

Correspondence

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Colin Campbell

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The psychiatric ward as a therapeutic space

Papoulias *et al*¹ have added a great deal to our understanding of the research exploring the effects of ward design on both patients and staff. They highlight the breadth of study designs but also the varying quality of both patient and environmental measures. A further inherent limitation in many of the studies seems to be the difficulty in controlling for confounding factors such as staffing and patient characteristics.

Given these observations, it was unfortunate that our recent study² was not, at the time, ready for inclusion in this systematic review, as it adds to the body of work identified and also addresses some of the criticisms. Our work aimed to assess the impact of a changed ward environment on the levels of in-patient agitation and conflict on an NHS psychiatric intensive care unit (PICU).

Taking advantage of a PICU moving from an old, temporary building to a new, purpose-built ward, we were able to analyse routinely collected patient data that were markers of agitation and conflict, including number of seclusion episodes, duration of close observation, number of aggressive incidents and data from the Nursing Observed Illness Intensity Scale.³ We also had an evidence-based, objective, before-and-after measure of the ward environment: the Environment Assessment Inventory (EAI).⁴ This methodology, reviewing data before and after a ward change, enabled us to control for many of the important confounding factors that were highlighted by Papoulias *et al*,¹ as patient profiles, ward staffing and policies remained largely unchanged.

The results showed that the key measures of agitation and conflict were reduced on the new ward, and the EAI enabled us to identify quantifiable improvements and highlight critical design elements that had been improved upon.

Like many of the studies in the systematic review, ours suggested that the physical environment of the psychiatric ward had a significant effect on patient behaviours. Some of the critical changes included better visibility, increased space for therapeutic activities and more privacy in the form of single rooms. Papoulias *et al*¹ highlighted the common idea that improved privacy was a key environmental factor in reducing violence on psychiatric wards, and we too would make this interpretation. In the context of recent work by Ulrich *et al*,⁵ we concluded that it might be because patient privacy fosters a sense of control that reduces stress levels and in turn agitation and conflict, which are closely linked to violence.

We hope that our findings can be set alongside the work to date and provide further evidence for optimising patient care by using evidence-based and objective standards to improve the environment of psychiatric wards.

- 1 Papoulias C, Csapke E, Rose D, McKellar S, Wykes T. The psychiatric ward as a therapeutic space: systematic review. *Br J Psychiatry* 2014; **205**: 171–6.
- 2 Jenkins O, Dye S, Foy C. A study of agitation, conflict and containment in association with change in ward physical environment. *J Psychiatr Intensive Care* 2014; doi:10.1017/S1742646414000065.

- 3 Bowers L, Brennan G, Ransom S, Winship G, Theodoridou C. The Nursing Observed Illness Intensity Scale (NOIIS). *J Psychiatr Ment Health Nurs* 2011; **18**: 28–34.
- 4 Dix R, Pereira S, Chaudry K, Dale C, Halliwell J. A PICU/LSU environment assessment inventory. *J Psychiatr Intensive Care* 2005; **1**: 65–9.
- 5 Ulrich RS, Bogren L, Lundin S. Towards a design theory for reducing aggression in psychiatric facilities. Presented at *Arch 12: Architecture, Research, Care, Health* in Gothenburg, Sweden, 13 November 2012. Chalmers University (<http://conferences.chalmers.se/index.php/ARCH/arch12/paper/download/426/67>).

Oliver Jenkins, ST6 in General Adult Psychiatry, Norfolk and Suffolk NHS Foundation Trust. Email: oliver.jenkins@nsft.nhs.uk

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The systematic review by Papoulias *et al*¹ on the psychiatric ward as a therapeutic space reminds us of the important effects of environmental factors on in-patients. The physical environment is likely, however, to be particularly significant in settings where length of stay is long, whether in or out of hospital. The 1995 book by Halpern² describes the mental health effects of the built environment on residents of a housing estate, and the concerns of Papoulias *et al* should be explored in residential mental health facilities in the community.

For psychiatric in-patients, patient characteristics (including diagnosis) and psychosocial environmental factors are powerful determinants of what happens in the hospital, including behaviour disturbances, service user opinions and also, sometimes, illness outcomes.^{3,4} Clark⁵ was one of those who showed that different wards for different varieties of patient should have different sorts of environment, drawing on the extensive previous research in this field (e.g. Stanton & Schwartz⁶). A major problem with today's in-patient wards is that everyone has to be admitted to, and as like as not, stay in, the same environment, whether or not it suits them and their illness. This might remind clinicians with long memories of the features of the old observations wards, to which anyone putatively mentally ill could be admitted, primarily for triage and transfer to the setting which suited them best. Today there is, in these terms, only the triage.

- 1 Papoulias C, Csapke E, Rose D, McKellar S, Wykes T. The psychiatric ward as a therapeutic space: systematic review. *Br J Psychiatry* 2014; **205**: 171–6.
- 2 Halpern D. *Mental Health and the Built Environment: More than Bricks and Mortar?* Taylor & Francis, 1995.
- 3 Bouras N, Trauer T, Watson JP. Ward environment and disturbed behaviour. *Psychol Med* 1982; **12**: 309–19.
- 4 Watson JP, Bouras N. Psychiatric ward environments and their effects on patients. In *Recent Advances in Clinical Psychiatry – 6* (ed. K Granville-Grossman). Churchill Livingstone, 1988: 135–60.
- 5 Clark D. *Administrative Therapy*. Tavistock, 1964.
- 6 Stanton AH, Schwartz MS. *The Mental Hospital*. Basic Books, 1954.

Nick Bouras, Emeritus Professor, King's College London, Institute of Psychiatry, Psychology and Neurosciences; Jim Watson, Emeritus Professor, Guy's and St Thomas' Hospitals. Email: nick.bouras@kcl.ac.uk

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Author's reply: We are pleased to have received such commendations of our review on psychiatric ward design.¹ We believe, as the other commentators do, that this is a long-neglected area that needs more research to inform future investment – including the UK government's recently promised increase in in-patient wards for younger people.

The physical environment of healthcare facilities does affect the patient experience and their satisfaction and is recognised as

an integral part of care delivery.² The study mentioned in Dr Jenkins' letter strengthens the evidence base for the contribution of ward privacy to violence reduction.³ As that letter also indicates, measures have largely remained focused on clinical outcomes and any research can only hint at the key design components that drive these changes. Our review emphasised the need for patient-focused outcomes and their involvement in ward design. We have developed some novel methodology that can highlight positive and negative issues in current design from the patient perspective and have also developed measures to monitor the effects of changes in ward design. We hope that tools enabling robust, patient-centred evaluation of in-patient facilities might contribute to the recognition of the complex contribution of the material environment – in its physical and psychosocial dimensions – to patient outcomes.

- 1 Papoulias C, Csipke E, Rose D, McKellar S, Wykes T. Design in mind: the psychiatric ward as therapeutic space: a systematic review. *Br J Psychiatry* 2014; **205**: 171–6.
- 2 Department of Health. *Health Building Note 03-01: Adult Acute Mental Health Units*. The Stationery Office, 2013.
- 3 Jenkins O, Dye S, Foy C. A study of agitation, conflict and containment in association with change in ward physical environment. *J Psychiatr Intensive Care* 2014; **1**: 1–9.

Emese Csipke, Institute of Psychiatry, King's College London. Email: emese.1.csipke@kcl.ac.uk

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Discharges to prison from medium secure psychiatric units

The percentage of patients being discharged to prison from medium secure units has nearly doubled to 20% in just over a decade. The research captures a significant change in the practice of forensic psychiatry in England and Wales. When this area was discussed within the London region several years ago, colleagues who said that they were not doing this looked into the matter and found that they were. Doyle *et al*¹ do not report any variation in practice, which suggests there has been a uniform change (across the relevant services).

In considering why this has happened, the authors present a rather negative picture of sending back still-symptomatic, higher-risk people to prison, with inadequate aftercare. An alternative view is that this represents a new realism in forensic psychiatry. Medium secure provision has greatly expanded in the last 25 years but, as shown by the paper, the system is risk averse to community discharges. Such patients have low symptoms and stay longer in hospital. It is unlikely that more money will be allocated to forensic services and we have to make the best use of the resources we have.

In East London, appropriately transferring patients back to prison, alongside an improved rate of community discharge and the consistency of an admissions panel, has helped to manage demand. The service has gone from a waiting list of 25 patients to having beds quickly available for people presenting as acutely psychotic in prison. This is despite only sending people to the independent sector in exceptional cases and having no expansion in relevant beds over the time period.

The research is consistent with a change in the model that forensic psychiatrists have about prisoners. In the past, sending people with a diagnosis of psychotic mental illness back to prison was generally seen as inappropriate. Forensic psychiatry saw itself as having redeeming and containing roles, through identifying the

mentally ill in prison, transferring them to medium security, providing treatment, and then either discharging to the community or providing longer-term secure care if the person's risk and/or illness could not be satisfactorily managed.

The model now seems to regard prison as a form of 'community', to which some prisoners will be returned after being treated in hospital. It is logical that the relevant groups should be those for whom safe and effective ordinary discharge is unlikely. They may have a primary diagnosis of mental illness, but this might not be the primary problem for a significant group (e.g. career criminals and those who committed serious offences unrelated to mental illness). It is acknowledged that some practitioners will not welcome this philosophical and practice shift.

The fate of those returning to prison is an issue for both commissioning and service provision. NHS forensic and/or general adult services should follow up all those who are returned to prison. They should remain in the care programme approach (CPA) process, with 6-monthly CPA reviews and a local care coordinator who keeps in regular contact with them. This would assist with monitoring, management of relapses and aftercare. In East London, we have a consultant and community nurse with prison roles that include helping to manage returned prisoners. Although mental health prison in-reach is variable, such arrangements help provide a framework for prison aftercare.

In respect of the idea of a prison hospital, as advanced in the paper, this is the approach in South Australia (and elsewhere). Other than for patients found unfit or insane, most patients have the master status of prisoner, whether on remand or sentenced. At the end of their prison sentence, or if their remand ends, they have to be released from the forensic hospital, but can ordinarily be detained in a non-forensic mental health unit. This system has the disadvantage that there are no hospital orders.

A combination approach has merit. Hospital orders could be used for those who require a hospital care pathway and the court could still order people to hospital otherwise (e.g. for a trial of treatment). Mentally ill prisoners would receive more prompt treatment in a hospital within the prison estate. Each major metropolitan area or part of England and Wales could have such a prison hospital (regulated as usual by the Care Quality Commission). Prisoners could be informal patients, whereas currently they are being denied the 'least restrictive' approach enshrined within the Mental Health Act 1983. This would bring prison psychiatry in line with ordinary adult psychiatry practice. The underused hybrid order could be resuscitated for intermediate cases.

It is therefore to be hoped that this paper will promote active consideration of the best way to manage patients presenting in prison. I note that, unfortunately, the seminal study by Coid *et al* of half the secure units in England and Wales,² which showed marked variation in the practice of forensic psychiatry, was not presented and discussed at an annual forensic conference. As a specialty we should not miss the opportunity to discuss this highly relevant piece of research.

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- 2 Coid J, Kahtan N, Gault S, Cook A, Jarman B. Medium secure forensic psychiatric services: comparison of seven English health regions. *Br J Psychiatry* 2001; **178**: 55–61.

Neil Boast, Consultant Forensic Psychiatrist, London. Email: Neil.Boast@eastlondon.nhs.uk

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