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Psychiatric Bulletin (2002), **26**, 380–382

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Acute wards: problems and solutions

Modern milieux: therapeutic community solutions to acute ward problems

In 1953 the World Health Organization produced a report dealing with 'essential mental hospital provisions'. The report emphasised the importance of the atmosphere of the hospital:

> 'The most important single factor in the efficacy of the treatment given in a mental hospital appears to the Committee to be an intangible element which can only be described as its atmosphere, and in attempting to describe some of the influences which go to the creation of this atmosphere, it must be said at the outset that the more the psychiatric hospital imitates the general hospital as it at present exists, the less successful it will be in creating the atmosphere it needs. Too many psychiatric hospitals give the impression of being an uneasy compromise between a general hospital and a prison. Whereas, in fact, the role they have to play is different from either; it is that of a therapeutic community' (World Health Organization, 1953)

It spelled out the constituents of this atmosphere and emphasised the following:

(a) preservation of the patient's individuality;
(b) the assumption that patients are trustworthy;
(c) that good behaviour must be encouraged;
(d) the assumption that patients retain the capacity for a considerable degree of responsibility and initiative;
(e) the need for activity and a proper working day for all patients.

Although many improvements have been made in the intervening half century, the 2002 Department of Health guide on provision of adult acute in-patient care (Department of Health, 2002) states that there is 'incontrovertible and compelling evidence' that service users find hospital care 'neither safe nor therapeutic'. Where the 1953 report mentions patients' individuality ((a) above), the 2002 guide talks of 'inadequate arrangements for safety, privacy, dignity and comfort'. Likewise, point (e) specifies the need for activity, whereas the contemporary report emphasises the 'lack of activity that is useful and meaningful to recovery'.

However, the recent report is disappointing in its lack of attention to the overarching importance of the ward's atmosphere. Although the 'therapeutic activity milieu' is mentioned in the detailed advice, the primary importance of establishing a therapeutic environment is lost. Most of the 2002 report is concerned with administrative and technical requirements rather than human and social ones, such as the importance of relationships. As Bracken and Thomas (2001) have argued, the predominant challenges posed to psychiatry are now about values and ethics rather than science and technology. Perhaps experience gleaned from the therapeutic community field over the past 60 years can help to change that emphasis. This paper proposes that the principles used successfully to understand the work in modern therapeutic communities are translatable into practice that may help thinking about solutions to the crisis in acute care.

It is based on a workshop held at the College's *Mind Odyssey* conference in London in July 2001. After being given a loose framework based on current therapeutic community principles, it was run using an interactive format, where all the material was generated by the participants. They included clinicians from adult psychiatry, child psychiatry, old age psychiatry and psychotherapy and included representation from overseas. The framework used was a development one, which describes the qualities of 'required emotional experience' for patients in therapeutic communities (Haigh, 1999). The sequence starts with attachment, the experience of which makes people feel they belong. This is followed by psychological containment so that they feel safe. It then encourages and expects open communication and demands involvement so that they can start to understand their place among others. Finally, it empowers them so that they feel a sense of their own personal agency and are thus responsible for their own feelings, thoughts and behaviour.

The first task for the workshop participants was to come to a shared understanding of the psychological meaning of these five concepts. Once that was accomplished, for each concept, participants generated:

- reasons why they are not feasible in current psychiatric environments;
- hospital policies that would help bring them into force.

It is these two areas that are described here for each of the five environmental qualities.

https://doi.org/10.1192/pb.26.10.380 Published online by Cambridge University Press

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Attachment

Patients report such negative experiences of hospitalisation in the 2002 guide (Department of Health, 2002) that the chances of therapeutic attachment seem remote. It will be made worse by the 'revolving door' phenomenon, and inconsistency in the presence and dependability of key staff: these will promote insecure attachment. As a result, consultants, for example, are experienced as inconsistent parental figures. Ugly physical environments will add to the unlikelihood of establishing a secure relationship with the ward.

Policies that could change this might start with an expectation of absolute regularity and dependability of contact with keyworkers (as it would be in psychotherapy), which then has continuity with subsequent community care. Continuation of healthy contact with life outside the hospital should be promoted, such as by encouraging patients to bring in possessions and by having an open visiting policy.

Staff should all have mandatory education on attachment, particularly concerning the importance of loss and endings, and there should be a regular staff group meeting. The physical environment should be made homely, familiar and, where possible, be on a domestic scale. Inspection and quality enhancement processes should be run by other patients and ex-patients.

Containment

Wards are often experienced as unsafe by both patients and staff, and institutional dynamic factors frequently promote unhealthy transmission of anxiety and defensiveness. To make matters worse, staffing levels are often inadequate, not allowing thought to be given to such issues. Thus, spirals of deprivation and negative feedback operate with expectations being progressively lowered. Staff need to feel safe (e.g. from managerial anxiety) before they can establish a culture of safety for the patients. In milieux where containment is not experienced, it is common for destructive actions to be used as communicative gestures.

The single most important step in establishing a ward culture where psychological containment can be experienced is to enforce boundaries and for all members of the ward to adhere to them, both staff and patients. Staff must all be adequately trained, and this must be ensured through a properly resourced appraisal and continuing professional development (CPD) process. Adequate supervision of all staff should be required for continuing practice and written into terms and conditions of service to guarantee reflective practice.

A daily group meeting should be held for staff and patients to ensure emotional exchange and understanding. This does not need to be exploratory or in any way inquisitorial, but simply aim to make contact. Staff themselves need to establish a common sense of purpose, through staff planning meetings, 'away days' and other trust-building activities. Any staff members who demonstrate that they do not value each other and their patients must be subject to disciplinary action. The expectation of patients that staff respect each other must also be clearly articulated, and challenged if necessary. Without these ground rules, a ward could not guarantee a milieu that is experienced as safe.

Communication

There are numerous problems that increasingly hamper open communication. Administrative and legislative demands encourage non-personal communication, hierarchical impositions lead to defensiveness and a culture of blame and an unsafe emotional environment (or lack of containment) hampers expression of difficult subjects. An inconsistent ward ethos also closes down communication.

However, many difficulties are of a practical nature: staff are too busy to give adequate time to personal and meaningful communication; shift work, bank nurses, staff rotations and a rapidly changing ward population make it difficult to ensure that everybody has the necessary information, and there is often no suitable forum for communication. Few units have satisfactory induction procedures for staff or patients and staff with inadequate communication skills are often employed. Medical and technical jargon, complex diagnostic formulations and poor spoken English also make for bad communication.

To improve matters, certain communication channels must be guaranteed, for example by arranging duty rotas so that key nurse or nominated deputies are always available for scheduled clinical meetings, with the same applying to junior medical staff. Managers and consultants who are responsible for this should work closely together and be subject to performance review and open scrutiny, for example by being in the daily ward group, as well as addressing these aspects through patient advocacy systems.

Staff must be given clear expectations, with unambiguous job descriptions, good induction and suitable supervision. CPD and reflective practice are essential for all staff and need to be administered through an effective appraisal system. At least once a week, there should be a meeting of a staff support group that has established boundaries outside line management structures (i.e. multi-disciplinary, ward managers must attend and confidentiality rules must be agreed) (Haigh, 2000). Staff should use a shared and simple common language and it should be picked up by other staff and patients if they are not doing so.

Inclusion

It is difficult to engender a sense of inclusion for patients because of the diversity of problems, ages and social backgrounds on acute wards. There are also different stages within the process of hospitalisation, such as admission and pre-discharge. Confidentiality is often interpreted as the need to keep patients anonymous to each other and, in spite of this, there is often considerable lack of privacy. The medical model fosters the expectation for patients of being helped directly by those employed for the purpose, rather than contributing to help others. Unhelpful but strongly individualistic views,

https://doi.org/10.1192/pb.26.10.380 Published online by Cambridge University Press

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prominent in contemporary society, can foster attitudes where some patients regard other patients as 'aliens'. Inappropriate 'long stayers' on a ward can carry a culture of dependency and 'working the system', and sub-cultures are often formed (see Goffman, 1961), which foster destructive anti-group processes (Nitsun, 1996).

To improve the ethos of interdependence, which would contribute to more collective responsibility and shared care, all wards could have a user-friendly and accessible written induction information pack for patients (for example, 'A day in the life of ward 17', or 'Rough guide to ward 17'). In this there would be an explicit expectation that patients are there to give to others, whenever they are able, as well as to be given to themselves. This is the essence of a system of balanced rights and responsibilities, as in Etzioni's communitarianism (1995). This would be helped by a mentoring system for new patients that involves staff and other patients, to welcome them and explain any matters of policy and procedure.

There would be a weekly open-house or drop-in session for relatives, held at a convenient time for them, which certain key staff would always attend. Wards and units would have a patient's council, involving staff, advocacy support, patients who volunteer and interested ex-service users. There would also be an in-patient therapy group that would be welcoming and introduce people to each other. This group would not necessarily be for discussion of deep therapeutic issues, but would cover minor and major crises in the ward and appropriate domestic matters.

A move away from heterogeneous ward populations would help to make these transitions easier, for example by instituting wards for particular diagnoses, disorders or problems.

Agency

There are numerous ways in which current practice inadvertently or deliberately disempowers patients. Institutional routines normally take preference over individuals' autonomy and little freedom is allowed for patients' decision-making. Most units operate a top-down imposition of rules, procedure and policy; changes in care plans are often made without discussion and there is rarely a suitably user-friendly forum for grievances, discontent and unmet needs. Clearly, patients detained under the Mental Health Act are statutorily deprived of autonomy. However, to some extent 'everybody is disempowered now': the blame culture and elements of managerialism are hampering consultants' personal effectiveness, as well as that of those with much less authority.

Many changes are needed in order to move to a more empowering culture, for both staff and patients. First, information should be openly accessible – using brochures, leaflets, websites, discussion groups, road-shows and whatever is needed for a particular population. No care plan changes should be made without discussion. As well as formal staff groups, informal and scheduled support for all disciplines should be available without stigma or shame. Local policies should be produced much less easily: the policy of 'a policy for every eventuality' is actively disempowering. Policies that are produced should be created with more widespread accountability, using democratic processes such as citizens' juries, Delpi techniques, focus groups and large or median discussion and decision groups.

There needs to be more balanced thinking about risk and therapeutic opportunity. More risks need to be taken and shared responsibility for those risks must be negotiated. In a team, creative ideas should be valued above defensive thinking and ideals above complaints, moans and whinges. Consultants must establish a clear sense of their own professional identity and role (given social changes about medical authority), otherwise they will feel insecure or persecuted rather than empowered. Appropriate national policies to address this need to be formulated in consultation with bodies such as the College.

Conclusion

Stigma is generated by deep, mental mechanisms that divide the world into us and them. These therapeutic community principles try to prevent this by demanding a collective solution to day-to-day problems, based on shared experience and responsibility. The task to change a defensive and blaming culture into an open one that values a diversity of opinions is as large as challenging stigma. Although these ideas produced in the *Odyssey* workshop range from obvious to impractical, a quick-fix to such an institutionally ingrained problem is not feasible. But hopefully they can add some useful substance and experience to the discussion.

Acknowledgement

Thanks to Penny Campling who co-convened the workshop.

Declaration of interest

The author is Chair of the Association of Therapeutic Communities.

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https://doi.org/10.1192/pb.26.10.380 Published online by Cambridge University Press