurses who did not volunteer to be subjects may illustrate the problem of "evaluation apprehension" (Cook & Campbell, 1979, p. 67), that is, not wanting to appear "restrictive" to the investigator.

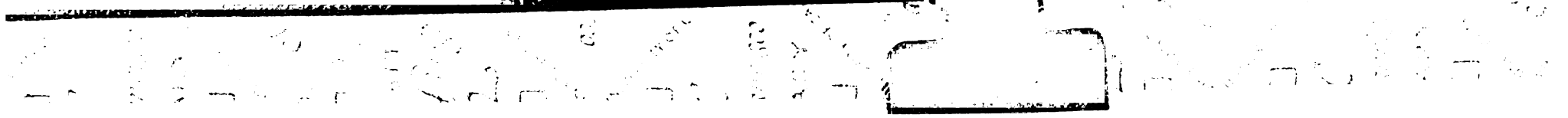
The sample consisted of 177 registered nurses from 29 psychiatric inpatient units. Eighteen units were located in private hospitals, eight units were located in county hospitals, one unit was located in a Veterans Administration hospital, and two units were located in a university hospital. Units were included according to the following criteria:

1. Acute care psychiatric treatment facility
2. Age of patient population 18 years or over.

The rationale for these criteria were:

1. Acute psychiatric treatment: While acute hospitalization increasingly includes acute medical care, the treatment emphasis remains on behavioral management; this selection limitation avoided restrictive conditions (such as confinement to bed) associated with primary medical treatment.
2. Age: Least restrictive legislation has been focused on the adult population; occasionally adolescents were treated on the adult units and these settings were included in the study.

No additional efforts were made to limit unit selection since the investigator sought to incorporate a broad range of psychiatric



treatment practices into the study. Statistical analysis of descriptive unit and patient characteristics were computed.

Previous investigation of individual restrictiveness variables have not included this variety of setting selection. Veterans Administration hospitals have been sites for a number of attitude and opinion studies (Cohen & Struening, 1962, 1964; Ellsworth, 1965) and for two investigations of restrictive treatment practices (Bursten, Fontana, Dowds, & Geach, 1980; Bursten & Geach, 1976). A community mental health center was the site for a retrospective study of restrictive care (Hargreaves, Gaynor, Ransohoff, & Attkisson, 1984), and a residential treatment facility for the developmentally disabled was the site for a study of methods to reduce the use of restrictive interventions (Davidson, Hemingway, & Wysocki, 1984). This study's range of facilities and units increases the likelihood of greater representation of approaches to psychiatric care, patient problems, and nurses.

Instruments

The following eight instruments were used in this study: Inventory of Structural and Treatment Restrictiveness, Opinions about Mental Illness, Resident Control and Tolerance for Deviance subscales of the Multiphasic Environmental Assessment Program, Staff Demographic Characteristics, Patient Demographic Characteristics, Case Vignettes, and the Nursing Philosophy Statement. Table 1 summarizes information about study instruments.

Table 1

Description of Study Instruments

Instrument	Author/Date	Number of Items	Variables Measured	Data Type	Time to Complete
Inventory of Structural and Treatment Restrictiveness	Garritson, 1983a	13	Structural Restrictiveness Treatment Restrictiveness	Nominal	5 min.
Opinions About Mental Illness	Cohen & Struening, 1962	51	Staff Characteristics Restrictiveness Authoritarianism Benevolence Mental Health Ideology Social Restrictiveness Interpersonal Etiology	Interval	15 min.
Resident Control	Moos & Lemke, 1979	16	Institutional Policy Restrictiveness	Interval	3 min.
Tolerance for Deviance	Moos & Lemke, 1979	18	Enforcement Restrictiveness	Interval	3 min.
Patient Demographic Characteristics	Garritson, 1983d	8	Patient Restrictiveness	Nominal and Interval	10 min.
Staff Demographic Characteristics	Garritson, 1983c	11	Staff Characteristics Restrictiveness	Nominal and Interval	2 min.
Case Vignettes	Garritson, 1983e		Beneficence Autonomy Distributive Justice	Nominal/Ordinal	8 min.
Nursing Philosophy Scale	Garritson, 1983b		Beneficence Autonomy Distributive Justice	Nominal/Ordinal	2 min.

The Inventory of Structural and Treatment Restrictiveness (ISTR) is a list of seven restrictive characteristics of the objective structure of a setting (including locked doors, use of seclusion and restraint, toilet stalls and showers without doors and curtains, rural location) and six aspects of treatment employed in the setting, including use and level of antipsychotic medications, other somatic treatments, and presence of treatment goals. (See Appendix A.) These items, selected through literature review and from the physical, somatic, and medication dimensions of the Restrictiveness of Care tool (Ransohoff et al., 1982) purport to contribute to the content validity of the ISTR.

The Opinions About Mental Illness tool (OMI) (Cohen & Struening, 1962), originally a 70-item tool utilizing a six-point Likert scale to evaluate responses to statements about mental illness, has now been revised to a 51-item tool. (See Appendix B.) The items were originally elicited from a pool of about 200 statements referring to cause, description, treatment, and prognosis of severe mental illness that were drawn from conversations, treatment conferences, current ideas in mental hospital settings, other mental illness opinion scales, and an attitude scale (Cohen & Struening, 1962).

This item selection process was assumed to contribute to the content validity of this tool. The test has not been updated since the early 1960s nor have other more valid or reliable mental health attitude tools been developed. Comments contributed by some subjects raised concern whether the tool's content remains valid. Subjects complained that the items were "poorly worded", "sexist", "leading", "archaic", "pejorative", and "saturated with generalities". Several subjects noted that items seemed to refer more to chronic institutionalized patients

than acute care patients. While the tool's content may be assumed to have been valid in the 1960s, changes in the care of the mentally ill and changes in nurses' education may have altered content previously considered valid.

Five factors identified by Cohen and Struening (1962) through factor analysis performed on the original 70-item tool and confirmed on the subsequent 51-item tool contribute to construct validity by supporting the theoretical assumption that opinions about mental illness are multidimensional. These factors have been labeled and are described as follows:

Factor A - Authoritarianism, containing 11 items and accounting for 47 percent of common variance in two samples, stresses the conception of mental patients as different from and inferior to normal people and requiring separation by locked doors, high fences, and guards.

Factor B - Benevolence, containing 14 items and accounting for an average of 15 percent of shared variance, reflects a kindly and paternalistic view of patients as social obligations. This perspective originates in religion and humanism rather than scientific or professional views.

Factor C - Mental Health Ideology, containing nine items and accounting for an average of 14 percent of shared variance, describes patients as capable of productive work and as able to live outside the hospital. Mental illness can be effectively treated much like any other disease.

Factor D - Social Restrictiveness, containing 10 items and accounting for an average of 14 percent of shared variance,

emphasizes the desire to restrict mental patients both during and after hospitalization for the protection of the family and society.

Factor E - Interpersonal Etiology, containing seven items and accounting for 10 percent of shared variance, reflects the view that mental illness arises out of interpersonal experiences such as deprivation of affection or as an effort to avoid problems.

The reported variance data pertain to the 70-item tool. The following reliability data are reported for the 51-item tool. Using Tryon's covariance form of the formula for the reliability coefficient, Struening and Cohen (1963) reported that the internal consistency of the five factors for three samples ranged from .35 to .80 in setting I, .39 to .80 in setting II, and .28 to .76 in setting III (p. 355). The Mental Health Ideology factor demonstrated the least internal consistency and the authors suggested that this factor requires further refinement. The Mental Health Ideology and Interpersonal Etiology factors were not analyzed in this study.

The Tolerance for Deviance (Appendix C) and Resident Control (Appendix D) tools, containing 18 and 16 items respectively, are two subscales of the Policy and Program Information Form of the Multiphasic Environmental Assessment Program (MEAP) (Moos & Lemke, 1979). Originally developed for the environmental assessment of sheltered care settings for the elderly, the MEAP is composed of items drawn from literature review, observations and interviews in sheltered care facilities, and review of public records. The final selection of items was based on face validity, moderate to high item-interrelatedness,

subscale independence, and ability to discriminate between settings (Moos & Lemke, 1979). Additionally, subscales and items were theoretically consistent. The Tolerance for Deviance scale, which measures the extent to which aggressive, deviant, destructive, or eccentric behavior is tolerated, has an internal consistency score of .80 and test-retest reliability of .78. The Resident Control scale measures the extent to which patients influence policy and program and has an internal consistency score of .87 and a test-retest reliability of .74.

Staff Demographic Characteristics (SDC) is a checklist of 11 demographic items including age, education, religious identification and participation, sex, and employment status and provides general descriptive data and variables identified in previous studies as significant correlates of attitude. This tool was developed by the investigator for this study. (See Appendix E.)

Patient Demographic Characteristics (PDC) is a checklist of eight items, including severity of illness, legal status, age, race, education, occupational level, and sex, that on the average best described the patient population of the setting. This tool was developed by the investigator for this study. (See Appendix F.)

Case Vignettes (CV) depicting restrictive situations in psychiatric care were used to elicit ethically-based nursing interventions. Respondents ranked three interventions according to their agreement with the approach and rationale represented by the intervention. In addition, the respondent was asked to comment on his/her first choice selection. These vignettes were developed by the investigator for this study. (See Appendix G.)

Content validity of the case vignettes was ensured by selecting situations representative of restrictiveness as described in literature review. Six cases were submitted to a group of psychiatric nurse clinical specialists for evaluation of whether the interventions reflected the specified ethical principles. Three cases finally selected from this review had at least a .88 agreement between raters and a criterion standard. For example, raters agreed 88 percent of the time on the match between an intervention and its intended ethical principle.

In order to assess test-retest reliability, these nurse specialists ranked the interventions according to their first, second, or third choice for intervening in the case. These nurses repeated this ranking process two to three months later. The Bowker Test of Symmetry (Marascuilo & McSweeney, 1977) demonstrated no significant difference between test-retest rankings for all interventions for each vignette.

Nursing Philosophy Statement (NPS) consists of three abstract statements about the nature of nursing. Each is designed to reflect one of the following ethical principles: distributive justice, autonomy, or beneficence. (See Appendix H.) This tool was developed by the investigator for this study. As with the case vignettes, the philosophical statements were submitted to a group of psychiatric nurse clinical specialists who evaluated whether the statements reflected the specified ethical principles. The raters agreed at least 75 percent of the time on the match between the philosophical statements and the specific ethical principles.

The nurse raters were also asked to rank these philosophy statements according to how well they represented their thoughts about

nursing. The nurses repeated this ranking two to three months later. The Bowker Test of Symmetry (Marascuilo & McSweeney, 1977) demonstrated no significant difference between test-retest rankings for the philosophy statements.

Scales and available validity and reliability data are summarized in Table 2.

Tool Limitations

The mono-method approach to measuring both the restrictiveness variables and the ethical principle variables may have resulted in an additional study limitation. Paper and pencil tools were used for all measurements, thus limiting the generalizability of results to nurses who respond in writing. Additional perspectives that might have been gleaned from alternative approaches, such as observation and interview, were not included.

The problem of "evaluation apprehension", which may have influenced sample selection, may have also effected measurement of the constructs since participants may have answered questions in ways to make themselves appear "less restrictive". This was most apparent with the Opinions about Mental Illness tool when one subject noted in the test margin that she was uncomfortable admitting that she thought the mentally ill should be sterilized. Others may also have felt uncomfortable with this or other items on this tool, but answered in more neutral terms or even in opposition to their actual thoughts.

Table 2

Study Variables and Available Reliability and Validity Data

Variable	Number of Items	Percent of Variance Accounted for	Coefficient Alpha	Instrument
Structural Restrictiveness	7			Inventory of Structural and Treatment Restrictiveness
Institutional Policy Restrictiveness	16		.87	Resident Control Scale
Enforcement Restrictiveness	18		.80	Tolerance for Deviance
Treatment Restrictiveness	6			Inventory of Structural and Treatment Restrictiveness
Patient Restrictiveness	8			Patient Demographic Characteristics
Staff Restrictiveness Psychosocial Attitude	51			Opinions about Mental Illness
Authoritarianism		47**	.79*	
Benevolence		15**	.55*	
Mental Health Ideology		14**	.60*	
Social Restrictiveness		14**	.22*	
Interpersonal Etiology		10**	.59*	
Demographics	11			Staff Demographic Characteristics
Ethical Decision Making	12			Case Vignettes/Nursing Philosophy Statement

* Reflects average coefficient alpha of three samples, 51-item tool

** Reflects scores obtained on the original 71-item tool

The mono-method, forced-choice approach to ranking the case vignette interventions may also have contributed to measurement bias. Several subjects noted that none of the interventions best represented their ideas for providing care. While some subjects did use the "additional comments" space to further express their ideas, the forced-choice ranking gives the impression of agreement with the options provided.

Procedure

Following approval by the University of California, San Francisco Human and Environmental Protection Committee (No. 930116-01), letters were sent to the Directors of Nursing and/or Nurse Researchers at ten Bay Area hospitals with psychiatric services and one out-of-state psychiatric hospital (Appendix I). Additionally, the investigator was contacted by a nursing supervisor at a psychiatric facility in southern California, and this hospital was also included in the sample.

Follow-up telephone calls were made to each facility to determine interest in participating in the project, to determine the facility's specific requirements for conducting research in that setting (such as the facility's own human subjects' review), and to confirm an appointment for discussing the project with nursing staff. One Director of Nursing elected not to have her two units participate, and one facility presented so many delays that it was dropped from the sample.

Each facility also presented unique requirements for discussing the research with the staff. For example, in some settings the investigator was able to discuss the research at each unit's nursing staff meeting.

In other settings, the investigator presented the research to nursing supervisors who in turn presented the project to the staff. Additionally, the investigator relied on nursing supervisors in the two facilities out of the Bay Area to discuss the research with their staffs. The nursing supervisors in all facilities also distributed test packets to the mailboxes of nurses who could not attend meetings conducted by the investigator. Thus subjects were contacted in three ways: 1) by the investigator during nursing staff meetings, 2) by the supervisor in nursing staff meetings, and 3) through distribution of test packets to nurses' mailboxes. Despite these variations in eliciting nurse participation, no patterns explaining refusals to participate were identified. Volunteers ranged from 20 percent to 84 percent of registered nursing staff on the units.

Each test packet contained an Information Sheet/Informed Consent explaining the research and requesting participation (Appendix J). A self-addressed postage-paid envelope was included with each packet to facilitate return of test data. Packets were coded only for hospital and unit. No effort was made to identify nurses who did or did not participate since the investigator was concerned that this might aggravate any "evaluation apprehension" associated with the opinion or ethics measurement tools. Each subject was able to individually return his/her packet to the investigator through the mail, eliminating further responsibility by the supervisor to collect packets and eliminating the possibility of pressure by supervisors on subjects to volunteer.

Two weeks were allotted for return of test packets. A letter was sent to each head nurse thanking him/her and the staff for participating

in the study and urging anyone who was interested but who had not yet completed the packet to do so.

The format for the investigator's presentations to nursing staff included introduction as a nurse and a doctoral student at the School of Nursing at the University of California. The investigator explained the general purpose of the study, reviewed the test instruments, the consent form, and the procedure for returning packets and invited questions. While some units did agree to provide on-duty time for test completion, the nurse took the time as his/her own schedule permitted. Other settings did not provide on-duty time and the nurse completed the packet on his/her own time. The investigator had no further contact with subjects following the presentations and no volunteers contacted the investigator with questions or concerns about the study. Several subjects did write comments on their test packets.

Only unit supervisors were asked to complete the Inventory of Structural and Treatment Restrictiveness and the Patient Demographic Characteristics tools in order to limit the number of tools and amount of time required by staff to complete the instruments. It was anticipated that this tool limitation would increase staff participation, although this assumption cannot be validated. Five unit supervisors failed to return unit and patient descriptive information, resulting in data for 24 inpatient treatment units.

Summary

The survey design, selected for its suitability in gathering a variety of data, was discussed in this chapter. Sample selection, study

instruments, and procedures for collecting data were explained. A convenience sample of 177 registered nurses from 29 psychiatric inpatient units - purposefully selected to represent a variety of institutions and approaches to mental health care - completed instruments measuring policy, enforcement and attitudinal restrictiveness, staff demographics, and ethical rationales for decision making. Data reflecting structural and treatment restrictiveness and patient characteristics were collected from 24 psychiatric units.

CHAPTER IV

FINDINGS

Data analysis procedures are discussed in this chapter for the study's quantitative and qualitative data. Findings are presented for the study's main questions and are organized according to the following sections: 1) descriptive and comparative findings for restrictiveness qualities of psychiatric inpatient units, 2) descriptive, comparative, and qualitative findings for ethical decision making, and 3) findings related to the relationship between psychiatric inpatient environments and nurses' ethical decision making.

Data Analysis Procedures*

Descriptive statistics, including frequencies, ranges, means, and standard deviations, were used to compare restrictiveness qualities of psychiatric inpatient units for locked and unlocked settings. More detailed statistical comparison of these data was not possible due to an insufficient number of unlocked units in the sample. The Pearson

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* Data were analyzed using the Statistical Package for the Social Sciences (10th edition, SPSSX). Computer time was provided by UCSF Instructional Use of Computer Funds. Don Chambers served as statistical consultant.

Correlation Coefficient was used to evaluate the relationships between selected interval-type patient demographic and treatment data.

Demographic characteristics of nurse subjects from locked and unlocked units were compared using the student's t-test for interval data and Chi-square tests for nominal data. Relationships between these nurse demographic items and other study variables were also analyzed using the Pearson Correlation Coefficient and the t-test.

Discriminant analysis was used to assess the ability of three restrictiveness variables, measured by Resident Control and Tolerance for Deviance tools and the Authoritarianism, Benevolence, and Social Restrictiveness factors, to distinguish between nurses from locked and unlocked units. Discriminant analysis was also used to assess the impact of structural, attitudinal, and programmatic restrictiveness variables on ethical decision making. First choice interventions for Case Vignette 1 and the Nursing Philosophy Statement each served as the dependent variable for two analyses. Unit Security Status, Resident Control, Tolerance for Deviance, Authoritarianism, Benevolence, and Social Restrictiveness served as independent variables. Due to an insufficient number of subjects per ethical category for Case Vignettes 2 and 3, discriminant analysis could not be employed. The relationships between the independent variables and the first choice selections for Vignettes 2 and 3 were analyzed using analysis of variance.

Frequency data were used to describe subjects' selection of ethically-based interventions and philosophy statements. The Bowker Test of Symmetry (Marascuilo & McSweeney, 1977) was used to compare first choice selections for each case vignette and the Nursing

Philosophy Statement in order to assess changes in approaches to decision making for different clinical situations. Finally, comments made on the vignettes and philosophy statement were analyzed for themes and insights about selections.

Descriptions of Restrictiveness Qualities of Psychiatric Inpatient Units

Study Question: What are the restrictiveness qualities of psychiatric inpatient units?

Structure

Eight unlocked and sixteen locked units comprised the sample. The unlocked units evenly represented urban and suburban neighborhoods, while slightly more than half of the locked units were in urban locations. At least three-quarters of all the units were located in multiple story buildings and in multiple building complexes. These locations probably account for the access to shopping, entertainment, and religious and social services enjoyed by at least 75 percent of all units. The units generally maintained open living quarters with only one unlocked unit restricting access to the bathrooms at night and two locked units restricting access to bedrooms during the day. The locked units more frequently limited access to the laundry and kitchen during both daytime and evenings (62.5%). One locked unit also had doors removed from toilets and showers. As might be expected, 14 (93.5%) locked units employed restraints and seclusion, while one unlocked unit used these techniques. Table 3 presents the comparison of structural

Table 3
Structural Restrictiveness Characteristics
for Unlocked and Locked Units

Characteristic	Unlocked Units n = 8	Locked Units n = 16
Neighborhood		
Urban	50.0	56.3
Suburban	50.0	43.7
Rural	0.0	0.0
Type of Building		
Single story	25.0	12.5
Multiple story	75.0	87.5
Setting		
Single building	12.5	0.0
Multiple buildings	87.5	100.0
Community Access		
Shopping	87.5	75.0
Entertainment	87.5	75.0
Religious services	75.0	81.3
Social services	87.5	81.3
Unit		
Open	25.0	NA
Unlocked (pressure)	0.0	NA
Unlocked (pass)	75.0	NA
Locked (pass)	NA	87.5
Locked (no pass)	NA	12.5
Doors locked		
Bedrooms, day	0.0	12.5
Bathrooms, day	0.0	0.0
Bathrooms, night	12.5	0.0
Lounges, day	0.0	0.0
Lounges, evening	0.0	0.0
Laundry, day	12.5	62.5
Laundry, evening	0.0	62.5
Kitchen, day	12.5	62.5
Kitchen, evening	12.5	56.3
Doors Removed		
Bedrooms	0.0	0.0
Toilets	0.0	6.3
Showers	0.0	6.3
Movement Limited		
Soft posey	25.0	40.0
Restraint	12.5	93.3
Seclusion	12.5	93.3

Note: Numbers refer to column percents

restrictiveness characteristics for the study's locked and unlocked units. The percentage of severely ill patients was significantly related to the number of units that limited patient movement by locking the doors to laundry facilities during the day ($p = .007$). No other relationships were found between severity of illness, census or staffing variables, and movement limitation variables.

Treatment

Individual, group, and family therapies were provided on all unlocked units. Five (62.5%) unlocked units provided rehabilitation and four (50.0%) gave electroshock therapy. All locked units provided individual therapy while 15 (87.5%) provided family therapy and 11 (68.8%) provided group therapy. Eleven (68.8%) locked units provided rehabilitation and eight (50.0%) gave electroshock therapy. Positive reinforcement was frequently used on both types of units for behavior modification (unlocked = 87.5%; locked = 75.0%). "No response" was a seldom-used technique (unlocked = 25.0%; locked = 37.5%), and no aversive techniques were used in either type of setting. Unlocked units had a greater range in their frequency of psychotropic medication use, with 25 percent using medications occasionally, 62.5 percent using medications frequently, and 12.5 percent always using medications. On the locked units, 75 percent frequently used medications while 25 percent always used this treatment. Table 4 presents data for treatment restrictiveness.

The average registered nurse/patient ratio on unlocked units on the day shift was 1:7. The average staffing for unlocked units on the day shift was 3.25 registered nurses, 0.625 psychiatric technicians, and

Table 4
Treatment Restrictiveness Characteristics
for Unlocked and Locked Units

Characteristic	Unlocked Units n = 8	Locked Units n = 16
Therapies		
Individual psychotherapy	100.0	100.0
Group	100.0	68.8
Family	100.0	87.5
ECT	50.0	50.0
Psychosurgery	0.0	0.0
Rehabilitation	62.5	68.8
Behavior Modification		
Positive reinforcement	87.5	75.0
Time out	62.5	68.8
Remove value	25.0	43.8
No response	25.0	37.5
Aversive stimuli	0.0	0.0
Psychotropic Medication		
None	0.0	0.0
Occasionally	25.0	0.0
Frequently	62.5	75.0
Always	12.5	25.0
Treatment Plans		
Yes	100.0	100.0
No	0.0	0.0

Note: Numbers refer to column percents

1.25 aides. The average registered nurse/patient ratio on locked units on the day shift was 1:6. The average staffing for locked units on the day shift was 3.00 registered nurses, 1.75 psychiatric technicians, and 1.75 aides. Average evening staffing on unlocked units for registered nurses was 2.00, for psychiatric technicians was 1.00, and for aides was 1.37. Average evening staffing on locked units was 2.31 registered nurses, 1.50 psychiatric technicians, and 1.60 aides. Average

registered nurse staffing on unlocked units at night was 1.12 compared to 1.18 for locked units. Average psychiatric technician staffing on unlocked units at night was .75 compared to 1.31 for locked units. Average aide staffing on unlocked units at night was 0.87 in contrast to 1.06 for locked units. No relationships were found between average staffing variables and patient variables of census, age, race, sex, severity of illness, or legal status. Thus, on the average, registered nurse staffing was slightly higher on the day shift for unlocked units while it was slightly higher on evening and night shifts for locked units. Locked units tended to employ slightly more auxiliary staff than unlocked units. Table 5 presents data on staffing patterns. Average staffing was not related to ward policy or atmosphere scores as measured by the Resident Control and Tolerance for Deviance tools and the Authoritarianism, Benevolence, and Social Restrictiveness factors of the Opinions about Mental Illness tool.

Patient Demographics

Unlocked units had an average census of 22 patients. These patients were primarily middle-aged adults (44%), Caucasian (88%), female (59%), voluntary (98%), and considered moderately ill (53%). The average length of stay was 67 days, though the hospitalization length ranged from 7 to 300 days. Fifty-two percent had either no work history or were unskilled, while 47 percent were skilled or professional workers. Fifty percent had no more than a high school education, and 37 percent were at least college graduates.

Locked units had an average census of 19 patients. These patients were primarily young adults (47%), Caucasian (63%) or Black (18%), male

Table 5
Mean Staffing for Unlocked and Locked Units

Staffing	Unlocked Units n = 8			Locked Units n = 16		
	$\bar{X}$	SD	Range	$\bar{X}$	SD	Range
Days						
RNs	3.25	1.16	2 - 5	3.00	1.09	1 - 5
PTs	.63	1.06	0 - 3	1.75	1.57	0 - 5
Aides	1.25	1.16	0 - 3	1.75	1.94	0 - 5
Evenings						
RNs	2.00	.93	1 - 3	2.31	.70	1 - 4
PTs	1.00	1.41	0 - 4	1.50	1.54	0 - 5
Aides	1.37	1.30	0 - 3	1.62	1.70	0 - 5
Nights						
RNs	1.12	.35	1 - 2	1.18	.66	0 - 3
PTs	.75	.70	0 - 2	1.31	1.07	0 - 4
Aides	.88	.84	0 - 2	1.06	1.28	0 - 4

(52%), severely ill (85%), and either voluntary (43%) or on three-day involuntary admission (35%). The average length of stay was 36 days and ranged from 0 to 180 days. Fifty-five percent had either no work history or were unskilled while 43 percent were skilled or professional workers. Sixty-one percent had no more than a high school education, and 37 percent were at least college graduates. Table 6 presents patient demographic data for locked and unlocked units.

Table 6

Patient Demographic Characteristics for Unlocked and Locked Units

Characteristic	Unlocked Units n = 7-8	Locked Units n = 14-16
Census		
Mean	22.12	18.73
Range	12 - 45	8 - 35
Sex		
Male	41.25	51.68
Female	58.75	48.31
Age		
Adolescent	16.62	7.80
Young adult	24.87	46.93
Middle adult	43.75	28.53
Older adult	14.50	16.73
Race		
Chinese	.63	5.37
Japanese	.25	1.31
Filipino	0.00	1.75
American Indian	0.00	.63
Hispanic	3.75	6.93
Black	6.42	18.31
Caucasian	87.71	63.06
Other	.50	2.43
Occupational Status		
Never worked	31.75	28.71
Unskilled laborer	21.00	27.85
Skilled laborer	29.62	29.28
Professional	17.50	14.07
Education		
Less than high school diploma	23.25	31.64
High school diploma	27.25	30.76
College graduate	23.50	21.14
Graduate school	13.50	16.42
Severity of Illness		
Mild	11.75	3.18
Moderate	52.62	12.31
Severe	35.62	84.50
Legal Status		
Voluntary	98.42	42.93
Involuntary, 72 hour hold	1.42	35.18
Involuntary, 14 day hold	0.00	12.75
Conservatorship	.14	9.12

Note: Numbers refer to column percents unless otherwise specified

The Pearson Correlation Coefficient was used to determine if patterns of relationships between patient demographic variables existed. Correlations were considered significant if $p \leq .01$. Several variable clusters were apparent.

Percentages of Japanese, Filipino, and American Indian patients and patients on involuntary 10-14 day holds were positively intercorrelated. Percentages of Japanese, Filipino, Black, and Hispanic patients were negatively associated with percentage of Caucasians. Percentages of Blacks and Filipinos were positively correlated. Both were positively associated with involuntary 72-hour admission. Percentage of Caucasians was positively associated with voluntary admission. Percentage of voluntary patients was positively associated with percentage female, while percentage of involuntary 72-hour admission was positively associated with percentage male. These correlations suggest that Caucasian patients and female patients tended to be hospitalized voluntarily and separately from minority patients. Involuntarily admitted patients were likely to be male and from a racial minority group.

The percentage of unskilled worker was positively associated with the percentage of involuntary 72-hour admission, percentage with high school diploma, and percentage Chinese. Percentage unskilled worker was negatively associated with percentage Caucasian, voluntary admission, professional occupation, and graduate school education. This suggests that high-school-educated Chinese with no work skills are likely to be hospitalized involuntarily. No comparable data for professional Chinese were available. Educated, professional Caucasians are likely to be hospitalized voluntarily.

The percentage of adolescent patients was correlated with percentage never worked, no high school diploma, and length of hospital stay. Percent adolescent was negatively associated with percentage of middle-aged adults. The percentage of young adult patients was negatively correlated with percentage old adults. The percentage of middle-aged adults was negatively associated with percentage of no high school diploma, percentage of severely ill patients, and length of stay. This cluster suggests that psychiatric settings segregate patients according to age and that length of hospitalization is related to work skills and education level.

There was a significant negative relationship between the percent of adolescent patients and authoritarianism ($p = .004$). There were no other significant relationships between patient demographic variables and ward policy or atmosphere scores as measured by the Resident Control and Tolerance for Deviance tools and the Authoritarianism, Benevolence, and Social Restrictiveness factors of the Opinions about Mental Illness tool.

Nurse Demographics

Demographic characteristics were compared for nurses working on locked and unlocked units. The significance level was set at $p \leq .01$ in order to control for error associated with multiple statistical comparisons (Goodwin, 1984; Reid, 1983). Categories were combined for Chi-square analysis when necessary to maintain expected cell frequencies.

Table 7 presents staff demographic characteristics for the two groups. There was no difference between the mean age of nurses on

Table 7

Staff Demographic Characteristics and the Significance of Difference between Groups

Characteristic	Unlocked Units n = 69-71	Locked Units n = 97-99	df	Test	p
Age					
Mean (years)	37.74	36.62	165	t = .82	.4137
Range (years)	23 - 62	24 - 62			
Years of psychiatric nursing					
Mean (years)	8.52	7.39	168	t = 1.23	.2199
Range (years)	0 - 25	0 - 32			
Years of other nursing experience					
Mean (years)	4.07	6.10			
Range (years)	0 - 25	0 - 30			
Basic Education					
Diploma	32.2	27.2			
A.A.	16.1	34.0	2	$X^2 = 6.100$	.0473
Baccalaureate nursing	51.6	38.6			
Highest Nursing Preparation					
No additional	61.5	79.6	1	$X^2 = 5.500$	.0190
A.A. Baccalaureate Masters Doctorate	38.5	20.4			
Race					
Caucasian	92.3	82.5	1	$X^2 = 2.420$	.1195
Black Hispanic Chinese Japanese American Indian Filipino Other	7.7	17.5			

Table 7 (continued)

Characteristic	Unlocked Units n = 69-71	Locked Units n = 97-99	df	Test	p
Religion					
None	15.4	25.0			
Protestant	32.3	30.2	3	$X^2 = 2.274$	.51
Catholic	33.8	30.2			
Jewish	18.5	14.6			
Other					
Frequency of Religious Participation					
None	43.0	58.7			
Holidays	30.0	21.6	2	$X^2 = 3.859$	.14
Weekly	26.1	19.5			
More than once a week					
Current position					
Staff nurse	69.2	69.4	1	$X^2 = 0.0$	1.00
Head nurse					
Clinical specialist	30.8	30.6			
Other					
Employment status					
Per diem, Registry					
Permanent part-time	36.9	25.5	1	$X^2 = 1.900$	.16
Permanent full-time	63.1	74.5			
Sex					
Male	16.9	19.8	1	$X^2 = .063$	.80
Female	83.1	80.2			
Time on current unit					
Mean (years)	2.60	2.46	166	$t = .33$	.74
Range (years)	0 - 15	0 - 9			

Note: Numbers refer to column % unless otherwise specified; Categories in brackets combined for analysis.

unlocked units (37.74 years) and locked units (36.62 years). The nurses' average years of psychiatric nursing experience was slightly higher for nurses on unlocked units (8.52 years) than on locked units (7.39 years). Nurses on unlocked units (51.0%) more frequently had a baccalaureate degree as their basic preparation than nurses on locked units (38.0%). Nurses on unlocked units (38.5%) had a higher frequency of education beyond their basic preparation than nurses on locked units (20.4%). There was a greater frequency of non-Caucasian nurses on locked units (17.5%) than on unlocked units (7.7%) although, in general, staff were primarily Caucasian. There were no differences in religious identification or participation in religious activities between the two groups. There were no differences between groups in the percentage of staff nurse participants in other positions. There were slightly more part-time employees (which included per diem and permanent positions) on the unlocked units (36.9%) than on the locked units (25.5%). Slightly more males worked on locked units (19.8%) than on unlocked units (16.9%); however, staffing was predominantly female in both settings. There was no difference between the average number of years worked on the units, though the range indicated that staff stayed longer on unlocked units (0 - 15 years) than on locked units (0 - 9 years).

The relationships between nurse demographic items and programmatic and attitudinal restrictiveness were analyzed using the Pearson Correlation Coefficient and analysis of variance. The alpha level was set at $p \leq .01$ to control for error associated with multiple statistical tests. A significant difference was noted for the variables Race and Social Restrictiveness ($p = .002$). Caucasian nurses had a significantly

lower mean Social Restrictiveness score (12.41) than non-Caucasian nurses (17.86).

Mean staff attitude scores, their intercorrelations, and correlations with program restrictiveness variables are presented in Table 8. Authoritarianism and Social Restrictiveness were positively correlated, and both were negatively correlated with Benevolence ($p = .000$). Social Restrictiveness was negatively correlated with the program variable measured by the Resident Control tool ($p = .005$).

Policy and Enforcement

Mean scores and indicators of variability for the policy and enforcement restrictiveness variables are also presented in Table 8. The standard deviation and range figures for both the mean Resident Control score (23.04) and mean Tolerance for Deviance score (33.39) indicate a large dispersion of results. These variables' scores were not intercorrelated though, as previously noted, policy restrictiveness as measured by Resident Control had a mild negative association with attitude as measured by Social Restrictiveness ($p = .005$).

Discriminative Power of Structural, Attitudinal, and Programmatic Restrictiveness Variables

Discriminant analysis was used to assess the ability of the Resident Control and Tolerance for Deviance tools and the Authoritarianism, Benevolence, and Social Restrictiveness factors of the Opinions about Mental Illness tool to distinguish between nurses on locked and unlocked units. This statistical approach to analysis was

Table 8

Mean Staff Attitude and Programmatic Scores and Pearson Correlation Coefficients

Attitude and Programmatic Scores (n = 166-173)	$\bar{X}$	SD	Range	Authoritarianism	Benevolence	Social Restrictiveness	Resident Control
Authoritarianism	13.39	5.86	2 - 39				
Benevolence	47.91	6.21	27 - 63	-.30*			
Social Restrictiveness	14.06	6.52	1 - 38	.54*	-.34*		
Resident Control	23.04	14.24	0 - 75	-.16	-.03	-.22*	
Tolerance for Deviance	33.39	17.38	0 - 94	.10	.04	-.05	.04

* $p \leq .005$

preferred due to its ability to control the error rate and preserve power. The simultaneous assessment of all variables was also consistent with the study's interactive conceptual framework.

The ability of the five items to discriminate between the locked and unlocked status of the units was statistically significant ($p = .0001$). The institutional policy variable measured by Resident Control made the greatest contribution to the discriminant function. The Social Restrictiveness factor and Tolerance for Deviance score made weak contributions, while the Authoritarianism and Benevolence factors made minimal to no contributions to the function.

The means of these variables for the locked and unlocked units also illustrate their ability to differentiate between the two groups. The mean Resident Control score was greater for the unlocked group (29.11) compared to the locked group (18.47). The mean Social Restrictiveness score was greater on locked units (14.94) than on unlocked units (12.44). The mean Tolerance for Deviance score was greater on open units (35.47) than on locked units (31.85). The mean Authoritarianism score was higher on locked units (14.07) than on unlocked units (12.47). The mean Benevolence score was very similar between the two units (unlocked = 47.92; locked = 47.85). Table 9 presents group means and standard deviations for each tool/factor for locked and unlocked units and it presents the tool/ factors' contributions to the discriminant function.

Table 9

Relationships of Independent Variable Scores
to Unit Security and Discriminant Function

Tools/Factors (n=164)	Unit Security: Unlocked Units $\bar{X}$	Unlocked Units SD	Locked Units $\bar{X}$	Locked Units SD	Discriminant Function Coefficients*
Resident Control	29.11	14.29	18.47	12.62	.85694
Tolerance for Deviance	35.47	15.95	31.85	18.37	.23803
Authoritarianism	12.47	5.76	14.07	5.89	-.12137
Benevolence	47.92	6.45	47.85	6.23	-.08533
Social Restrictiveness	12.44	5.80	14.94	6.89	-.26205

* Discriminant Function Chi-square = 27.146, df = 5, p = .0001

Ethical Principles

Study Question: How are the ethical principles of beneficence, autonomy, and distributive justice represented in clinical decisions by psychiatric nurses?

Analysis of Ranks

Table 10 presents results of the frequency of selection for ranks for the three possible interventions for each case vignette and the frequency of philosophy statement ranks for the Nursing Philosophy Statement.

Vignette 1. Analysis of frequency data for Vignette 1 indicates that 59.8 percent of the subjects selected the beneficence-based principle for their first choice. The autonomy-based principle was selected most frequently (49.4%) for the second choice. The justice principle was selected by 122 subjects (76.2%) as their third choice.

Vignette 2. Analysis of frequency data for Vignette 2 indicates that 78.7 percent of the nurses selected the beneficence-based intervention for their first choice. The justice-based intervention was selected most frequently (66.9%) for the second choice, and the autonomy- based intervention was selected most frequently (69.4%) for the third choice.

Vignette 3. Analysis of frequency data for Vignette 3 indicates that 72.0 percent of the subjects selected the beneficence-based intervention for their first choice. The justice-based intervention was selected most frequently (69.6%) for the second choice, and the autonomy-

Table 10

Frequency of Intervention Selection for Case Vignettes and the Nursing Philosophy Statement

Vignettes/Philosophy	1st Choice f	2nd Choice f	3rd Choice f
Vignette 1 (n = 160-165)			
Intervention #1 - Autonomy	37.9	49.4	11.9
Intervention #2 - Beneficence	59.8	22.9	11.9
Intervention #3 - Justice	2.3	23.7	76.2
Vignette 2 (n = 160-164)			
Intervention #1 - Beneficence	78.7	15.0	6.9
Intervention #2 - Justice	9.1	66.9	23.7
Intervention #3 - Autonomy	12.2	18.1	69.4
Vignette 3 (n = 148-150)			
Intervention #1 - Beneficence	72.0	12.8	14.2
Intervention #2 - Justice	16.7	69.6	14.9
Intervention #3 - Autonomy	11.3	17.6	70.9
Nursing Philosophy Statement (n = 154-161)			
Statement #1 - Justice	6.8	22.1	71.4
Statement #2 - Beneficence	59.6	33.1	6.5
Statement #3 - Autonomy	33.5	44.8	22.1

based intervention was selected most frequently (70.9%) for the third choice.

Nursing Philosophy Statement. Analysis of frequency data for the Nursing Philosophy Statement indicates that 59.6 percent of the subjects selected the beneficence-based intervention for their first choice. The autonomy-based intervention was selected most frequently (44.8%) for the second choice, and the justice-based intervention was selected most frequently (71.4%) for the third choice.

Analysis of Differences between First Choice Interventions

Using Bowker's Test of Symmetry (Marascuilo & McSweeney, 1977) to determine if changes in first choice selections were random, comparisons were made between the first choices for Vignettes 1 and 2, Vignettes 1 and 3, Vignette 1 and the Nursing Philosophy Statement, Vignettes 2 and 3, Vignette 2 and the Nursing Philosophy Statement, and Vignette 3 and the Nursing Philosophy Statement. There was a significant difference between the first choice interventions for Vignettes 1 and 2 and Vignettes 1 and 3 ($p < .005$). The principle contribution to the difference in each case was made by subjects selecting the autonomy principle for Vignette 1 and the beneficence principle for Vignettes 2 and 3. Significant differences were also present between Vignette 2 and the Nursing Philosophy Statement and Vignette 3 and the Nursing Philosophy Statement ($p < .005$). In both cases, the contribution to the differences was made by subjects selecting beneficence as their first choice for the vignettes and autonomy for their first choice for nursing philosophy.

Analysis of Consistency

"Consistency" was defined as the selection of at least two first choice interventions for the case vignettes whose ethical rationale matched the principle of the first choice philosophy statement. Seventy-seven subjects (46.7%) did not consistently make first choice selections according to this criterion. The same percentage of subjects (46.7%) selected interventions and the philosophy statement that reflected the beneficence principle. Ten subjects (6.1%) consistently selected the autonomy rationale, while only one subject (.6%) consistently selected the distributive justice principle.

Analysis of Comments

Subjects' comments were treated as raw data and were analyzed through theme identification in order to account for and illustrate quantitative findings (Wilson, 1985). Seventy-two subjects (41%) commented on at least one vignette or philosophy statement. Themes are presented in this section and substantiated with the raw data comments.

Case Vignette 1. This vignette presented the subject with a dilemma of appropriate after-care for a 39-year-old chronic, institutionalized, schizophrenic woman. This patient was recently hospitalized following her dramatic physical decline when her father left her home alone for an extended period.

As noted in the frequency data, only four subjects selected the justice principle intervention of sending the patient home due to the cost of institutional care. This solution places social impact ahead of the individual's needs and was apparently a nonviable option for most respondents. However, the autonomy principle intervention (#1) and the

beneficence principle intervention (#2) did not seem to provide clear direction for choice, either. Only two nurses selecting autonomy commented that the patient's life with father was acceptable.

> Due to her history of OK functioning at home, the patient can probably be restabilized at home.
>
> The patient's father has been supportive enough to enable her to maintain for the past five years.

Only one nurse had strong feelings favoring institutionalization.

> This patient should not, under any circumstances, return home.

More frequently, respondents qualified their selection of either intervention with suggestions that the patient receive a visiting nurse, supportive day care, and intensive outpatient treatment. Some suggested enlisting the father's assistance through education, counseling, family therapy, and a support group to maintain the patient at home. Thus subjects were reluctant to resign the patient to an isolated life at home.

> The home environment and self-care are most important. Therefore, add an outpatient program such as day treatment and family therapy to identify problem areas and assist with coping.

Nurses selecting intervention #2 (institutional placement) were concerned with the patient's poor quality of life both at home and potentially in an institution. The institution seemed to be the lesser of two evils.

> Failure to eat and skin breakdown are more restrictive than institutional living.
>
> The patient is already institutionalized. Life with father is not so great, and she will need care when he dies. Therefore she is better off in a good institution that would maximize her chances to enjoy life.

The most frequently recommended institution was community-based residential care.

> I prefer a board-and-care home to provide structure without the debilitating effects of the hospital.
>
> A residential treatment center would be a balance between security and freedom.

Nurses wanted to avoid state hospital placement and expressed concern for poor staffing, lack of money, and poor management of these facilities.

> My first choice is #2 if "institution" is a rehabilitation setting. Otherwise my first choice is #1 (home placement) since the state hospital is not conducive to rehabilitation.

No comments indicated any expectation that this patient could ever function totally independently, and the placement dilemma was in finding a supportive setting that would enhance, not further detract, from her life.

> Due to her history of being institutionalized, she is susceptible to becoming dependent. Yet father's home seems too unstructured and has questionable support.
>
> Send her to an institution since she is barely functioning at home. The institution's effects must also be assessed to determine their improvement on her quality of life.

No one suggested asking this patient where she wanted to be placed after discharge. Regardless of their intervention selection, subjects operated from a "caring for the person" perspective and struggled with the limitations of the rule-like interventions by adding situation-related information to fulfill the "caring for the patient" requirement. Their aim was to enhance this patient's quality of life.

Case Vignette 2. This vignette presented the nurse with a treatment dilemma for a 25-year-old acutely psychotic male who has had two episodes of self-mutilation (chewing off his thumb and finger). This man is noncompliant with psychotropic medications. Subjects were asked to rank three interventions dealing with injectable medications

for the patient's benefit, injectable medications to decrease hospital stay and expense, and patient determination of what, if any, treatment he wanted.

The nurse's moral responsibility to provide care was a significant theme for subjects selecting intervention #1 (injectable medications to avoid further mutilation episodes).

> Consider the patient's choice, but the profession has the responsibility to help the patient from further self-mutilation.
>
> Professionals are responsible to prevent repeated self-mutilations.

The nurse is culpable due to the patient's psychotic state and concomitant lack of judgment. His history of noncompliance and even his hospitalization are signals to "take over".

> The patient does not show enough judgment to allow him the choice for treatment.
>
> Though the patient's preferences are important, poor judgment and history of noncompliance indicate need for staff to take control of medication administration.

Self-mutilation may be a special case of poor judgment that is particularly unacceptable.

> I believe in the right to choose to accept/reject treatment, but not when the patient is self-destructive or disturbed.
>
> IM medications are the best choice due to psychotic symptoms resulting in mutilation.

Not only is self-mutilation an assault on oneself, it is also a social threat.

> This patient needs a structured medication regimen since his hands are needed to be self-functioning.
>
> Long-acting medications (are needed) due to the patient's history and likelihood of further decompensation. Society's interest is greater than the patient's.
>
> Self-mutilation costs money to society.

Even subjects selecting the autonomy intervention (#3, respect the patient's choice) did not seem convinced of such a radical autonomy perspective. They recommended a variety of additional interventions such as therapy, alternative medication trials, attention to environmental stressors, and education to gain the insight to voluntarily select injectable medications.

The profession's responsibility to provide care to the patient with impaired judgment was the central theme in this case. As with Vignette 1, additional treatment recommendations were made to enhance a "caring for the person" process.

Case Vignette 3. The third vignette presented the subjects with care of a 16-year-old woman with anorexia nervosa who was medically unstable due to vomiting and electrolyte imbalance. Comments on this case showed the least amount of conflict and focused on the need to resolve the medical crisis.

> This is a crisis situation and therefore has a high likelihood of death.
>
> Others must stabilize her physical condition (electrolyte imbalance) before further psychiatric treatment or medications (are tried).

The provision of medical treatment requires objectivity and intensity.

> Maintain a "matter of fact" attitude while providing feedings so as not to get this treatment confused with punishment.
>
> One needs to use force/strength to stabilize medically since she is young.
>
> This patient needs stringent supervision, including maybe IVs, to prevent vomiting.

Nurses selecting alternatives to tube feeding as their primary approach to care were nevertheless unwilling to allow the patient to remain in

medical danger. One nurse from a behavior modification unit acknowledged,

> During the initial period of hospitalization, staff must take control of the patient's program.

Another nurse who selected the autonomy principle admitted,

> If she doesn't "choose" to cooperate, save her life. (Autonomy) may be an unrealistic choice since patients often decline when left independent.

The life-threatening nature of this situation requires intensive nursing intervention. The patient's opinion is not a major factor, as in Vignette 2. Controversy revolved around whether tube feeding or some other measures should be employed, although all agreed that the patient's life must be saved.

Nursing philosophy. Nurses selected the beneficence principle statement almost twice as often as the autonomy statement and almost ten times more often than the distributive justice statement. Some subjects needed to justify their choice of "caring for and promoting individuals' well-being" by blaming the medical model for interfering with patient autonomy.

> Ideally, the "autonomy" principle should be the most significant role/function of nursing, but the medical model prevents the patient's input/perceptions.

> Nursing cannot/does not respect dignity, autonomy, and individuality due to the medical model and Big Brother approach to health care, i.e. we have power, we'll take care of you.

Others justified their choice of the beneficence principle by noting that autonomy is limited by the patient's judgment and choice.

> Not every individual strives toward self-direction and independence.

> The autonomy statement is nice in fields other than psychiatry, but when patients' perceptions and judgments are severely impaired by their illness, the nurse can still respect the individual while providing a safe environment by substituting his/her judgments and perceptions for the patient's.

Even nurses selecting the autonomy statement as their first choice indicated that it was limited by certain patient conditions such as impaired judgment.

> This is idealism. The system does not provide room. Nursing does not provide care according to clients' perceptions of need. This is especially apparent with acute and violent patients.

> I respect the patient's decision to refuse treatment if it's thought out, he/she has all the information. It's debatable when the person is not judged competent.

> Each patient deserves nursing care. When the person can't express needs, the nurse must recognize and attempt to meet needs.

Some nurses selecting the distributive justice statement seemed dissatisfied with the forced ranking directions of the tool.

> It's illogical to rate three very separate statements. All three are OK.

> This choice (justice) refers to quantity, the others to quality; therefore they're not comparable.

> I would prefer to pick factors from each.

These comments indicate that the autonomy principle is problematic in psychiatric nursing practice. Regardless of whether subjects selected beneficence or autonomy for their first choice, they commented on the limitations of patient autonomy as a primary component of nursing philosophy. The social roles created by the health care delivery system hinder the patient's expression of his/her autonomy. However, the greatest impediment to patient autonomy is his/her own impairments that prevent comprehension and diminish safety.

Environmental Impact on Ethical Decision Making

Study Question: Is there a relationship between the restrictiveness of psychiatric inpatient environments and ethical principles of beneficence, autonomy, and distributive justice in psychiatric nursing practice?

Discriminant analysis was also used to determine the impact of selected restrictiveness variables on ethical decision making as represented by case vignettes and the Nursing Philosophy Statement. The independent scores for Unit Security (locked or unlocked), Resident Control, Tolerance for Deviance, Authoritarianism, Benevolence, and Social Restrictiveness were used to discriminate between nurses' choice of autonomy or beneficence for Vignette 1 and the Nursing Philosophy Statement. The third ethical category, distributive justice, was dropped from the analysis due to an insufficient number of subjects selecting this as their first choice to meet statistical assumptions. These restrictiveness variable scores were not adequate in Vignette 1 to discriminate between subjects' selection of autonomy or beneficence as their primary approach to patient care. These scores were able to discriminate between subjects' selection of autonomy or beneficence for the Nursing Philosophy Statement ($p = .011$). The Authoritarianism factor contributed the most information to the discriminant function, while Social Restrictiveness and Benevolence made moderate contributions to the function. Examination of the groups indicates that the mean Authoritarianism score was higher for those selecting autonomy (14.81) than for those selecting beneficence (12.45) as their first choice for nursing philosophy. The mean Benevolence score was higher for those

selecting beneficence (48.69) as their first choice than for those selecting autonomy (46.54). There was little difference in mean Social Restrictiveness scores between groups (autonomy group = 13.30; beneficence group = 13.62). Unit Security, Resident Control, and Tolerance for Deviance made weak contributions to the function, indicating that attitude rather than unit structure and program had the most impact on ethical decision making. Score means, standard deviations, and contributions to the function are presented in Table 11.

Discriminant analysis was again the preferable analytic method for evaluating the impact of these independent variables on ethical choice, due to its ability to keep alpha at a known level and to increase power (Goodwin, 1984; Reid, 1983). However, due to insufficient sample size, Case Vignettes 2 and 3 could not be analyzed using discriminant analysis. A series of analyses of variance were performed, but these tests also failed to identify any relationships between restrictiveness variables and choice of ethical approach.

Summary

This chapter presented data analysis procedures and findings according to three categories: 1) restrictiveness qualities of psychiatric inpatient units, 2) ethical decision making, and 3) the relationship between psychiatric inpatient environments and ethical decision making.

Data for 24 psychiatric inpatient units were used in this study. Security status was the principle structural factor distinguishing these units. Eight units were unlocked and 16 were locked. Locked units were

Table 11

Relationships of Independent Variables to Ethical Groups and Discriminant Function

Variable/Tool (n=149)	1st Choice Nursing Philosophy Statement				Discriminant Function Coefficients*
	Autonomy Group $\bar{X}$	SD	Beneficence Group $\bar{X}$	SD	
Unit Security	1.49	0.50	1.61	0.48	.31882
Resident Control	25.67	17.85	22.32	12.65	-.21764
Tolerance for Deviance	33.71	17.00	32.56	17.49	.02362
Authoritarianism	14.81	6.78	12.45	5.14	-.94795
Benevolence	46.54	6.90	48.69	5.45	.48731
Social Restrictiveness	13.30	6.73	13.62	5.88	.67266

* Discriminant Function Chi-square = 16.523, df = 6, p = .011

more likely to limit patient access to laundry and kitchen facilities than unlocked units. There was little difference between the two types of units in location, access to community services, or patients' access to bedrooms, bathrooms, and lounges. Individual psychotherapy was routinely offered on both types of units, while unlocked units were more likely to offer group and family therapies. Locked units were somewhat more likely to use medications and to use "removal of a valued item" and "no response" as behavior modification techniques. On the average, registered nurse staffing was slightly higher for unlocked units on the day shift while registered nurse, psychiatric technician, and aide staffing was greater for locked units on evening and night shifts.

On the average, unlocked units had a slightly higher census than locked units. The patient population was more likely to be middle-aged, Caucasian, female, and voluntarily admitted on unlocked units. Patients on locked units were somewhat more likely to be young adults, Caucasian or Black, male, and severely ill. Pearson Correlation Coefficients also indicated that Caucasian female patients tended to be hospitalized voluntarily and separately from minority patients. Educated, professional Caucasians were likely to be hospitalized voluntarily. Involuntarily admitted patients were more likely to be male and from a racial minority group. Patients also tended to be segregated according to age, and length of hospitalization was related to work skills and education level.

One hundred seventy-seven nurses were subjects in this study. There were no statistically significant differences between nurse demographic categories for staff from locked and unlocked units. Nurses from unlocked units were slightly more likely to have basic preparation

at the baccalaureate level and to have pursued additional nursing education beyond their basic preparation. Nurses from locked units were slightly more likely to be non-Caucasian. Non-Caucasian nurses had a statistically significant higher mean Social Restrictiveness score (Opinions about Mental Illness tool) than Caucasian nurses, though the low internal consistency score for this factor raises doubt about the reliability of the measurement and the correlation.

Discriminant analysis was used to assess the ability of programmatic and attitudinal variables to distinguish between nurses on locked and unlocked units. The ability of the five tool and factor scores (Resident Control, Tolerance for Deviance, Authoritarianism, Benevolence, and Social Restrictiveness) to discriminate between locked and unlocked unit status was statistically significant. The Resident Control score made the greatest contribution to the discriminant function.

Analysis of the frequency of ranked results for the interventions/ philosophy statements indicated that the beneficence-based intervention/ statement was consistently selected as the first choice. The autonomy-based intervention was most frequently selected as the second choice for Vignette 1 and the Nursing Philosophy Statement, while the distributive justice-based intervention was the second choice for Vignettes 2 and 3. The justice-based intervention was the third choice for Vignette 1 and the Nursing Philosophy Statement, and the autonomy-based principle was the most frequently selected third choice for Vignettes 2 and 3.

The Bowker Test of Symmetry was used to determine whether changes in first choice selections for case vignettes and the Nursing Philosophy Statement were random. There were significant differences between first

choice selections for Case Vignettes 1 and 2, Case Vignettes 1 and 3, Case Vignette 2 and the Nursing Philosophy Statement, and Case Vignette 3 and the Nursing Philosophy Statement, indicating that these differences were not results of random chance. The contribution to these differences was made by subjects selecting the autonomy principle for Case Vignette 1 and the Nursing Philosophy Statement and then selecting the beneficence principle for Case Vignettes 2 and 3.

Several themes were derived from written comments for the vignettes and philosophy statements. "Quality of life" and "caring for the person" were central concerns of Case Vignette 1. "Professional responsibility" and "patient competency" were important issues in Case Vignette 2. "Aggressive use of life-saving techniques" was a theme for Case Vignette 3. The "role for a concept of autonomy" was a focus for comments in the philosophy section.

While the beneficence principle was the most consistently selected perspective, its choice was most clear cut for situations that involved bodily harm or that were life threatening (Case Vignettes 2 and 3). The lack of a clear mandate for one ethical perspective indicates a situational approach to nursing ethical decision making.

The structural variable of Unit Security Status was combined with the programmatic and attitudinal variables to determine if these items could discriminate between nurses' choices of ethical principles on case vignettes and the Nursing Philosophy Statement. These variables were weakly discriminative for the autonomy and beneficence principles on the Nursing Philosophy Statement. The Authoritarianism score made the greatest contribution to the discriminative function, indicating that attitude rather than unit structure and program had the most impact on ethical decision making.

CHAPTER V

DISCUSSION

An overview of the study's purpose, questions, and theoretical framework is presented. Findings are discussed in terms of their contribution to the study's questions and in light of existing knowledge. Study limitations, implications for clinical practice, and recommendations for research conclude the chapter.

Overview

The purpose of this study was to examine the relationship between psychiatric treatment environments and ethical decision making in psychiatric nursing practice by answering the following questions:

1. What are the restrictiveness qualities of psychiatric inpatient units?
2. How are the ethical principles of beneficence, autonomy, and distributive justice represented in clinical decisions by psychiatric nurses?
3. Is there a relationship between the restrictiveness of psychiatric inpatient environments and ethical principles of beneficence, autonomy, and distributive justice in psychiatric nursing practice?

The psychiatric treatment environment has been conceptualized in this study as consisting of interacting physical, psychological, and social properties. These properties incorporate the structural, treatment, policy, enforcement, and patient and staff characteristic variables proposed in the literature as dimensions of restrictiveness.

The ethical principles of beneficence, autonomy, and distributive justice are prima facie principles to be considered when making moral decisions. Personality factors and situational pressures may influence choice of ethical principles. The legal perspective of least restrictiveness assumes that patient autonomy and self-determination are enhanced in less restrictive settings. However, least restrictiveness may, in fact, be morally problematic for nurses who tend to emphasize caring and meeting patient needs.

Restrictiveness

The multifaceted conceptualization of restrictiveness which guides this study embodies challenges to the notions that restrictiveness is an objective, environmental feature external to the patient, is a quality of classification of residential facility, and is expressible on a continuum (Bachrach, 1980). Justification for this multifaceted perspective is based on the assumption that no overriding variable encompasses all other restrictiveness items. Descriptive data for qualities of units' environments are discussed in terms of their ability to represent unique aspects of restrictiveness versus whether some one variable incorporates all others.

Physical Environment

The 24 participating psychiatric inpatient units were "most restrictive" settings according to the rankings proposed by Krauss and Slavinsky (1982). The units' restrictiveness was further distinguished by specifying the locked or unlocked nature of the setting. Sites were easily categorized by their security status, and the locked-door characteristic further refined the generalization of "most restrictive" provided by the institutional, inpatient nature of the care setting. Other structural variables did not provide further refinement.

While the locked status of the units in this study was not absolutely predictive of the presence or absence of other structural restrictiveness qualities, the study's findings suggested patterns of variables that were either shared by or unique to the settings. "Building", "Setting, "Neighborhood", and "Community Access" failed to distinguish between unit participants since almost all were located in multiple-story buildings in complex settings with access to community services. This variable pattern reflects the urban/suburban site location which would tend to have greater access to resources than rural facilities. The institutional nature of the buildings increases the restrictiveness of the setting while the access to community resources decreases restrictiveness.

Limitations on patients' movements by locked kitchen or laundry doors or from use of restraint and seclusion were more characteristic of locked settings than unlocked settings. These impediments increase restrictiveness. However, since the locked units were much more likely to have additional locked living areas, these detailed variables do not provide significant information for further differentiation of the

degree of locked unit restrictiveness. Thus the units' security status can be considered to be an overriding variable that incorporates other unit structural characteristics.

Variations within the locked and unlocked unit categories in means of limiting patient movement do contribute to Bachrach's (1980) charge that a continuum of restrictive facilities cannot be identified. However, the study's findings suggest that some uniformity does exist among settings and that individual variations are not sufficient to override the general differentiating category of security status.

No significant patterns of relationships between movement limitation variables and patient or staff characteristics, which reflect the psychological dimension of the environment, account for the additional structural limitations. The lack of relationship between movement limitation items and patient severity of illness variables supports findings by Kellam and colleagues (1966), who concluded that many restrictive ward practices resulted from issues other than intensity of patients' bizarre behavior.

Institutional policy and enforcement, which reflect the social dimension of the environment, were also unrelated to the movement limitation items. Thus conditions that resulted in individual unit variations in limitations on physical movement are not explained by the general social and psychological features of the environment. The interaction of institutional conditions and treatment philosophies result in innovative solutions and policies unique to each setting (Strauss et al., 1981), and these unmeasured qualities may explain individual variations.

Social Environment

Institutional policy, as measured by Resident Control, was a significant discriminator between locked and unlocked units. Unlocked units had a higher mean Resident Control score than locked units indicating that patients overall had greater decision making opportunities in unlocked settings. Since almost half of the patients on the locked units were admitted voluntarily and were therefore presumably competent and capable of making decisions, their autonomy would be enhanced on unlocked units where greater opportunities for decision making are provided.

Treatment did not provide additional characteristics for further subdividing locked and unlocked units into more or less restrictive settings. All the units provided treatment planning and individual psychotherapy and almost all provided group and family therapies, rehabilitation therapy, and behavior modification based on positive reinforcement and time out. All the units used psychotropic medications to some degree, and half of both the locked and unlocked units had electroshock treatment available. Both types of units had similar mean staffing patterns. Since no pattern of treatment variables further differentiated the restrictive nature of locked and unlocked settings, this general quality is best used to describe the restrictiveness of the individual patient's care.

The Tolerance for Deviance score additionally failed to substantially distinguish between types of units, possibly because a number of behaviors listed on this tool would be intolerable in any setting based on general safety requirements of the individual or community. For example, physically attacking other residents or staff

or smoking in bed are not "tolerable" behaviors since they potentially result in harm to all individuals in the setting. These tolerated/not tolerated behaviors provide basic guidelines for ward "shape" (Strauss et al., 1981). They delineate minimal rules regarding what is acceptable behavior in the setting and in what situations limits will be enforced. These rules provide staff some minimal means for controlling and organizing their work environments (Strauss et al., 1981).

Patients' legal status reflects the capacity to force treatment on an individual. This variable did not distinguish locked from unlocked settings. While almost all patients on unlocked units were voluntary, only slightly more than half of patients on locked units were involuntary. Thus legal status, as a quality of "enforcement", is specific to the individual rather than a setting.

Psychological Environment

The greater frequency of young adult, severely ill, and involuntary patients on locked units contrasts with the frequency of middle-aged, Caucasian, mild to moderately ill, and voluntary patients on unlocked units; this first group reflects the young, chronic population (Schwartz & Goldfinger, 1981). This population is the indirect recipient of least restrictiveness legislation. While these patients might have been hospitalized previously in state facilities, they are now the consumers of an array of community resources (Bachrach, 1982). They have an indefinite need for supportive services, yet the combination of nonoptimal services and patient noncompliant and/or dangerous behaviors results in hospital readmissions and confinement to jail. While these patients' average restrictiveness experience may be

reduced through deinstitutionalization, their maximum restrictiveness may actually be higher due to involuntary confinement, seclusions, and restraint (Hargreaves et al., 1984).

The patient population on the locked units was consistent with a national profile of state hospital patients. Young men with low socioeconomic status, especially Blacks, are disproportionately represented and Mexican-Americans are underrepresented in the state hospital sample (DeRisi & Vega, 1983). Table 12 presents the mean racial group representation for the study's locked units in California hospitals and compares these to the California state hospital population and general population estimates. The Asian and Black averages are clearly overrepresented, while Caucasians are underrepresented in the study sample. This overrepresentation of minorities may be partially explained by the racial composition of the San Francisco Bay Area.

While dangerousness was not addressed in this study, it is the most common ground for involuntary commitment in California and accounted for the greatest variance in restrictiveness in the study by Hargreaves and colleagues (1984). While Hargreaves et al. did not find a relationship between race and restrictiveness, Blacks were disproportionately represented in another study's sample of secluded patients (Soloff & Turner, 1981). The California admission patterns for Blacks and Hispanics may reflect variations in willingness to seek mental health services, greater tolerance for deviant or dangerous behavior among minorities, or systematic bias in dispositions by law enforcement personnel (DeRisi & Vega, 1983, p. 143). Hargreaves and colleagues (1984) suggest that patients considered dangerous may be at greater risk

Table 12

Comparison of Mean Racial Group Estimates for Locked Units in California Sample and California State Hospital Population Estimates*

Sample	California Locked Units (n = 9)	California State Hospital Estimates-1982	General Population Estimates
Caucasian	36.4	67.3	66.6
Black	31.8	17.7	7.6
Asian**	11.8	2.0	5.0
Hispanic	12.3	11.6	19.0

Note: Numbers refer to percents

* DeRisi & Vega, 1983

** Asian defined as Chinese and Japanese

for extremely restrictive care because they receive less than optimal treatment. The relationship between patient demographics, particularly race, and restrictiveness requires further study.

The lack of relationships between average census and ward policy and atmosphere as measured by Resident Control, Tolerance for Deviance, and the Authoritarianism, Benevolence, and Social Restrictiveness factors of the Opinions about Mental Illness tool failed to support other findings that increased ward size tends to create pressures toward rigid structure, to increase staffs' need to control and manage, and to decrease patient independence. The similarities in ward size in this study may account for failures to identify these previously noted differences (Moos, 1972, p. 417).

The impact of patient characteristics on the overall milieu has been documented in various personal accounts (Banes, 1983). The specific impact of seclusion on other patients has been noted (Binder & McCoy, 1983). Patient behavior and group interaction has been interpreted as a shared set of values and beliefs operationalized through a system of social roles and cliques (Caudill et al., 1976, p. 144). Based on the assumption that the social and cultural environment depends in part on the typical characteristics of its members, the contrasts in patient groupings between the locked and unlocked units suggest that there might be differences in the perception of qualities of the environment. The failure of study findings to identify any relationships between patient characteristics and ward policy scores as measured by Resident Control and Tolerance for Deviance may indicate that these scores were not sensitive measures of ward milieu and/or that some other variable influences the establishment and significance of milieu features for patients.

The nurse participants on locked and unlocked units were strikingly comparable. Table 13 compares sample characteristics with national demographic figures for registered nurses (U.S. Department of Health & Human Services, 1983). The median age of the sample, 35 years, was slightly lower than national figures. The percentages of non-Caucasian and male nurses were greater than national averages. This may illustrate the claim that psychiatry has been a traditional specialty for male nurses and it may also illustrate the community mental health movement's emphasis on cultural understanding as a prerequisite for care providers (Feldman, 1983; Mericle, 1983).

Table 13

Comparison of Sample Demographic Characteristics with National Registered Nurse Demographic Figures*

Sample	Caucasian	Non-Caucasian	Female	Male	Median Age Years
Registered Nurse Subjects (n=177)	86.1	13.9	80.6	18.2	35
Registered Nurse National (n=1,662,382)	91.5	7.2	96.4	2.7	38.4

Note: Numbers refer to percent unless otherwise indicated

* U.S. Department of Health and Human Services, 1983

Demographic figures for nurses employed in psychiatric hospitals are difficult to obtain since nurses are not considered "psychiatric nurses" without a master's degree. It is estimated that about 5 percent of all registered nurses identify themselves as psychiatric/mental health nurses regardless of their educational preparation, and about two-thirds of these nurses have less than baccalaureate preparation (Taube & Barrett, 1983). Study subjects' education was similar to this national pattern.

The relationship between nurse demographics and ward milieu was suggested by a pattern of findings. A positive, significant relationship was noted between Social Restrictiveness and the non-Caucasian variable. Social Restrictiveness was also negatively associated with Resident Control. Locked units had a higher frequency

of non-Caucasian staff, a higher mean Social Restrictiveness score, and a higher frequency of minority patients. Since non-Caucasian staff have been actively recruited into community mental health settings based on their presumed sensitivity to patients' culture and lifestyle, this pattern of findings raises a question about the general nature and therapeutic impact of this cultural understanding. This pattern of findings remains inconclusive due to the previously-noted low reliability of the Social Restrictiveness factor score.

Mean attitude scores, as measured by the Authoritarianism, Benevolence, and Social Restrictiveness factors of the Opinions About Mental Illness tool, failed to discriminate between locked and unlocked settings. Mean staff attitude scores and comparisons to the mean scores of nurses and psychiatrists in the original tool testing sample are presented in Table 14. While subjects' mean Authoritarianism and Social Restrictiveness scores are lower and mean Benevolence scores are higher than scores of the original nurse test subjects, the scores are comparable in light of standard deviation figures.

The low mean Authoritarianism is consistent with previous findings of low Authoritarianism scores of white collar workers (Rabkin, 1972). However, the low mean Social Restrictiveness scores in this study are not typical of white collar findings. The low mean Authoritarianism and Social Restrictiveness scores are more typical of the "nonauthoritarian, permissive, egalitarian orientation" of psychologists, social workers, clergy, and psychiatrists (Cohen & Struening, 1963, p. 120). These authors suggest that higher Authoritarianism and Social Restrictiveness scores are at least in part related to hierarchical position and nature of one's patient care responsibilities. For example, staff with greater

Table 14

Opinions about Mental Illness Tool
Comparison of Mean Scores: Study Subjects and
Original Nurse and Psychiatrist Subjects*

Subjects	Authoritarianism	Benevolence	Social Restrictiveness
Study Subjects (n = 173)	13.39	47.91	14.06
Cohen & Struening Nurse Subjects (n = 88)	18.85	45.30	20.65
Cohen & Struening Psychiatrist Subjects (n = 18)	14.10	42.30	19.80

* Cohen & Struening, 1962

responsibilities for managing patients and lower status in the hospital hierarchy are more authoritarian and restrictive. Nurses' low mean Authoritarianism/Social Restrictiveness scores in this study may indicate a shift in status with greater identification with the nonauthoritarian attitudes of other professional staff. Nurses' high Benevolence scores are consistent with high Benevolence by nurses in the original tool development and in comparisons between occupational groups (Cohen & Struening, 1962, 1963). This dimension entails a quality unique to nursing, encompassing a humanistic perspective that does not make as strong a contribution to others' professional identities.

The lack of any significant relationships between education, age, and sex and attitude scores contrasts with conclusions by the original test developers as well as findings in other studies (Clark & Binks,

1966; Cohen & Struening, 1962; Rabkin, 1972; Walt & Gillis, 1979). The strong negative relationship between Social Restrictiveness and Resident Control contributes a significant behavioral correlate to the study of social psychiatry. Nurses influence the patients' social environment through their 24-hour-a-day association, yet there is minimal documentation of specific relationships between nurse attitudes and therapeutic effectiveness (Shanley, 1981).

Ethical Decision Making

Nurses' responses to case vignettes and the philosophy statement illustrate act utilitarianism. Utilitarianism "asserts that we ought in all circumstances to produce the greatest possible balance of value over disvalue for all persons affected" (Beauchamp & Childress, 1979, p. 21). The act utilitarianism approach to ethical decision making is based on the notion that morally right actions are determined by the nonmoral value they produce (Beauchamp & Childress, 1979, p. 20). Actions may be guided by general rules, but the rules are breakable when necessary for the general good. The prima facie principles of beneficence, autonomy, and distributive justice provide general rules guiding psychiatric nursing actions.

Ethical Principles

Study findings indicate that while the beneficence principle was most frequently selected, its choice was not particularly consistent within individuals and varied according to situations provided by the vignettes. This evidence supports other findings for the powerful role

of situational factors on behavior and on nurses' moral judgments (Crisham, 1981; Ketefian, 1981; Murphy, 1978; Wicker, 1969). In the first vignette, nurses selected both the autonomy and beneficence principles to achieve the nonmoral goal of improving the patient's quality of life. Nurses more consistently selected beneficence to promote individual well-being in Vignettes Two and Three, though they were again more divided between beneficence and autonomy for their overall philosophy. Patient limitations and professional responsibility to maintain bodily integrity and social safety may be necessary circumstances for shifting the balance between these principles to allow beneficence to predominate.* The study's vignettes did not tap into circumstances in which the autonomy-beneficence balance would shift so that autonomy predominates. Identification of such circumstances would contribute to nursing's conceptualization of autonomy and its operationalization in practice.

The role of the distributive justice principle in nursing ethical decision making was less clear. Initially intended to portray treatment based on equal allocation of social benefits and burdens, distributive justice became a viable alternative to the radical autonomy perspective and its implications for harm to the patient in Vignettes Two and Three. The primary rankings of beneficence and secondary rankings of distributive justice underscore the significance of the nurse/patient relationship for delineating the scope of beneficence in practice. The

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*Three sources for the duty to be beneficent are reciprocity (act beneficently in order to repay received benefits), needs of others, and explicit or implicit contracts (Abrams, 1982). Patient limitations and professional responsibility exemplify the needs of others and contractual-based sources of beneficence.

virtuousness and kindness of the nurse as opposed to other models of distribution or other notions of primary duties become the basis for the organization and delivery of health care services.

While subjects did not demonstrate predominant concern with third-party obligations, some rationalized their weakly paternalistic interventions according to community welfare and some expressed a primary obligation to family members. This represents an awareness of multileveled professional relationships and contrasts with other models emphasizing principle obligations to the state (Beauchamp & McCullough, 1984).

Concern for individual well-being, quality of life, and professional responsibility for bodily integrity and social safety are themes found in a variety of nursing theories. Health has been described as a state of integrity of the human being and the capacity to live in one's physical, biologic, and social environment, achieving some measure of human life potential (Orem, 1980), a maximum potential for daily living through optimum use of one's resources (King, 1981), the measure of effective adaptation and degree of attainment of social well-being (Levine, 1973, cited in Fawcett, 1984), and the maximum well-being within the potential of the individual and groups (Rogers, 1970). Nursing has been described as a service which "acts to preserve the organization and integration of the patient's behavior at an optimal level under those conditions in which behavior constitutes a threat to physical or social health" (Johnson, 1980, p. 214), which includes promotion of health, maintenance and restoration of health, care of the sick and injured, care of the dying, and meets a social need (King, 1981), and "which has a direct and overriding responsibility to society"

(Rogers, 1970, p. 122). While the individual is frequently characterized as a biopsychosocial being by nurse theorists, the person is also viewed as having the capacity to perceive, think, decide, identify goals, and select means to achieve them (King, 1981), as having an achievement subsystem whose function is mastery or control of some aspect of self or environment (Johnson, 1980), as engaging in deliberate action, and as having the capacity for self-knowledge (Orem, 1978, cited in Fawcett, 1984). Thus study findings and themes derived from nursing theories reinforce each other's identification of a nursing perspective which defines the individual as having the capacity for autonomous action who may also require nursing care to achieve and maintain optimal well-being. The individual's physical limitations as well as society's needs influence nursing intervention.

Restrictiveness Variables and Ethical Decision Making

The attitude scores of Authoritarianism, Benevolence, and Social Restrictiveness made significant contributions to the choice of the autonomy and beneficence principles only for the overall philosophy statement. Authoritarianism made the strongest contribution to the discriminant function, and those subjects selecting autonomy as their first choice had a higher mean Authoritarianism score. When considered in the context of comments blaming the medical model for impinging on nurses' concerns for autonomy and proclaiming attention to autonomy as idealism, the relationship between authoritarianism and autonomy raises questions about the contribution of nurses' attitudes to their own sense

of autonomy and their ability to recognize and engender autonomy in their patients.

In a recent study of the ethical decision-making patterns of 775 senior nursing students, 89 percent agreed with bureaucracy-oriented decisions which were designed to reflect nursing responsibilities to the authority of the hospital or institutional system that employed the nurse. Eight percent made initial decisions that reflected nursing's responsibilities to a physician's or the medical community's attitudes and authority. No students made initial decisions oriented toward the welfare and rights of the patient and family (Swider, McElmurry, & Yarling, 1985). This decision-making pattern illustrates nursing's traditional orientation of deference to authority (Binder, 1983).

High mean Benevolence scores made only a moderate contribution to the discriminant function, though nurses selecting the beneficence principle as their first choice for their overall philosophy also had a higher mean Benevolence score. While this factor seemed to distinguish nurses from other professions during original Opinions About Mental Illness tool development, it was not consistently translated into action to guide responses to vignettes.

Other study variable scores (Resident Control, Tolerance for Deviance, and Unit Security) made negligible contributions to the discrimination between autonomy and beneficence. This may indicate that nurses do not associate the rules, regulations, and structure of their workplace with beliefs about nursing care and patients.

The lack of an ideologically consistent approach to patient care and apparent failure to associate the work site's operational philosophy with the conceptualization of nursing practice supports conclusions

reached 20 years ago that nurses lacked a professionally-based ideological position to guide their actions (Strauss et al., 1981, p. 362). Since almost three-quarters of the nurses in this study did not have a baccalaureate degree in nursing and ideological commitments are acquired during professional training, it is not surprising that attitudes and work place characteristics were unrelated to ethical decision making.

The socialization pattern of women in American society, the public image of nursing, and medical dominance in the hospital structure also influence nursing's lack of a professionally-based ideological position (Yeaworth, 1978). Women are primarily socialized to assume wife and mother roles, and jobs or careers are pursued in addition to these basic activities. Nursing is consistent with the wife/mother roles with its image of the nurse as supportive, nurturing, and self-sacrificing (Donnelly, Mengel, & Sutterley, 1980; Kalisch, Kalisch, & Clinton, 1982; Yeaworth, 1978). Institutional authority structures which maintain nurses in subservient positions and which minimize the nurse's numerous independent decision-making actions constitute the nursing practice forum. These factors coupled with expanded labor force opportunities for women may explain the decline in women entering nursing as well as suggest that those who do enter nursing may purposefully select its nurturing opportunities. Professional ideology is of secondary interest, and the non-baccalaureate educational setting does not challenge this priority.

Nurses' unique position in the health care delivery system may also account for inconsistent approaches to ethical decision making. Responsibilities to patients, physicians, and the health care

institution may force the nurse to adopt a collection of rationales for interventions. "An incompatible mixture of beliefs becomes an essential component of the strategy to maintain a minimal coherence between beliefs and acts in specific instances" (Mitchell, 1982, pp. 170-171).

Gilligan (1983) challenged the personality trait/situational effects explanations of moral behavior and proposed an "ethics of care" dependent on the "contextual understanding of relationship" (p. 40). Failure to conceptualize, explain, and understand the role of caring and responsibility in moral development results in the tendency to explain its manifestation by personality trait and situational effects variables. Gilligan's moral theory of caring is based on three modes of understanding responsibility: 1) the self and the need for inclusion and connection to others to ensure survival, 2) increased concern for the needs of others and the self to establish and maintain relationships of mutual dependence and care (the notion of not hurting others predominates at this level), and 3) concern for self in the context of interdependence rather than mutual dependence. Caring and responsibility are viewed within the context of connections to all involved in the relationship network, and caring is developed and supported through these contextually-based relationships. The ethic of caring does not replace justice* and its emphasis on individual rights. Gilligan proposed that justice and caring reflect "the fundamental tension in human psychology between the experience of separation and the experience of connection" (p. 47) and sustain the concept of morality.

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* The term justice in this theory refers to rights and is not interchangeable with the distributive justice principle.

Gilligan's theory enriches the initial personality trait/situational explanation of this study's findings. The justice/caring tension is parallel to the autonomy/beneficence balance in nursing ethics. Nurse theorists acknowledge this tension in frameworks that emphasize the need for nurse-patient contracts to ensure patient rights (Johnson, 1978, cited in Fawcett, 1984) and mutual goal-setting (King, 1981) while intervening to maximize the individual's well-being. Nurses' concerns for themes of professional obligation, quality of patients' lives, bodily integrity and well-being, and family and society's needs reflect a caring and responsibility perspective and an awareness of interconnecting relationships. Apparently situationally-based responses actually demonstrate sensitivity to the context for understanding and for guidance with interventions. The nurse/patient relationship, the basis for role responsibility in nursing practice, is a natural framework for a moral theory based on caring and responsibility in human relationships.

A Nursing Conceptualization of Least Restrictiveness

The nurse/patient relationship is operationalized within the structure of the service setting and specific daily tasks, and these structures and tasks are further justified and constrained by sociomoral norms (Agich, 1982). Nursing's Social Policy Statement (ANA, 1980) underscores this social-moral influence on nursing practice. Social sanctions have permitted nurses to expand their task responsibilities to include technologic, diagnostic, and therapeutic activities (Fry, 1983).

Yet society also powerfully sanctions humanitarian and caring attributes of nursing's role responsibility (Newton, 1981).

While Agich (1982) contended that the language of rights (which is the framework for least restrictive legislation) is appropriate to contexts in which moral relationships have broken down, he fails to recognize the influence of rights-based philosophy on medical ethics. Legalism (the resolution of moral problems through the language of the law) and its appeal to individualism is soundly situated in American thinking and acts as a constraining social norm on the benevolent and potentially paternalistic practice of nursing. Due to this constraining quality, the incorporation of a legally-based concept of least restrictiveness into nursing standards, theory, and clinical practice may seem to be a misapplication.* Yet the combined philosophical traditions represent normative values that would be sacrificed if either beneficence or autonomy predominated. A central task of nursing ethics is to identify the limits of each model in light of the other. Achievement of this balance is complicated by nursing's concern with family and community needs since the interests of these frequently competing domains may conflict. This struggle forms the basis of nursing's conceptualization of the least restrictive alternative. Gilligan's contextually-based theory of caring and responsibility, in conjunction with nursing conceptualizations of the balance between patient rights and nursing interventions, provides a framework for formulating a "least restrictive" approach to clinical care.

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*The contribution of Jane Louise Rubin's (1984) dissertation, "Too Much of Nothing: Modern Culture, the Self and Salvation in Kierkegaard's Thought", to the investigator's thoughts about "conceptual misapplication" is gratefully acknowledged.

Study Limitations

Limitations related to subject sampling, tool validity and reliability, and possible bias due to testing procedures were presented in Chapter 3. Briefly, these limitations involved convenience sampling of both nurses and psychiatric inpatient units, questionable current validity of the Opinions About Mental Illness tool, and mono-method and evaluation apprehension bias.

Data analysis revealed additional limitations. An insufficient number of unlocked psychiatric units to meet statistical assumptions prevented statistical comparison for structural, treatment, and patient demographic variables. Comparisons between locked and unlocked units could only be made via frequency data. An insufficient number of subjects in some ethical principle categories prevented use of discriminant analysis for all case vignettes although an alternative statistical analysis was employed.

Assessment of structural restrictiveness would have been enhanced with a tool that would provide an overall score. Structural restrictiveness could then be conceptualized as a continuous variable rather than a nominal variable and more refined comparisons could be made.

Validity and reliability results for case vignettes gathered during pretesting were rudimentary. The Additional Comment section provided richer data about ethical decision making, though responses could not be assumed to be representative of the sample or of psychiatric nurses in general. In addition, identified themes were derived from a limited sample of raw data and may reflect investigator bias.

The goal of this study - to conceptualize and assess restrictiveness of psychiatric inpatient units and ethical decision making and to evaluate any relationship between the two areas - may have been too large an undertaking given the current level of knowledge and available measurement tools. More focused and refined description, assessment, and measurement of either concept might have provided more definitive data to be a basis for future investigation.

Implications for Clinical Practice

Findings suggest concrete ways nurses can influence restrictiveness of their treatment settings. Shifts in nurses' assignments, management techniques, or unit policies and increased awareness may encourage unlocking bathroom and bedroom doors. Community meetings with patient input into certain ward decisions may increase resident control on locked units.

Patients' capacities to be admitted voluntarily should be carefully assessed. Patients capable of making decisions on their own behalf should be hospitalized on open units, which in general are less restrictive. Patients who are not competent but who are nevertheless cooperative with medical treatment should not necessarily be allowed to voluntarily consent to treatment. They deserve legal review and protection from paternalistic medical interference.

The low mean Authoritarianism and Social Restrictiveness scores support the contribution of the interdisciplinary team concept to social psychiatry. Nurses' attitudes may reflect the influence of the nonauthoritarian attitudes of other professional staff, and

interdisciplinary teamwork provides an opportunity to experience this influence.

Findings have significant implications for education of psychiatric and mental health nurses. A majority of participants had no special training in psychiatric nursing. Since enrollment in psychiatric nursing specialty programs is currently declining (Chamberlain & Marshall, 1983), it can be anticipated that many nurses employed in psychiatric hospitals will not have the educational preparation necessary to consider alternative behavioral management techniques or ethical implications of their interventions.

Thematic findings highlight the conceptual and practical influence of the notion of "the nurse/patient relationship". The emphasis on the one-to-one relationship as the nurse's primary obligation indicates that nurses' sensitivities to third-party interests, particularly economic interests, remain unsophisticated. Since nursing care reflects a significant cost of any inpatient treatment and since nurses have obligations to employment institutions and society, it is important for nurses to become more informed about and sensitive to the economic impact of their services.

Findings related to the concept of restrictiveness and ethical decision making are not limited to psychiatric nursing practice. The process of balancing the beneficence and autonomy models of the patient's best interest as well as incorporating distributive justice concerns are central to all nursing specialties. The balancing dilemma may be resolved differently depending on the individual patient's capacity for autonomous action, care requirements, and other competing third-party interests, and the resolution of this dilemma will be

apparent in the degree of restrictiveness of the environment and the care experienced by the patient. Burnside (1984) expressed concern about paternalistic decision making and use of restraints in nursing care of the geriatric patient. These restrictive interventions illustrate the significance of the beneficence model and the opportunity to apply the concept of the least restrictive alternative to other specialties.

Findings have significance for development of the ethics and philosophy of nursing. Findings highlight areas such as the conceptualization of the person, professional traditions, changing professional obligations, and capacities for intervention that are operationalized in activities that vary in degrees of restrictiveness. Incorporation of the concept of least restrictive intervention into the Standards of Psychiatric and Mental Health Nursing Practice (ANA, 1982) requires clarification of the profession's philosophical position. Thus nursing theorists and philosophers must conceptualize the person as more than a compilation of needs and must provide the theoretical tools to evaluate multiple obligations in clinical situations.

Future Research

Future research should be based on an improved measure of restrictiveness. Since environmental restrictiveness has been distinguished from treatment restrictiveness, measurement tools should include separate evaluations of these factors. Continued explication of the theoretical basis of restrictiveness must occur simultaneously with tool development. Is the concept based on a physical-psychological-

sociological understanding of the environment or does the concept reflect only objective characteristics?

Future research should reestablish the validity of the Opinions About Mental Illness tool. Item validity was established in the early 1960s and changes in social attitudes and levels of tolerance may have undermined original accuracy.

Future research should aim toward developing valid and reliable measures of ethical decision making. Since the use of case vignettes is an acceptable approach, variations in vignette circumstances would allow assessment of additional situational variables (Flaskerud, 1979). Other approaches to elicit ethical decisions and to identify key clinical events would include open-ended interviews regarding vignettes or other critical incidents. Special attention should be given to factors resulting in the primacy of patient autonomy.

Description of restrictive practices should be expanded from psychiatric settings to include settings for patients with other illnesses or settings for patients in specific developmental stages. For example, what are the historical, social, and institutional forces influencing restrictive/least restrictive nursing practices for patients with tuberculosis or leprosy, the geriatric or maternity patient? Treatment restrictiveness of psychiatric and other patients should also continue to be described and studied in relation to the effectiveness of treatment, patient characteristics, and staff qualities.

A phenomenological approach should be used to describe the experience of nurses delivering restrictive care. The experience of patients who receive intrusive or paternalistic treatment or who receive less restrictive alternatives should also be described.

Future studies should identify factors that decrease restrictiveness without decreasing the quality of patient care. For example, do staff with explicit nursing frameworks emphasizing promotion of patient independence (i.e. Orem's self-care model) use less restrictive interventions and environmental management techniques than staff with different or nonexistent philosophies? Do staff with a high degree of professional autonomy use less restrictive interventions than staff in rigid, hierarchical organizations?

Finally, future studies should explore the historical, philosophical, and religious traditions unique to nursing to identify modes of thought that influence attitudes toward patients and care giving. These traditions should be compared and contrasted with traditions of other health professionals. Nursing's unique humanitarian emphasis may result in a special interpretation of the beneficence-autonomy-distributive justice balance and may make a special contribution to the understanding of the morality of professional responsibility.

Summary

The physical, psychological, and social dimensions of restrictiveness have been described and discussed. The locked or unlocked nature of the unit, patient characteristics, and degree of resident decision making provided significant findings capable of differentiating units. This multifaceted theoretical formulation could be challenged by those who believe that the physical environment is a sufficient overriding variable to describe restrictiveness. For

example, the findings for patient characteristics and degree of decision making might also be viewed as subcomponents of the overall locked structural status. The multifaceted conceptualization gives each dimension equal significance and suggests various perspectives to understand treatment environments. The findings that settings could not be differentiated by availability of treatments, toleration of deviant behavior, or staff characteristics illustrate standards of care, safety, and personnel preparation commonly accepted in urban psychiatric treatment settings. Whether these standards would be maintained in other geographic locations remains unanswered. Finally, findings and the discussion differentiate "least restrictive environment" as a quality contributed to and impacted upon by all aspects of the treatment milieu from "least restrictive treatment" which describes the care received by the individual.

Nurses' ethical decision making, as reflected by forced choice of ethically-based intervention and philosophy statements, reflected an act utilitarianism approach. The prima facie principles of beneficence, autonomy, and distributive justice were represented in decision making, though their selection was not consistent. Situational aspects of the vignettes had a more significant influence on the choice of ethical principle than any restrictiveness variables. Although the beneficence principle was most frequently selected, nurses were also guided by nonmoral goals of professional responsibility, patient limitations, maintenance of bodily and social safety, and improvement in the patient's quality of life. Choice of ethical principle seemed to depend, in part, on its usefulness to achieve these goals.

The particular significance attributed by nurses to both autonomy and beneficence and sensitivity to contextual circumstances are represented in Gilligan's theory of responsibility and caring. This theory in conjunction with selected nursing perspectives provides a framework for further conceptual development of "the least restrictive alternative". Study limitations, clinical implications, and suggested future research conclude the chapter.

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APPENDIX A

INVENTORY OF STRUCTURAL AND TREATMENT RESTRICTIVENESS

Inventory of Structural and Treatment Restrictiveness

I. Structure

Questions 1, 2, 3, and 4
Check one item that best describes your setting.

1. Is the neighborhood primarily:

____urban
____suburban
____rural

2. Is the treatment facility located in a:

____single story building
____multiple story building

3. Is the treatment facility located in a:

____single building setting
____multiple building setting

4. Is the treatment unit:

____open, with freedom to come and go
____unlocked, with informal pressure to remain on premises
____unlocked, with need to obtain formal permission (pass)
____locked, with possibility of passes
____locked, with no possibility of passes
____other (describe)

Questions 5, 6, 7, and 8
Check all items that describe your setting.

5. For patients with passes, is there transportation or walking access to:

____shopping
____entertainment
____religious services
____social services
____not applicable

6. Doors are locked to prevent or limit patient access to:

____bedrooms during the day
____bathrooms during the day
____bathrooms during the night
____lounges, television rooms during the day
____lounges, television rooms during the evening
____laundry facilities during the day
____laundry facilities during the evening
____kitchen facilities during the day
____kitchen facilities during the evening
____other (describe)
____not applicable

7. Doors and curtains are removed from:

____bedrooms
____toilets
____showers
____other (describe)
____not applicable

8. Is patient movement limited by:

____soft posey jacket
____restraints (i.e., four-point restraint or full body restraint)
____seclusion
____other (describe)
____not applicable

II. Treatments

Questions 1 and 2
Check all items that describe your setting.

1. The following therapies are provided:

____individual psychotherapy
____group therapy
____family therapy
____rehabilitation therapy
____electroconvulsive therapy
____psychosurgery
____other (describe)

2. Behavior modification programs are based on:

____positive reinforcement for desired behavior
____exclusion/time out for undesired behavior
____removing something of value for undesired behavior
____no response to undesired behavior
____locked seclusion/time out for undesired behavior
____physical restraint for undesired behavior
____aversive stimuli such as mild electric shock or desensitization for undesired behavior
____other (describe)

Questions 3, 4, and 5
Check one item that best describes your setting.

3. Psychotropic medications are:

____never used
____used occasionally
____used frequently
____used always

4. Medications are usually administered as:

____oral tablets/capsules
____elixir
____injectable

5. Are treatment plans and goals written for each patient?

yes____
no____

6. How many staff are on your unit for:

Days	Evenings	Nights
____RNs	____RNs	____RNs
____Psychiatric technicians	____Psychiatric technicians	____Psychiatric technicians
____Aides	____Aides	____Aides

APPENDIX B

OPINIONS ABOUT MENTAL ILLNESS

OPINIONS ABOUT MENTAL ILLNESS

Jacob Cohen
Elmer L. Struening

The statements that follow are opinions or ideas about mental illness and mental patients. By mental illness, we mean the kinds of illness which bring patients to mental hospitals, and by mental patients we mean mental hospital patients. There are many differences of opinion about this subject. In other words, many people agree with each of the following statements while many people disagree with each of these statements. We would like to know what you think about these statements. Each of them is followed by six choices:

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

Please check (√) in the space provided that choice which comes closest to saying how you feel about each statement. You can be sure that many people, including doctors, will agree with your choice. There are no right or wrong answers: we are interested only in your opinion. It is very important that you answer every item.

* * * * *

1. NERVOUS BREAKDOWNS USUALLY RESULT WHEN PEOPLE WORK TOO HARD.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

2. MENTAL ILLNESS IS AN ILLNESS LIKE ANY OTHER.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

3. MOST PATIENTS IN MENTAL HOSPITALS ARE NOT DANGEROUS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

2.

4. ALTHOUGH PATIENTS DISCHARGED FROM MENTAL HOSPITALS MAY SEEM ALL RIGHT, THEY SHOULD NOT BE ALLOWED TO MARRY.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

5. IF PARENTS LOVED THEIR CHILDREN MORE, THERE WOULD BE LESS MENTAL ILLNESS.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

6. IT IS EASY TO RECOGNIZE SOMEONE WHO ONCE HAD A SERIOUS MENTAL ILLNESS.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

7. PEOPLE WHO ARE MENTALLY ILL LET THEIR EMOTIONS CONTROL THEM: NORMAL PEOPLE THINK THINGS OUT.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

8. PEOPLE WHO WERE ONCE PATIENTS IN MENTAL HOSPITALS ARE NO MORE DANGEROUS THAN THE AVERAGE CITIZEN.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

9. WHEN A PERSON HAS A PROBLEM OR A WORRY, IT IS BEST NOT TO THINK ABOUT IT, BUT KEEP BUSY WITH MORE PLEASANT THINGS.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

10. ALTHOUGH THEY USUALLY AREN'T AWARE OF IT, MANY PEOPLE BECOME MENTALLY ILL TO AVOID THE DIFFICULT PROBLEMS OF EVERYDAY LIFE.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

11. THERE IS SOMETHING ABOUT MENTAL PATIENTS THAT MAKES IT EASY TO TELL THEM FROM NORMAL PEOPLE.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

12. EVEN THOUGH PATIENTS IN MENTAL HOSPITALS BEHAVE IN FUNNY WAYS, IT IS WRONG TO LAUGH ABOUT THEM.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

3.

13. MOST MENTAL PATIENTS ARE WILLING TO WORK.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

14. THE SMALL CHILDREN OF PATIENTS IN MENTAL HOSPITALS SHOULD NOT BE ALLOWED TO VISIT THEM.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

15. PEOPLE WHO ARE SUCCESSFUL IN THEIR WORK SELDOM BECOME MENTALLY ILL.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

16. PEOPLE WOULD NOT BECOME MENTALLY ILL IF THEY AVOIDED BAD THOUGHTS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

17. PATIENTS IN MENTAL HOSPITALS ARE IN MANY WAYS LIKE CHILDREN.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

18. MORE TAX MONEY SHOULD BE SPENT IN THE CARE AND TREATMENT OF PEOPLE WITH SEVERE MENTAL ILLNESS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

19. A HEART PATIENT HAS JUST ONE THING WRONG WITH HIM, WHILE A MENTALLY ILL PERSON IS COMPLETELY DIFFERENT FROM OTHER PATIENTS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

20. MENTAL PATIENTS COME FROM HOMES WHERE THE PARENTS TOOK LITTLE INTEREST IN THEIR CHILDREN.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

21. PEOPLE WITH MENTAL ILLNESS SHOULD NEVER BE TREATED IN THE SAME HOSPITAL AS PEOPLE WITH PHYSICAL ILLNESS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

22. ANYONE WHO TRIES HARD TO BETTER HIMSELF DESERVES THE RESPECT OF OTHERS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

23. IF OUR HOSPITALS HAD ENOUGH WELL TRAINED DOCTORS, NURSES, AND AIDES, MANY OF THE PATIENTS WOULD GET WELL ENOUGH TO LIVE OUTSIDE THE HOSPITAL.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

24. A WOMAN WOULD BE FOOLISH TO MARRY A MAN WHO HAS HAD A SEVERE MENTAL ILLNESS, EVEN THOUGH HE SEEMS FULLY RECOVERED.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

25. IF THE CHILDREN OF MENTALLY ILL PARENTS WERE RAISED BY NORMAL PARENTS, THEY WOULD PROBABLY NOT BECOME MENTALLY ILL.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

26. PEOPLE WHO HAVE BEEN PATIENTS IN A MENTAL HOSPITAL WILL NEVER BE THEIR OLD SELVES AGAIN.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

27. MANY MENTAL PATIENTS ARE CAPABLE OF SKILLED LABOR, EVEN THOUGH IN SOME WAYS THEY ARE VERY DISTURBED MENTALLY.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

28. OUR MENTAL HOSPITALS SEEM MORE LIKE PRISONS THAN LIKE PLACES WHERE MENTALLY ILL PEOPLE CAN BE CARED FOR.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

29. ANYONE WHO IS IN A HOSPITAL FOR A MENTAL ILLNESS SHOULD NOT BE ALLOWED TO VOTE.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

30. THE MENTAL ILLNESS OF MANY PEOPLE IS CAUSED BY THE SEPARATION OR DIVORCE OF THEIR PARENTS DURING CHILDHOOD.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

5.

31. THE BEST WAY TO HANDLE PATIENTS IN MENTAL HOSPITALS IS TO KEEP THEM BEHIND LOCKED DOORS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

32. TO BECOME A PATIENT IN A MENTAL HOSPITAL IS TO BECOME A FAILURE IN LIFE.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

33. THE PATIENTS OF MENTAL HOSPITALS SHOULD BE ALLOWED MORE PRIVACY.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

34. IF A PATIENT IN A MENTAL HOSPITAL ATTACKS SOMEONE, HE SHOULD BE PUNISHED SO HE DOESN'T DO IT AGAIN.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

35. IF THE CHILDREN OF NORMAL PARENTS WERE RAISED BY MENTALLY ILL PARENTS, THEY WOULD PROBABLY BECOME MENTALLY ILL.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

36. EVERY MENTAL HOSPITAL SHOULD BE SURROUNDED BY A HIGH FENCE AND GUARDS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

37. THE LAW SHOULD ALLOW A WOMAN TO DIVORCE HER HUSBAND AS SOON AS HE HAS BEEN CONFINED IN A MENTAL HOSPITAL WITH A SEVERE MENTAL ILLNESS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

38. PEOPLE (BOTH VETERANS AND NON-VETERANS) WHO ARE UNABLE TO WORK BECAUSE OF MENTAL ILLNESS SHOULD RECEIVE MONEY FOR LIVING EXPENSES.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

39. MENTAL ILLNESS IS USUALLY CAUSED BY SOME DISEASE OF THE NERVOUS SYSTEM.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

6.

40. REGARDLESS OF HOW YOU LOOK AT IT, PATIENTS WITH SEVERE MENTAL ILLNESS ARE NO LONGER REALLY HUMAN.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

41. MOST WOMEN WHO WERE ONCE PATIENTS IN A MENTAL HOSPITAL COULD BE TRUSTED AS BABY SITTERS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

42. MOST PATIENTS IN MENTAL HOSPITALS DON'T CARE HOW THEY LOOK.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

43. COLLEGE PROFESSORS ARE MORE LIKELY TO BECOME MENTALLY ILL THAN ARE BUSINESS MEN.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

44. MANY PEOPLE WHO HAVE NEVER BEEN PATIENTS IN A MENTAL HOSPITAL ARE MORE MENTALLY ILL THAN MANY HOSPITALIZED MENTAL PATIENTS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

45. ALTHOUGH SOME MENTAL PATIENTS SEEM ALL RIGHT, IT IS DANGEROUS TO FORGET FOR A MOMENT THAT THEY ARE MENTALLY ILL.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

46. SOMETIMES MENTAL ILLNESS IS PUNISHMENT FOR BAD DEEDS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

47. OUR MENTAL HOSPITALS SHOULD BE ORGANIZED IN A WAY THAT MAKES THE PATIENT FEEL AS MUCH AS POSSIBLE LIKE HE IS LIVING AT HOME.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

48. ONE OF THE MAIN CAUSES OF MENTAL ILLNESS IS A LACK OF MORAL STRENGTH OR WILL POWER.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

49. THERE IS LITTLE THAT CAN BE DONE FOR PATIENTS IN A MENTAL HOSPITAL EXCEPT TO SEE THAT THEY ARE COMFORTABLE AND WELL FED.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

50. MANY MENTAL PATIENTS WOULD REMAIN IN THE HOSPITAL UNTIL THEY WERE WELL, EVEN IF THE DOORS WERE UNLOCKED.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

51. ALL PATIENTS IN MENTAL HOSPITALS SHOULD BE PREVENTED FROM HAVING CHILDREN BY A PAINLESS OPERATION.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

PLEASE CHECK BACK AND MAKE SURE THAT YOU HAVE NOT LEFT OUT ANY STATEMENTS

OR PAGES OF STATEMENTS

APPENDIX C

TOLERANCE FOR DEVIANCE

TOLERANCE FOR DEVIANCE

RULES RELATED TO POTENTIAL "PROBLEM" BEHAVIORS

Directions: Please use the following categories to describe your unit's policies with respect to these behaviors and activities. Check the blank of the most appropriate category.

1. Allowed - This kind of behavior is expected; no special attempt is made to change it.

2. Tolerated - This kind of behavior is expected, but an effort is made to encourage the individual to function better or more appropriately.

3. Discouraged - An attempt is made to discourage or to try to stop this behavior.

4. Intolerable - A person who persisted in this type of behavior would probably have to move out, be transferred, or be controlled.

	Allowed 1	Tolerated 2	Discouraged 3	Intolerable 4
1. Refusing to participate in programmed activities.....	☐	☐	☐	☐
2. Refusing to take prescribed medicine.....	☐	☐	☐	☐
3. Taking medicine other than that which is prescribed.....	☐	☐	☐	☐
4. Taking too much medicine, intentionally or otherwise.....	☐	☐	☐	☐
5. Smoking in bed.....	☐	☐	☐	☐
6. Being drunk.....	☐	☐	☐	☐
7. Wandering around the building or grounds at night.....	☐	☐	☐	☐
8. Leaving the building during the evening without letting anyone know.....	☐	☐	☐	☐
9. Refusing to bathe or clean oneself regularly.....	☐	☐	☐	☐
10. Creating a disturbance; being noisy or boisterous.....	☐	☐	☐	☐
11. Pilfering or stealing others belongings.....	☐	☐	☐	☐
12. Damaging or destroying property, e.g., tearing books or magazines..	☐	☐	☐	☐

	Allowed 1	Tolerated 2	Discouraged 3	Intolerable 4
13. Verbally threatening another resident.....	☐	☐	☐	☐
14. Physically attacking another resident.....	☐	☐	☐	☐
15. Physically attacking a staff member.....	☐	☐	☐	☐
16. Threatening to attempt suicide....	☐	☐	☐	☐
17. Attempting suicide.....	☐	☐	☐	☐
18. Indecently exposing self.....	☐	☐	☐	☐

APPENDIX D

RESIDENT CONTROL

RESIDENT CONTROL

Directions: To what extent are patients involved in policy-making in the following areas? Check the box of the most appropriate category.

	Staff/Admin. basically decide by themselves (1)	Staff/Admin. decide, but residents have input (2)	Patients decide, but staff has input (3)	Patients basically decide by themselves (4)
. Planning entertainment such as movies or parties...	☐	☐	☐	☐
. Planning educational activities such as courses and lectures.....	☐	☐	☐	☐
. Planning welcoming and/or orientation activities.....	☐	☐	☐	☐
. Deciding what kinds of new activities or programs will occur.....	☐	☐	☐	☐
. Making rules about attendance at program activities.	☐	☐	☐	☐
. Planning daily or weekly menus.....	☐	☐	☐	☐
. Setting meal times.....	☐	☐	☐	☐
. Setting visitors' hours.....	☐	☐	☐	☐
Deciding on the decor of public areas, e.g., pictures in halls, plants, etc.....	☐	☐	☐	☐
Dealing with safety hazards.....	☐	☐	☐	☐
Dealing with other patient's complaints.....	☐	☐	☐	☐
Making rules about the use of alcohol.....	☐	☐	☐	☐
Selecting new patients	☐	☐	☐	☐
Moving a patient from one bed or room to another.....	☐	☐	☐	☐
Deciding when a troublesome or sick patient will be asked to leave.	☐	☐	☐	☐
Changes in staff (hiring or firing).....	☐	☐	☐	☐

APPENDIX E

STAFF DEMOGRAPHIC CHARACTERISTICS

Staff Demographic Characteristics

Directions: Answer each item as it applies to yourself.

1. Age____

2. Years of psychiatric nursing experience____

3. Years of other nursing experience____

4. Education (check all that apply)

   Diploma____
   A.A.____
   Baccalaureate, nursing major____
   Baccalaureate, nonnursing major____
   Masters, nursing major____
   Masters, nonnursing major____
   Doctorate, nursing major____
   Doctorate, nonnursing major____

5. Race

   Chinese____ Hispanic____ Japanese____ Filipino____
   Black____ Caucasian____ American Indian____ Other(describe)____

6. Religion

   None____ Jewish____
   Protestant____ Other(describe)____
   Catholic____

7. Frequency of religious participation

   None____
   Weekly____
   More than once a week____
   Holidays____

8. Current position

   Staff nurse____
   Head nurse____
   Clinical specialist____
   Other(describe)_____

9. Employment status

   Per diem/Registry____
   Permanent part-time____
   Permanent full-time____

10. Sex

    Male____
    Female____

11. How long have you worked on your current unit?

    years____
    months____

APPENDIX F

PATIENT DEMOGRAPHIC CHARACTERISTICS

Patient Demographic Characteristics

Directions: Answer each item in terms of your unit's typical patient population. If the patient population today is typical, answer each item using today's data. If it is not typical, answer each item by estimating the data.

1. What is the average census per day on your unit?____

2. On the average, how many of your patients are:

   Adolescent (less than 18 years)____
   Young adult (19-30 years)____
   Middle adult (31-55 years)____
   Older adult (56 years and over)____

3. On the average, how many of your patients are:

Chinese____	American Indian____	Hispanic____
Japanese____	Black____	Other____
Filipino____	Caucasian____	

4. On the average, how many of your patients have the following occupational status?

   Never worked in paid employment____
   Unskilled laborer____
   Skilled laborer____
   Professional____

5. On the average, how many of your patients have reached <u>each</u> of the following levels of education?

   Less than high school education only____
   High school graduate only____
   Some college only____
   College graduate only____

6. On the average, how many of your patients are:

   male____
   female____

7. On the average, how many of your patients when first admitted to your unit are:

   Mildly ill____
   Moderately ill____
   Severely ill____

8. On the average, how many of your patients have the following legal status when first admitted to your unit?

Voluntary____
Involuntary, 72-hour hold____
Involuntary, 14-day hold____
Conservatorship____

9. What is the average length of stay for patients on your unit?

_____

APPENDIX G

CASE VIGNETTES

Directions for Case Vignettes

The next section contains three case vignettes. Three possible interventions are provided for each vignette. There is no right or wrong answer. For each vignette, rank the three interventions according to how closely each matches your thoughts about managing the case (1 = first choice, 3 = last choice).

Vignette 1

R.M. is a 39-year-old chronic schizophrenic female brought to the psychiatric hospital by her father when he became concerned over her weight (67 pounds, 5'6") and her statements of wanting to die. She is an emaciated, sloppily dressed woman with rigid posture and a decubitus ulcer on her coccyx. R.M. had been hospitalized at the state hospital from ages 19 to 34 years following her decompensation when she attempted to live away from her family. Her father brought her home from the state hospital following her mother's death. Her life with father consists of eating two very small meals each day and reading. Her current decline has been precipitated by father's visit to Europe, leaving her alone. While hospitalized, R.M. slowly gained 20 pounds and eventually participated in some structured activities. While discharge plans strongly recommend a supportive environment for her, she returned to her father's home.

A. Rank the following solutions according to how closely each matches your thoughts about the disposition for R.M. (1 = first choice, 3 = last choice).

____ 1. R.M. should return home to maximize her freedom of movement and choice of activities.

____ 2. R.M. should be hospitalized at an institutional setting to best provide for her physical and emotional needs.

____ 3. R.M. should return home since institutional care is costly and space is limited.

Additional comments:

Vignette 2

L.A. is a 25-year-old man hospitalized in an acute psychiatric setting after chewing off his thumb. He is cooperative and denies remorse over the loss of his thumb. This is the second hospitalization and second episode of self-mutilation for L.A. Several years ago he bit off his small finger in an effort to regain the love of a lost girl friend. The second episode occurred after he was reprimanded by a church member for his inability to solicit funds for the church. L.A. has a history of poor compliance with oral medication and while he is ambivalent about taking any medications at all, he was finally stabilized on injectable prolixin. Placement was arranged in a local half-way house though he desired to return to a church-run home.

A. Rank the following treatment options according to how closely each matches your thoughts about the treatment of L.A. (1 = first choice, 3 = last choice).

____ 1. Long-acting injectable medication will provide L.A. the greatest chance of remaining symptom-free and of avoiding further mutilation episodes.

____ 2. Long-acting injectable medication will decrease the likelihood of continued expensive and lengthy hospitalization.

____ 3. L.A.'s choice for type of treatment, whether oral, injectable, or none at all, should be respected.

Additional comments:

Vignette 3

W.L. is a 16-year-old female admitted to an in-patient psychiatric unit with a diagnosis of anorexia nervosa. She is 5'4" and weighs 70 pounds. Her medical condition is not stable and after continued vomiting resulting in electrolyte imbalance, the staff must institute one of the following interventions.

A. Rank the interventions according to how closely each matches your thoughts about the care of W.L. (1 = first choice, 3 = third choice).

____ 1. W.L. should receive tube feedings in order to correct the electrolyte imbalance and prevent further weight loss.

____ 2. W.L. should receive the same supervision (i.e. knowing her whereabouts, encouragement to eat) that any other acutely disturbed patient might receive in order to at least ensure her safety.

____ 3. W.L. should remain as independent as possible to initiate and/or cooperate with normal eating patterns.

Additional comments:

APPENDIX H

NURSING PHILOSOPHY STATEMENT

Philosophy of Nursing Statement

Directions: Rank each perspective according to how well it represents your thoughts about nursing (1 = first choice, 3 = last choice).

_____1. Nursing care should be equally available to any who require it. Since resources are limited, it is preferable to provide minimally adequate care to all people than to provide a maximum amount and quality of care to a few.

_____2. Society has an obligation to meet the needs of its members. Nursing, guided by its knowledge and understanding of human needs, is a mechanism by which society provides care, promotes health, and improves the well-being of its citizens.

_____3. Each individual strives toward self-direction and independence and his/her actions represent his/her best judgements at the moment. Nursing respects this dignity, autonomy, and individuality of the patient and provides care according to the patient's perception of his/her needs.

Additional Comments:

APPENDIX I

LETTER TO DIRECTORS OF NURSING

Susan Hunn Garritson, R.N., M.S.
University of California
401 Parnassus Avenue, Box 12-D
San Francisco, California 94143

January 1, 1984

Dear Director of Nursing:

My name is Susan Hunn Garritson and I am a doctoral candidate in the School of Nursing at the University of California, San Francisco. As a psychiatric nurse clinician with 5½ years of experience in acute in-patient care and 2½ years experience in administration, I am aware of the complex daily challenges of caring for psychiatric patients and managing the patient community. Psychiatric nurses must supervise and provide care to patients in situations where there are not always clear-cut and predictable approaches.

I am studying nurses' interventions and their reasons/rationales for using certain approaches. Many characteristics of a setting, the patient, and the nurse are likely to influence options available to the nurse for providing care, and I will consider the relationships of these factors.

I would like to meet with you to discuss the study in more detail and to request participation of nursing staff from your facility. I will be telephoning you in the next few days to make an appointment to meet with you. I look forward to discussing my project with you and greatly appreciate your time in considering this research.

Sincerely,

Susan Hunn Garritson, R.N., M.S.
Doctoral Candidate

APPENDIX J

INFORMATION SHEET AND INFORMED CONSENT

INFORMATION SHEET/CONSENT FORM

My name is Susan Hunn Garritson and I am a doctoral candidate in the School of Nursing at the University of California, San Francisco. As a psychiatric nurse clinician with 5½ years of experience in acute inpatient care and 2½ years experience in administration, I am aware of the complex daily challenges of caring for psychiatric patients and managing the patient community. Psychiatric nurses must supervise and provide care to patients in situations where there are not always clear-cut and predictable approaches.

I am studying nurses' interventions and their reasons/rationales for using certain approaches. Many characteristics of a setting, the patient, and the nurse are likely to influence options available to the nurse for providing care, and I will consider the relationships of these factors.

Your participation in this research is voluntary and your results will remain confidential. Your decision about participating will have no influence on your job. You may decide to withdraw from the study at any time without repercussion. Your agreement to participate is indicated by returning the research tools. You may keep this form for your information. It will take about 45 minutes to 1 hour to complete the questionnaires.

There is no immediate benefit for you in participating. I will provide written and verbal feedback to you and your unit about the findings when the study is completed. The knowledge gained may be useful in understanding the complex factors influencing patient care.

You are welcome to contact me at any time if you have questions or concerns about the study. My phone number is (415) 681-8080, X 360. You may also contact the Committee on Human Research, University of California, San Francisco if your questions cannot be resolved by this investigator. The committee can be reached between 8:00 am and 5:00 pm Monday through Friday by calling (415) 666-1814 or by writing Committee on Human Research, University of California, San Francisco, California 94143.

Many thanks for your consideration of this project.