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Editorial

From the inside out: Star Wards – lessons from within acute in-patient wards

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Since Philippe Pinel first removed the shackles in the Bicêtre hospital in Paris during the 1790s, it has been fashionable to talk of freedom within psychiatric care. Beyond the fashionable talk, how realistic is it to expect and even facilitate true patient autonomy and responsibility in PICUs? There are obvious potential problems including severity of illness, individual capacity and safety issues. Arguably, the biggest barriers are the expectations of staff and patients themselves.

Star Wards (Janner, 2006) arose out of my experience as a detained in-patient at St Ann's hospital, north London. I wasn't an easy or inexpensive patient and assume I was a good candidate for a PICU. I was suicidal and continuing to self-harm, even when being 'specialed' 24 hours a day. The staff were unswervingly non-judgmental, patient, kind and supportive. When I left, I felt compelled to reflect and to build on what I'd experienced. Also informed by my experience as a manager of community care day and residential services, and as a campaigner against the inappropriate use of prison, I pondered.

Based on my own experience, I thought about what would help create in-patient stays that were *actively* therapeutic and what would shift ward culture from being one of observation to one of engagement. I also wanted all the concepts to be equally applicable to people on locked wards. What developed were 75 practical, mainly low-cost, ideas spanning seven areas of in-patient life. This underpinning philosophy and tool kit for change we called Star Wards.

Star Wards is a new project, working with mental health trusts to help improve the daily experiences of acute in-patients and treatment outcomes. Our suggestions for wards include 'fluffy' ideas such as comedy evenings (now happening in lots of hospitals) and fluffiest of all, pets as visitors and residents. But at the heart of the initiative is the role that wards and staff can play in increasing patient autonomy within an environment that was historically designed to remove patient self-determination. The main concepts were simple and obvious during the daily experience of living in an in-patient ward. They included:

- talking therapies and self-management
- recreation and conversation
- physical health and activity
- visitors
- care planning
- ward community
- patient responsibility

These seven strands are based on our vision of acute wards, including PICUs, where:

- talking therapies play as substantial a role as medication
- patients are supported in enhancing management of their symptoms and treatment

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- there is a strong culture of patient mutual support, with the potential for extending this once they've left hospital
- a full programme of daily activities doesn't just eliminate boredom but actively contributes to accelerating patients' recovery
- patients retain and build on their community ties

The Star Wards initiative is the result of a firm commitment to these issues. The framework is currently adopted in over 200 wards, across England and Wales and two wards in New Zealand are piloting the ideas and approach promoted by Star Wards. A consistently reported theme through our network is that they also seem to be enjoying the experience!

Feedback within the Star Wards community indicates that staff appreciate the ease with which ideas can be introduced and a framework where existing good practice is acknowledged, celebrated and shared with other wards – including within their own trust (as effective internal communication can be notoriously difficult to achieve). Patients are experiencing immediate benefits, for example, Bowmere hospital in Cheshire has initiated arrangements so that vistorless patients can be visited by local volunteers whose interests match those of the patients.

Understandably, and often necessarily, much of the PICU expertise, research and day-to-day (or minute-by-minute) focus is on preventing and coping with violence. Safety has to be the starting point for ensuring an endurable, let alone therapeutic, experience for patients. Also of great importance is at least a tolerable, although at best an enjoyable and rewarding working life for staff. Maybe the patient and staff experiences are much more dependent upon each other than is often openly acknowledged.

Research repeatedly demonstrates that providing a stimulating, therapeutic environment, and crucially one where patients feel listened to by staff, isn't a distraction from ensuring safety. On the contrary, it is a prerequisite. *The National Audit of Violence* undertaken by the Royal College of Psychiatrists' Research Unit (Healthcare Commission, 2005) was an extensive survey of wards; it found that both staff and patients identified reducing boredom as a key factor in avoiding violent incidents. A typical comment was:

'I get bored stiff. Only option seems to be TV or sleep.'

A Review of the Available Evidence commissioned by the National Patient Safety Agency (Marshall et al, 2004) referred to an American study (Katz and Kirkland, 1990) that showed:

'Peaceful wards were characterised by regularly structured activities, predictability derived from leadership, clear staff roles, a sense of calm, and an atmosphere of trust.'

While this quote only hints at the role of patient responsibility, an interesting *Checklist for Assessing Your Organization's Readiness for Reducing Seclusion and Restraint* (Colton, 2004) is more explicit:

'Programs that have been successful in reducing the use of seclusion and restraint are typically based on empowering clients – this is often referred to as *strengths-based* treatment – to take responsibility for their behaviours... rather than imposing external control through the unit program and staff interactions.'

This principle means that programmes should provide opportunities for individual 'self-determination', for example through being able to make choices and having experiences that help patients' self-knowledge and self-control.

From simple activities like board games, to more organisationally demanding events like the football tournaments that the National Association of Psychiatric Intensive Care Units (NAPICU) award-winning Tarn PICU in Oxleas NHS Trust arranges, each activity provides an opportunity for patients to take responsibility for their actions. The interpersonal trust that is required and reinforced by such activities is often evident more systemically in

care planning structures. The report *Learning from Each Other* (American Psychiatric Association et al., 2003) recommends:

'Involve patients in treatment planning – you may gain a different perspective on what you're doing. The few patients whose behaviours result in the majority of seclusion and restraint are very constructive when we ask them to brainstorm an alternative. This then becomes part of their revised treatment plan, said a clinical leader. The beauty of that, of course, is that it puts the locus of control where it's supposed to be – on the patient.'

As well as patients taking responsibility for our own actions and recovery, we have an important but often over-looked role in supporting each other. Quirk et al. (2004) described how much in-patients value peer support and reassurance when faced with a volatile ward environment. It could be said that PICUs are not the place for patients to be able to safely support each other. But conversely, when you're feeling 'really out of it', the empathy, company and comfort of someone in the same situation can be just what you need. Connecting with someone from your own cultural background can often be a source of bonding, especially if the patients share the same minority language.

At the 'heavier' end of peer support, there are practical and ethical issues about other patients being involved in de-escalation and even episodes of physical intervention. But it is possible to imagine how within a culture of strong patient mutual support, that the very different dynamic within the relationships between fellow patients could support staff efforts to calm a volatile situation. This can particularly be the case when there may be an ethnic difference between the staff and the patient.

I was fortunate to be able to visit Grendon Prison, which operates as a therapeutic community for offenders who have substantial psychiatric and criminal backgrounds. Squeezed into a tiny, bleak cell with three heavily tattooed community members, I was struck by the concern and indeed care, that they expressed about the emotional welfare and the safety of other members. Described by Morris (1999) as:

'Externally imposed security is replaced, however, by an internally imposed security; security imposed by each community, by each group, and by each individual. Grendon men maintain 'Good order and discipline' not because they have to, but because they want to.'

One of Star Wards' central propositions is that acute ward stays shouldn't be characterised mainly by containment and pharmacological intervention. Talking therapies should be a standard provision. Not couch-lying and trawling through excruciating childhood memories, but gentle exploration of daily challenges twinned with simple techniques from Cognitive Behavioural Therapy (CBT) and other 'practical' therapies.

About 15% of in-patients share my diagnosis of borderline personality disorder (BPD) (Winston, 2000). The tailored therapy for BPD designed by Anthony Bateman and colleagues, Mentalisation Based Therapy (Bateman & Fonagy, 2004) also offers the possibility of easy techniques which can build our skills in managing the illness, including its distressing impact on others. Improving our ability to mentalise – recognise what's going on in our own and other people's heads – is a useful life-skill, not just for people with BPD.

The level of talking therapy can be adjusted as people's mental state improves. It could consist of 1:1 time with a key named nurse simply exploring symptoms. More complicated interventions, for example reality testing delusions, would vary dependent upon the patient's ability to take it on board at that time. Equally, it may involve engaging with the patient and forming a therapeutic relationship.

Visits from family and friends can be really beneficial to patients who are at their most unwell, and make a small contribution to freeing up staff to engage with other patients. Simple things can help foster visits, such as making visitors welcome and providing a pleasant space for them.

In the UK, now would seem to be a good time to be involved with acute care. There are several important national initiatives to improve standards, not least the Healthcare Commission's service review of acute wards (Healthcare Commission, 2007). The Royal College of Psychiatrists has set up Accreditation for Acute Inpatient Mental Health Services (AIMS), a new and independent accreditation service (Cresswell et al., 2007). Wards joining the scheme and achieving the standards will unquestionably be in the forefront of the provision of excellent care. And NAPICU, including this journal, can play a crucial role in achieving sustainable standards of excellence. The National Institute for Mental Health in England (NIMHE) itself is providing strategy direction and practical resources at national, regional and local levels to support the transformation of acute wards.

In this editorial, from my own experience as a psychiatric in-patient, I have introduced the simple and inexpensive ideas that can greatly improve the experience of an in-patient stay. For those who have embraced Star Wards' ideas, our feedback suggests their wards are better places. Some of the wider themes may seem scary and unfamiliar especially the notions of patients taking part in controlling their own ward community, including disturbance. In most psychiatric wards and indeed in most institutions, the collective 'community' produced by residents and staff, its rules, values and culture has always had a profound effect on the experience of those who live there. Maybe therein lays the most profound truth about the nature of acute in-patient psychiatric wards. At the most basic level we are all in this together.

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