Transforming an out-of-date psychiatric hospital into a patient friendly space: a matter of taking risks, Intervention 2017, Volume 15, Number 1, Page 76 - 81

Personal reflection

Transforming an out-of-date psychiatric hospital into a patient friendly space: a matter of taking risks

Mahesan Ganesan

The author describes his experience as a psychiatrist in a large psychiatric hospital near Colombo, the capital of Sri Lanka. While there, he attempted to transform the wards under his supervision into patient friendly spaces through empowering both patients and staff members. This personal reflection shows that sometimes it can be wise not to have a plan, but to make use of opportunities as they arise.

Keywords: conflict, mental health, patient friendly services, psychiatry, reform, Sri Lanka

The fear of becoming numbed

The hospital I work for was built almost 200 years ago. It had a bad name, stigmatised throughout the country as the place to send '*mad peop*le'. For some time, it was common practice for patients to be tied to the wall at night, in a sitting position, so they could not get up nor go to the toilet. Then, in the morning, they would be cleaned up using a garden hose. This practice of restraint continued until the year 2000.

I first came to the hospital during my training, from 2002 until 2004, and I returned as an acting psychiatrist in 2006. I did not like it at all, because of the way the hospital staff acted towards the patients. Patients were still often tied up when their behaviour was problematic. They sometimes were beaten or not given clothes to wear. Even in those days, I had already begun to attempt to make changes.

For example, patients at that time were not allowed to shave themselves, due to the possibility of harming themselves with a razorblade. So, there was a barber that came to shave them. The barber would go from one ward to the next, and as there were so many patients, he could only shave a patient once every 10–14 days. That may have been a sensible arrangement in the old days, but now we have all these disposable razors and it is very difficult to harm yourself (or others) with a disposable razor. I felt that every man should have the right to have a shave every day, and proposed that patients be allowed to use disposable razors. My plan created an outcry from the nurses, with additional resistance from the administration of the hospital, as they felt that introducing disposable razors was an irresponsible risk.

When I saw that the hospital culture could not tolerate this small change, I became afraid that I might also become desensitised to the inhuman treatment of patients. I was a bit shocked by the fact that other psychiatrists did not seem to care very much. They did not feel that it was their duty to defend helpless patients who had no other voice in the institute. Perhaps their indifference was due to the fact that they only had a biomedical education and were not trained in social psychiatry. In any case, I did not want to become *numbed* like them.

For that reason, I elected to be posted to work as a psychiatrist in a different part of the

country, where I had the opportunity to build mental health services from scratch[1]. There, I discovered that building something new is a hell of a lot easier that trying to change a 200-year-old institution.

Resistance

I returned to the hospital in 2008 because I felt I should do something. There was a new director in place who was striving to make improvements, so I felt I had an ally. The new director gave me the space to try to implement improvements. Furthermore, now I was better prepared for the fact that nurses and the hospital administration often saw ideas of implementing even the smallest change as a threat.

Infringements on the rights of patients in this hospital were already being monitored by Nest, an independent, community based mental health organisation in Sri Lanka. After nearly 20 years of engagement, Nest now has its own space within the hospital premises and offers a wide variety of activities for patients aimed at re-socialising them and making them less dependent on hospital staff. They have also signed a Memorandum of Understanding with the hospital administration. Unfortunately, the majority of hospital nursing staff see the Nest workers as threat to their hierarchy. They distrust them, because the Nest workers have no medical training. As a result, they hardly send any patients to use their services. Even the occupational therapists at the hospital, who should be close to Nest because they too have a very low status in the eyes of the hospital nurses, never visit the activity room run by the Nest workers.

The resistance to change from nurses is understandable. Changes to the status quo creates more work as changes require more interaction with patients. Also, as a result of greater empowerment, patients become more assertive and demanding in terms of their treatment in the hospital. While I see that as a sign of improvement in their mental health, for some nurses it makes things less efficient and predictable.

Many nurses also want to maintain their place in the existing hierarchy, as they are afraid of losing status. There is a lot of group pressure among the nurses, so those who want to support new ideas and practices often have a hard time.

Moreover, many nurses are afraid of taking risks. They fear that, if something goes wrong, they will get the blame. In addition to this, some feel that new ideas are a devaluation of their current approach and role. They experience any proposal for change as an unfair form of personal criticism, not as a possibly useful result of advancing knowledge and insight.

Even when, in my ward, I can show that changes can make things better for both patients and nurses – with some of the nurses actually starting to enjoy their job – there is little transfer to neighbouring wards. The consultant psychiatrists of neighbouring wards are not really opposed to my plans usually, but they do not see reforms as a part of their responsibility. So the uptake of new insights and approaches goes very slowly, frustratingly slowly, even within the same hospital.

The first step: too big

When I returned to the hospital my first attempt to bring about change was to remove the padlocks from the doors of the in-patient wards that were my responsibility. For most patients, being in a closed or secure ward was unnecessary. Perhaps I was in too much of a hurry, or did not explain clearly enough why opening up the hospital was important to prepare patients to return to their home environments. I was certainly too naïve, as I had just assumed that staff would see the patients as human beings and therefore, be willing to treat them as such. This was clearly not the case. The staff was anxious about patients '*escaping*'. I told staff that if they were able to change the ward into a welcoming

environment, most patients would not wish to '*escape*' into an environment where they would feel less safe. The director was supportive of my plan, but the administration wasn't and blamed the nurses if a patient '*took off*'. I was facing a mutiny and had to give in. It was clear that the first step had been too big.

Joining and reinforcing a trend

Another thing I tried, this time more successfully, was stopping unnecessary physical restraint of patients with blankets. This practice was already on a downward trend when I returned, as most consultant psychiatrists did not approve of it. However, it still often happened without the consultants' knowledge, for example at night when they were not around. Moreover, many consultants did not actually react if they saw patients who were being restrained this way. I did react, and in some cases I made a bit of a scene or threw a bit of a tantrum. I did not blame anyone directly, but I would make sure that the patient was released immediately.

As mentioned, in 2008 the nursing staff I worked with did not talk much with the patients. Nurses were not empowered to do much more than follow the orders of the doctors, which usually meant simply dispensing the medication prescribed by the doctors. I wanted them to become more involved. So I engaged them to join the intake assessment with the doctors, inviting them to '*think along*' with the decision to admit patients to the hospital and on the choice of medication. I felt this could be helpful, especially as the nurses often knew the '*revolving door*' patients (those that returned repeatedly) and their families, and would be able to offer suggestions on managing these patients.

I expected some resistance, this time from the young doctors who did the intake assessments, but there was none. However, there was another problem. At night, it was a problem for the nurses to walk to the place where assessment meetings were held. The problem was caused by a group of about 150 stray dogs resident inside the compound of the hospital, during the day they did not present a big problem, but after dark they become quite territorial and attacked people – including the nurses. So I ensured that fences along the pathway were made higher, not to keep the patients in, but to keep the aggressive stray dogs out. This left no excuse for the nurses to use to avoid the intake assessment meetings.

Spreading the reforms

I started the process of change with the nurses from the wards where I worked. Their colleagues, from other wards, immediately began to criticise them, saying things like: '*you are adding to our workload, this is not our job*'. The nurses from my wards did not want to burden me with this information, and also did not want to denounce their colleagues, so did not tell me about this until later. In any case, the nurses that supported my ideas had a rough time and received a lot of negative comments from their colleagues.

Regardless of the criticism, the idea of involving the nurses during intake assessment meetings did eventually spread to other wards after I discussed it with my colleagues during consultants' meetings. However, there was still resistance. About a year ago, one of the consultants wanted to return things to the way they had been and questioned the presence of nurses during intake. Perhaps some doctors felt threatened by the know-how of the nurses, or were afraid to lose some of their status or power. This incident stimulated me to help the nurses improve their input, so that the value of their presence could become more visible. The difficulty here was that I was unable to show '*hard evidence*' that better decisions were made about patients when the nurses took part in assessment meetings.

Soon after my arrival, I also launched the idea of creating an opportunity for patients to use the telephone so they could stay in touch with family and friends. The patients would have to pay for their calls which, in turn, meant that the nurses would have to ask their families to deposit money for this purpose. Some nurses found that this was beneath their dignity, and others were afraid that they would be accused of pocketing the money themselves. When this resistance was dealt with, a new problem arose. Some nurses would ask the patient who he or she was going to call. Phoning a family member was usually allowed. However, phoning others – for example a boyfriend – was sometimes considered unnecessary by these nurses and they felt entitled to force their opinion on the patients. This resulted in some of their nurses using the phone as an instrument to assert their power over patients. When I commented on it, these nurses accused me of being insensitive and claimed they did this for the wellbeing of their patients.

Tackling institutional problems

It was often necessary to address institutional dysfunction beyond the mental health care regime. When I returned to the hospital in 2008, another serious issue quickly became apparent, food was being stolen from the patients on a regular basis. This became evident when I initiated a change where the meals would be prepared for one of my wards. Instead of the central kitchen, meals would now be prepared in a small kitchen on the ward itself. The meals would be cooked by the nurses, with help of the patients, so that they would be more active and exercise the skills involved in making a meal. Of course, some nurses resisted, it would be extra work for them and in a kitchen you need to use knives – what would happen if a patient would see a knife?! However, eventually the kitchen in the ward was up and running smoothly. This is when it became clear that food was being stolen from the patients. According to government regulations, the weekly ration for patients includes 7 x 850 grams of coconuts, yet only 4x 400 grams per patient was being delivered from the central kitchen. So where did the rest go? Also, if this was happening with food that is easily measured, what could possibly be happening with regard to more valuable ingredients like meat and fish? While we have been unable to completely eradicate this fraud, at least now we receive 7 x 400 grams per patient and the ward kitchen is still functioning.

In fact, as a result of the ward kitchen, the whole atmosphere during mealtimes has changed for the better. When the food came from the central kitchen, the nurses would plate up behind closed doors and hand out food plate-by-plate. The patients would be in a queue and there would often be fights among them as a result. Now the food is placed on the table as a buffet and the patients serve themselves. Meals are peaceful and quiet. Some patients are unable to serve themselves, so other patients take an extra plate and bring them food.

Waiting for opportunities and being prepared

I do not have a five-year-plan for helping the institution to reform, nor the power to carry out such a plan. Moreover, changes in people's behaviour, especially in a complex institution, often do not happen as a direct result of somebody else's plan. So, I wait until an opportunity comes along. Of course, I usually have five or six ideas in the back of my mind waiting for a chance.

Currently I have a plan to do something about the morning coffee. At present, patients cannot buy biscuits or a snack to go with coffee, but most people in this country have a little bite with their morning coffee, that is normal life. So why should patients not have this opportunity?

There is a little shop in the compound of the hospital, but it is outside the front entrance of the building, so the patients cannot go there. I have chatted with the owner and found out that he is willing to come into the hospital with a little cart of snacks around 10 am. The director supports this plan. He and I expect some resistance from the nurses if we start this. These days, I first think of what resistance can be expected when I come up with a new idea. I also try to find supporters beforehand. Among the nurses, some are much more flexible and less afraid of taking a little risk than others.

Stumbling along

Change takes a long time, but slowly some improvements have become visible. The amount of patients has gone down from 2000 in 2006 to around 900 in 2014, while the amount of staff has remained the same. So, the nurses should have more time available to help re-socialise patients. While there are still many nurses who avoid interaction with the patients, you can also now can see patients and nurses playing volleyball in the garden together sometimes. In an acute care ward I work in, the television now hangs at a normal height, and not close to the ceiling where no patient can reach it. When I initially suggested hanging it lower, as it is in most family homes, the nurses disagreed as they were afraid that the patients would smash the TV set. In the end, I had to bring a drill from home and move it into a lower position myself. The TV set remains undamaged and, as a result, patients can put it on or off, or change the channel without assistance from the staff.

Some struggles had the intended result and others didn't. With consent of the director, I had a little hut built in the garden, as a place where patients could smoke a cigarette without bothering other patients and the staff. In order to undermine the existing black market for cigarettes, families could bring cigarettes, which the nurses then would hand out at agreed times. Unfortunately, someone leaked the news on this smoking hut for patients to the press and it caused a scandal in the national newspapers because it was thought to be against government policy. For most citizens of this country, smoking without hindering others is an entitlement (even if is bad for their own health), but it is not so for patients in a mental hospital where there are already so many restrictions on their freedoms. The smoking hut was closed. Now the patients secretly smoke in the toilets again and once again we have an exploitative black market for cigarettes. Some desperate patients will give their shirt for a cigarette.

Another change was achieved with regard to patients assuming responsibility for taking their own medication. In one long-stay ward, known as the halfway house, most of the patients now take their own medication, as they would have to if they were at home. Only those who have intellectual disabilities still get their pills through the nurses.

Further, recently, a trip was organised for the patients of the same ward, a bus-trip to the zoo. Unfortunately, there were only 20 seats in the hospital bus, while the ward has 36 patients. In this kind of situation, in the past, the head nurse would decide who could go and who could not. However, this time the social workers held a meeting with all patients and presented them with the travel constraints. After this, 16 patients decided not to join for a variety of reasons, so the problem was solved with their full participation.

Reforming things in this old prison-like hospital is hard work. There is still a lot to do. I would like to ensure the patients in the other wards also get a place to sit so that they do not have to spend the entire day on their beds. Getting old couches onto the ward, finding plastic garden furniture, having a roof extension built over the

veranda so that patients still can sit there when it rains, getting a donor for a fridge in the kitchen – none of these things will happen without effort. In an ideal world, this whole old hospital would be closed and replaced by very small units in general hospitals in various regions, closer to the homes of the patients. In this building, there is not enough space for the family of the patients to stay. As a result, family members cannot learn from the nurses things like not getting into a debate about a delusion, how to avoid conflict, or how to calm an agitated person down. Additionally, providing aftercare for discharged patients is impossible if they live hundreds of kilometres away. Yet, it does not look like this hospital is going to be closed, so we merrily keep stumbling along.

[1] See Ganesan, M., Building up mental health services from scratch: experiences from east Sri Lanka. *Intervention, 9*(3), 359-363.

Mahesan Ganesan, consultant psychiatrist, works at The National Institute for Mental Health (Angoda Mental Hospital and Mulleriyawa Hospital) in Colombo, Sri Lanka. email: mahesanganesan2009@gmail.com