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Acute wards: problems and solutions

Creating a psychotherapeutic culture in acute psychiatric wards

There has been a curious linguistic shift in the use of the word community in mental health (Holmes, 2001a). In the 1950s and early 1960s community psychiatry was synonymous with milieu therapy and the therapeutic community – that is, the attempt to create a vibrant community of patients and staff, in a shared space, working actively together to overcome disability, illness and stigma. The contrast was with insitutional psychiatry, caricatured as the silent, soulless and, at times, abusive wards of the Victorian mental hospital. The therapeutic community had two main psychotherapeutic tools: group therapy and creative therapies such as art therapy and psychodrama. These approaches were pioneered in specialist units such as the Henderson hospital (Norton & Haigh, 2002) but, more generally, progressive acute units emphasised the use of ward groups and the importance of patients playing an active part in decision-making.

With the end of incarceration and the replacement of large mental hospitals, those idealistic days seem far away. User surveys tend to be highly critical of in-patient care (Sainsbury Centre for Mental Health, 1998). In one survey, 57% of patients said they would have liked more contact with staff and 82% reported less than 15 minutes per day in face-to-face contact with staff (MIND, 2000). Indeed, today's acute wards run the risk of being not so much un-therapeutic as anti-therapeutic (compare Fagin, 2001), reflecting poor staff morale. Acute wards tend to be seen as unattractive places to work compared with community settings. There is rapid staff turnover and, especially in the inner cities, extensive use of 'bank' staff to make up numbers. The consequent lack of continuity and commitment means that custodial rather than therapeutic values prevail.

One way to survive the chaos and mental pain that are the raw materials of mental health work is to batten down the hatches and to retreat into a defensive world of cynicism and mild paranoia, in which exploration of feelings is considered to be disruptive and dangerous when it happens. Psychotherapists are seen, at best, as woolly-minded idealists who have no idea about the reality of acute psychiatric work and, at worst, as sinister psychoanalysts bent on disabling staff by laying bare their weaknesses to be exploited by managers and colleagues.

The case for psychological therapies

Hard evidence that psychological therapies can play a significant role in in-patient care is far from robust, perhaps because the attention of the research community has been focused elsewhere. Nevertheless, the research literature does provide some grounds for thinking that psychological approaches might play an

important role in improving quality of care in the in-patient setting.

First, there is the overwhelming evidence that psychosocial factors are relevant to the course of schizophrenia. In the home setting, high expressed emotion in carers is associated with increased risk of relapse (Leff & Vaughn, 1985). Similar findings apply to professional carers of patients living in hostels (Ball *et al*, 1992). Although expressed emotion studies have not, to my knowledge, thus far been undertaken in the in-patient setting, it seems likely that low levels of criticism and hostility in staff would also be associated with better outcomes in acute wards. This view is supported by studies using the Ward Atmosphere Scale (Moos, 1996), which suggest that patient satisfaction and reduced readmission rates in patients with schizophrenia are correlated with a ward atmosphere that strikes an appropriate balance between structure and spontaneity (Middelboe *et al*, 2001).

Second, there is the consistent finding in the psychotherapy research literature that the quality of the therapeutic alliance is the best predictor of a good outcome in therapy (Roth & Fonagy, 1996). When patients view their therapy in a positive light this predicts a low drop-out rate and significant reduction in symptomatology. Again, this finding is based mainly on out-patient settings, but if translated into in-patient care, it would suggest that skill in establishing a therapeutic alliance among ward staff would improve outcomes. This links with extrapolations from the attachment literature (Holmes, 2001b), which suggest that a prime function of mental health services is to provide a secure base for patients. In an in-patient context, a secure base would represent a familiar person in a familiar place to whom the patient can turn at times of threat or illness, characterised by a combination of responsiveness and sensitivity with the capacity to set limits and help cope with separation.

Third, there is evidence that difficulty in the staff–patient relationship is a significant predictor of in-patient suicide. Watts and Morgan (1994) found that, prior to suicide, there is a marked deterioration in relationships between patient and staff, characterised by increasing emotional distance and hostility, a condition that is dubbed malignant alienation. A psychotherapeutic approach can help contain and detoxify the difficult feelings that patients who are disturbed inevitably arouse in those who work with them.

Finally, there is the burgeoning literature on the efficacy of psychological methods in psychosis and other major psychiatric disorders (e.g. Drury *et al*, 2000). Cognitive–behavioural approaches to delusions, self-management of hallucinations and other techniques have

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mainly been delivered in out-patient settings. However, equipping ward staff with these psychological skills can strengthen the therapeutic alliance and provide the first steps in a psychotherapeutic approach, which can then be continued after discharge. Hostility and withdrawal on the part of staff often accompany a sense of being deskilled and unable to cope. Training in psychological therapy can help overcome this.

Practical measures

How can these general principles be translated into practical improvements in the in-patient environment? Given the rapid turnover and nature of clinical disturbance on most in-patient wards, it would be unrealistic and inappropriate to suggest that specific psychological therapies become the mainstay of work on the ward – those are needed later in the care programme, in the day care or out-patient setting. However, three key sets of skills are vital. First, there is the capacity to build a therapeutic alliance with patients and their relatives. Second, self-awareness and reflective practice should be developed, both at the level of the individual practitioner and in the staff team as a whole, thereby lowering expressed emotion and the likelihood of malignant alienation. Third, specific skills are needed in the management of personality disorder, eating disorder and psychological approaches to psychosis in the in-patient setting. The first two are requirements for all who work on an in-patient ward; the third can be developed by selected staff members who can then act as mentors for the staff team as a whole.

Ongoing training and detailed supervision of clinical work are integral to psychologically-informed practice; in the in-patient setting these are probably more important than any specific programmes. Regular supervision and staff support are the crucial ingredients in improving the quality of psychological care on acute wards.

Three levels of psychological input into acute care can be envisaged, each of which adds to the preceding level.

Level one

As a bare minimum, a weekly or fortnightly multi-disciplinary staff support group is required, facilitated by a psychotherapist with training in group dynamics, and actively supported and attended by senior staff, including consultant psychiatrists and ward managers. These are multi-function groups where the impact of difficult cases can be discussed and staff tensions can be explored in a safe and confidential setting. There is some evidence (Kho *et al*, 1998) that the existence of such a group serves to reduce the number of violent episodes on a ward, presumably by reducing expressed emotion and enhancing cohesion within the group.

Level two

An active programme of group therapy for patients is also needed, run by ward staff (including psychiatrists) and supervised by psychotherapists trained in group work. This may include a weekly or twice-weekly community meeting (or large group) for all patients and staff, and/or regular small groups for selected patients, depending on their level of function and diagnosis. The purpose of such group work is to foster awareness of the life of the ward as a whole, and to begin to make connections between clinical events such as exacerbation of symptoms, a violent outburst, deepened depression, alcoholic relapse or suicide attempt, in an interpersonal context, that is as a response to events within the ward community.

An acute ward is potentially such a chaotic place, with such rapid turnover and intensity of psychotic behaviour that this is no mean task. However, not to do so is to abandon any attempt to understand or engage closely with 'madness' – surely for a psychiatrist, a dereliction of primary duty.

Ward groups, however 'sticky' or apparently mundane, can become an integral part of ward life and are able to deal with the inevitable resistance that they arouse in patients and some staff, which is usually manifested in non-attendance. Techniques directly transposed from long-term group analytic work may be inappropriate in the in-patient setting. Developing an appropriate here-and-now, systemic, relevant and dynamic style for such groups represents a major clinical and research challenge (Mace, 2002).

Level three

There also needs to be specific expertise in and provision of psychological therapies for in-patients with psychosis, eating disorders or personality disorders. Staff members often do acquire additional training in psychological therapies, for example by attending a course in cognitive-behavioural therapy (CBT). However, the acquired skills tend to atrophy in the traditional ward setting. Insufficient thought is currently given to providing training appropriate to the in-patient setting, and to the management structures that are needed to support it. Selected staff members who have had training in CBT approaches in psychosis need to become part of a managed clinical network for psychosis services, and take the lead in supervising keyworkers who are helping their patients to cope with hallucinations and to challenge delusional ideas. Others are conversant with behavioural and interpersonal approaches to severe eating disorders and can take the lead with such difficult patients when they are admitted. Patients with personality disorder are among the most problematic of in-patient cases, invariably arousing strong feelings among staff. Expertise in the combination of responsiveness and limit-setting that is more appropriate for this patient group rarely comes without training and support. Here, too, having one or more staff members who are part of a managed clinical network for personality disorder, who have received



training in appropriate psychotherapy skills, can make a significant difference to outcomes (Holmes, 1999).

Conclusion

Fostering a psychological approach to in-patient care will require a shift in culture, management and training. There has to be a determined commitment from senior medical, nursing and management staff to create change. An in-patient psychological therapies implementation group is needed, with representatives from psychiatry (with one member of the consultant group taking the lead in acute care), psychotherapy, nursing, psychology, occupational therapy and management. Each professional grouping needs to think through the implications for its own particular discipline.

In spite of the important moves towards community care, the work of the consultant psychiatrist could, in theory, centre on the in-patient ward. That is where the most ill patients tend to be at any one time and the greatest efforts of the consultants should be concentrated there. Sadly, this is often not the case. The consultant will come onto a ward, usually shared with several other consultants, see his or her patients and depart. Maintenance of the ward culture and management of the ward as a whole is left, by default, to the nurses, rather than being a collaborative therapeutic enterprise managed by a 'combined parent' of medical and nursing staff.

The contention of this paper is that the re-discovery of a psychological culture on the acute unit can produce improved clinical outcomes, a reduction in untoward events and increased staff and patient satisfaction. The acute ward can become a place of creativity and change rather than of burden and threat. To achieve this requires a sustained research and management effort, but if successful, the positive impact on consultant morale could be significant and rejuvenating.

Declaration of interest

None.

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SARAH DAVENPORT

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A rehabilitation approach to in-patient care

This paper describes rehabilitation principles and some specialised practice that could usefully inform the provision of acute in-patient care. A low secure rehabilitation setting is described using a method of case formulation to embed an envelope of care around an individual patient within a therapeutic ward milieu. This increases the collaboration and transparency around individual care planning and the capacity for self-reflection within the multi-disciplinary team, in a manner that may be applicable to other in-patient settings.

The dynamics of in-patient settings

These are related to the dynamics of institutions, of psychosis and of abuse (Davenport, 1997).

There is a high prevalence of childhood sexual and physical abuse among psychiatric in-patients (Wurr & Partridge, 1996), with some responses being conditioned by previous abuse. Typical dynamics of abuse include splitting, revictimisation, difficulties within power relationships and sexualisation of relationships in general.

Patients receive care within an institution that operates social defences to reduce the anxiety, guilt,