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Presenting the case for acute mental health wards

DURING the past 10 years, acute mental health admission wards have come under increasing scrutiny. This has not generally cast acute wards in a positive light (Standing Nursing Midwifery Advisory Committee (SMAC), 1999), describing them for the most part as non-therapeutic and suggesting that they offer little privacy and minimal staff contact for patients.

Furthermore, acute wards have been subject to more than a decade of continual change. The gradual reduction in beds caused by the asylum closure programme and the adoption of a community-focused philosophy mean that psychiatric wards now care almost exclusively for patients who have severe and enduring mental health problems.

There is a corresponding increase in the numbers of detained patients and pressure to discharge (Gournay et al, 1998). The service user movement has also increasingly found its voice.

The large psychiatric institutions of the past were the origins of the psychiatric nursing profession and its traditional seat of power. Since their gradual closure, acute wards have been seen in an increasingly unflattering light – even though in the traditional asylum they were seen as the most prestigious area to work in. This has contributed to the erosion of the prestige of the acute mental health admissions ward, both in terms of staff recruitment and retention, and the nature of the nursing role.

The National Service Framework for Mental Health, sees acute wards as one among several 24-hour services. However, demoralisation and poor self-esteem in acute ward teams now appear to be the norm. The erosion of general psychiatry as an attractive career choice in nursing has resulted in problems with the recruitment and retention of appropriately trained staff (Mental Health Act Commission, 1997). The aim of this article is not to idealise acute wards – the intention is to show that they can still be of benefit to patients.

Safety and containment

In some ways the primary aim of acute admission wards, which can be described as that of ensuring the safe management and resolution of acute distress, has changed little over the years. Patient safety can be maximised by the containment that an effective acute ward can offer. This concept can be described by its origins in psychoanalytical thinking around the mother-baby relationship. As Obholzer (1994) describes: ‘If all goes well, the mother processes or “metabolises” the baby’s anxieties in such a way that the feelings become bearable; we then say that the anxieties have been “contained”.’

Flynn (1998) argues that when a severely disturbed patient is treated in an inpatient setting, the setting provides certain opportunities for ‘supportive containment’ of the patient. The concept of containment has particular relevance for the nursing role, although some nurses may not like the suggestion that they are ‘mothering’ their patients in any way. However, the concept of containment can help us to understand the way that the institution can benefit patients and help them to grow.

Containment may include the use of physical restraint. According to Winship (1998) the restrained patient may experience ‘a new synthesis of safety and containment if the restraint is delivered with care and insight on behalf of the nursing team’. Thus, the term ‘holding environment’ can be used in a more positive sense, as part of a therapeutic process.

Acute wards house – or ‘warehouse’, from a more cynical perspective – most patients in the acute phase of their compulsory stay. More effective acute wards contain the considerable anxieties of the patient, his or her loved ones, and, sometimes, the community at large. As Gabbard (1991) argues, many patients are only treated in a hospital precisely because they are too much of a burden for a single individual or family to contain without considerable support.

In short, acute wards contain patients that other services cannot manage or place. This relieves the other services of their anxieties, but can lead acute ward staff to feel that they are a kind of ‘last chance saloon’, left to manage everything that comes their way.

Acute wards do not have enforceable criteria for admission or referral and this may leave staff feeling vulnerable and exposed. The authors would argue that the current definition of a specialty is the ability of the service to say ‘no’ to a particular patient or group of patients defined by the presenting problem(s). We argue that acute general psychiatric wards are a specialty and should be acknowledg-
edged as such by all stakeholders.

**The ward environment**

Victorian institutions featured separate male and female areas. Modern acute wards are mixed and this is perceived as a problem by many. The government’s vision, *Modernising Mental Health Services* (Department of Health, 1998) includes the elimination of mixed-sex areas, as well as the ideal of having female-only wards.

Other initiatives are also taking a ‘back to basics’ approach. The creation of modern matrons and housekeepers employs the traditionalist terminology often used when acute inpatient care is discussed. Initiatives such as the King’s Fund’s ‘Enhancing the Healing Environment’ programme further emphasise that the acute ward environment is finally getting attention, and it is encouraging that mental health trusts have been asked to nominate nurses to lead the process.

Gabbard (1991) feels that ‘nurses must attend not only to individual clients but also to the group and the environment as a whole’. He argues that the creation of a healing, therapeutic environment is an achievable goal for nurses.

**Therapeutic work**

The therapeutic environment provides five important functions: ‘structure, involvement, containment, support and validation’ (Gunderson, 1978). We believe that acute functions: ‘structure, involvement, containment, support and validation’ (Gunderson, 1978). We believe that acute inpatient care is discussion. Initiatives such as the King’s Fund’s ‘Enhancing the Healing Environment’ programme further emphasise that the acute ward environment is finally getting attention, and it is encouraging that mental health trusts have been asked to nominate nurses to lead the process.

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