

## Milieu Therapy

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'I am part of all that I have met'.

ALFRED, LORD TENNYSON

Milieu, a French word loosely translated meaning environment, is used in psychiatry to describe treatments that depend on the patient's surroundings more than specific organic or psychological treatments. The concept of the therapeutic community and milieu therapy originated from Maxwell Jones at the Henderson Hospital, who realised the enormous untapped potential in staff of all grades. In a hierarchical structure, lower members tend to under-function, as seniors, by definition, are thought to know more and exercise control over juniors. Jones realised that even the ward maid had much to contribute from her personality and skills and specific knowledge of the patients.

A surprising number of patients are brought into hospital allegedly just for ECT or drugs. Why are they not given these as out-patients? In many cases the answer is because, perhaps unconsciously, we realise they need the hospital milieu as well as physical methods of treatment. Many patients, particularly in those wards that postpone specific treatment until the patient settles in, get better before the specific treatments are started. In those wards that give medication on admission, such improvement is often wrongly attributed to the medication. With many patients, the home environment has contributed to the illness and thus relevant treatment on an out-patient basis might be ineffectual. Changing the environment is potentially a strong therapeutic tool. The converse needs to be noted: withdrawal from home for others can be very traumatic; a good milieu is sensitive to and provides for this, the milieu successfully acting as a supportive family. If we continue to admit (i.e. abstract from home) a large number of patients to an admission ward, it becomes vital to structure the ward environment and the patients' activities in it to be meaningful and relevant. If we do not, we are neglecting a valuable and powerful resource.

Milieu then includes the whole atmosphere which surrounds you and particularly the people who are in it with you. It includes the anatomy and the physiology of the building. If the building is awkwardly designed, e.g. one cannot wash in private, this can undo much therapeutic work. More particularly relevant are the interpersonal relationships at patient/patient and patient/staff level. The staff/staff relationships are also very important to patients. After all, if in a patient's formative years, his personality has been affected by friction between the parents, discordant views among ward staff (who are members of the patient's present family) could reinforce this early damage. Milieu therapy then means using the whole ward as a supportive but also a dynamic and, at times, critical family.

All training is designed to tap and develop the potential of the individual. The mentally handicapped can be trained to do complicated things such as assembling TV sets, and this shows that the average factory worker doing this can do so on 10 per cent of his available ability—so, too, in the psychiatric ward. Many staff (and patients) function well below their potential because the structure and the environment does not permit personality growth and experiment. In the traditional ward, the hierarchy and accountability is given more emphasis than personal and interpersonal growth. It is also true that many less secure staff members feel much happier in a one-to-one private discussion; they are reluctant to risk stepping out more publicly and having the critical eyes of their peers on them. In their private discussions any member of the staff can act out their own difficulties and undermine the team effort. For this reason exclusive relationships are usually best avoided.

In the milieu, accountability is not so much to one's hierarchical superiors, but to the whole group. Patients are taught to be accountable to each other, to all members of staff. Patients and staff are encouraged to criticise each other because of their shared accountability and need for personal awareness and growth.

A potential danger in milieu therapy is that staff most attracted to this type of treatment might be personalities who are attracted to a laissez-faire environment. But structure is, like accountability, necessary. It is important for the structure to be flexible and adaptable. Patients and staff need to know the area in which they have freedom, but also the points beyond which they may not transgress and the penalty for transgression needs to be known. If they are learning new ways, they must, like children, learn the boundaries.

The diluting of the authoritarian role of, for example, the consultant or the head nurse, enables junior people to contribute more fully (after all, they often know much more about the patient than more senior members). The milieu prevents a 'we' and 'they' attitude; it teaches patients responsibility for their own actions. The group matures by being left feeling responsible for individual patients. The whole structure helps to mould and shape the individual's behaviour and performance in a healthy direction. The personalities of staff and patients are let loose but under the guidance of more experienced people.

Sometimes, the hierarchical structure needs to be, at any rate temporarily, accentuated to enable patients or staff with authority problems to project their difficulties on to a staff or patient member. Milieu and psychotherapy function partly to encourage and look at suppressed material. Free discussion in ward groups helps prevent members becoming stale and fixed in their views. It encourages open

examination of difficulties and the fact that the staff keep asking patients for suggestions about each other's needs, trains the individual patient for social maturation and develops the need to belong.

A good milieu also provides the right environment for specialised techniques, be they group or individual, to flourish. The discussion groups help in many ways, including prevention of jealousy about extra treatment given to one, or misunderstandings about why a patient is treated in a certain way, e.g. by being secluded. The groups also teach social cohesion; a common difficulty in the majority of psychiatric patients is difficulty in relating to others, they more frequently belonging to the 'out' group rather than the 'in' group. Psychiatric patients frequently tend to be egocentric, to be aware of their own difficulties rather than the difficulties of others; the social training of milieu

therapy helps combat this. Although all this is relatively new in Britain, the kibbutz system in Israel shares many of its principles, as does traditional tribal life.

A small but important point in milieu therapy is the personal and educative help staff can get both from other staff and patients. This also means that staff have more time to treat (rather than just look after) patients; or perhaps the ward could run with fewer staff—patients are taught to share the responsibility for a difficult patient and not leave it all to the staff. Free communication results in patients alerting staff to the fact that a patient is threatening to abscond—this also helps teach a patient responsibility. As in life (e.g. divorce) frequent changes of staff (from any discipline) can be disruptive and harmful. Patients particularly need to learn to trust and gain stability from their surroundings.

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## Correspondence

### *The Health Advisory Service*

DEAR SIRs

We write to protest about the methods of operation of the Health Advisory Service. We have been told that we must fully sectorise our service, and also that we must have special areas of consultant responsibility within our unit. We have four questions. First, does the HAS have objective evidence for its strongly held beliefs? (We doubt it.) Second, is it reasonable to impose these beliefs upon others who do not share them? Third, should it not be expected that advice should be adapted to local conditions? Finally, why is there no appeal procedure when an HAS Report contains advice which would lead to serious adverse effects on both our patients and those whom it is our responsibility to train?

We are proud of our service, which we have all worked very hard to create. (Indeed, even the visiting HAS team said how impressed they were by the dedication of our medical and nursing staff, and by the close collaboration between the University Department and the NHS teams.) We provide service in a district general hospital from five clinical teams to our small, densely-populated catchment area. Each team has some special interest in addition to taking general psychiatric admissions when they are on 'take', and our general practitioner colleagues are unanimous in wishing to preserve their freedom to refer an individual patient to the consultant of their choice. More important still—although less easy to document systematically—many of our patients have told us that they also value their freedom to choose a consultant. All this is to go: we are instructed to introduce rigid sectorisation.

All of us have had training in social psychiatry and our practice has been influenced by the finest social psychiatrists that this country has produced. They taught us to

insist on continuity of care so that a patient is looked after by the same team irrespective of where she or he is in the hospital. This must cease! If we follow the advice laid down, a young woman who was referred to consultant A because she lived in Acacia Avenue, would be referred to consultant B for day hospital care, to consultant C for in-patient care for her puerperal illness, to consultant D when her disturbed behaviour necessitated treatment in our high dependency ward, and finally to consultant E for rehabilitation. We are, of course, fortunate to have so many consultants, but then we are a major teaching hospital. Our visiting consultant colleague does not work in a teaching hospital, and sought to impose the standards of a suburban London mental hospital on a service which has many vivid points of contrast to his own.

We do not think that our views are necessarily right, but we do think that we have a right to have them, and that if they are to be completely disrupted we should be presented with some evidence for the change. Where is this evidence? Without it, we would have no difficulty in ignoring the HAS advice. However, our district health authority lacks our knowledge and is bound to overvalue advice which they receive from the HAS.

Finally, how does one appeal? It is no use writing to the Director of the HAS, since he adopts a defensive posture and refuses either to withdraw the advice or to send a team to revisit us. Has anyone else had similar experiences? And, if they have, what should we be doing about it?

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