Application of Therapeutic Community Principles to a High Secure Deaf Service

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ABSTRACT: Connaught Ward at Rampton Hospital provides the National High Secure Deaf Service for Men. Therapeutic Community (TC) principles have been used to inform the development and ongoing work of the service. This paper describes the work of the service and its particular difficulties. A discussion is then presented of the potential benefits and challenges that the use of TC principles has brought.

Key words: deaf; therapeutic community; high secure; forensic.

Introduction

Connaught Ward at Rampton Hospital provides the specialist National High Secure Deaf Service for Men. Whilst not a true therapeutic community (TC), the service employs TC principles to guide its practice. In working with this patient group areas of particular concern are communication and culture. Whilst communication difficulties and cultural differences make a TC approach appealing, they also make application of TC principles to the deaf population particularly difficult. Although modified TC approaches have previously been adopted successfully in a small number of units within high secure hospitals, these have been for hearing patients only. For example, Cedars Villa at Rampton Hospital was established in 2002 to provide treatment for patients with treatment-resistant schizophrenia with high-dependency needs (Davies & Mooney, 2004; Davies et al., 2005) and Woodstock Ward at Broadmoor Hospital follows a TC approach to cater for young men, the majority of whom have personality disorder (Quayle, France & Wilkinson, 1996).

In this paper we aim to outline the work of the National High Secure Deaf Service for Men and to put it into the wider context of the high secure hospital environment before briefly discussing relevant aspects of Deaf culture and communication. We then go onto explore how the service has adapted to meet

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and benefit from the application of TC principles as suggested by Haigh (1999), namely attachment, containment, communication, involvement and agency.

Although the term 'deaf' is generally used to indicate hearing impairment, it is useful at this early stage to distinguish between the terms 'deaf' and 'Deaf'. Whilst 'deaf' is used to describe someone with a level of hearing loss, the term 'Deaf' is used to describe someone who defines themselves through a cultural identity resulting from their experience of using sign language and growing up as a deaf person in a hearing society. Usually (but not always) a Deaf person will use sign language as their preferred method of communication (commonly British Sign Language, BSL in the UK), whereas a deaf person may prefer to use any combination of speech, lip-reading and/or some signing. It is also important to note that some Deaf people do not view themselves as having a sensory impairment but instead view themselves as part of a minority linguistic group. (For further background to these linguistic and cultural issues the reader is referred to Ladd, 2003; Padden & Humphries, 2005; and Sacks, 2000.)

Connaught Ward accepts admissions for men who are deaf regardless of their identity as either deaf or Deaf. Our responsibility is to provide a supportive and therapeutic service to men who traditionally have been isolated within hearing services due to problems of access and communication. Throughout this paper deaf with a lower case 'd' will be used to make reference to all individuals with a degree of hearing loss regardless of identity. If reference is made to deaf with a capital 'D' this is deliberate in order to make reference to the cultural identity associated with Deaf people.

Although the number of deaf men who require high secure care is very small (currently ten places are provided), it has been shown that deaf people are over-represented in secure psychiatric hospitals and prisons (Young, Monteiro & Ridgeway, 2000; Harry & Dietz, 1985) and have higher rates of violent and sexual offending (Young et al., 2000). The reasons for this are not clear but may include factors such as communication frustration, social exclusion, brain damage, learning disability and decreased educational and vocational opportunities (Miller & Vernon, 2003). It has also been shown that many deaf people receive inappropriate interventions from the criminal justice system (often being excused responsibility for minor offences), which means that they may not come into formal contact with forensic services until they have committed a more serious offence (Miller & Vernon, 2003; O'Rourke & Reed, 2007).

Rampton Hospital

Rampton Hospital is one of three English high secure (special) hospitals (the others being Broadmoor and Ashworth) which provide inpatient care to patients who are judged to present a 'grave and immediate danger to the public if at large' due to their 'dangerous, violent or criminal propensities' (NHS Act, 1977). This small number of patients detained in high security hospitals – approximately 1,850 per year in England and Wales throughout 1986 to 1995 (Butwell et al., 2000) – requires high levels of physical, procedural and relational security in order to deliver effective psychiatric treatment whilst also robustly managing

the risks they present. All the patients in Rampton Hospital are detained under either the Mental Health Act (1983) or, less commonly, the Criminal Procedure Insanity Act (1991).

The hospital opened in 1912 and is located near the town of Retford in North Nottinghamshire. The most striking thing about the hospital is the five metre high perimeter fence which encloses the entire site. Following recent security changes to the high secure estate the perimeter security of the hospital has been designed to be equivalent to that of a 'category B' English prison (Tilt, Perry, Martin et al., 2000). Entrance into and from the hospital is strictly controlled via a system of locked doors and within the hospital each individual ward and clinical area is also locked. Only staff have keys to the premises (although most patients have a personal key to their own bedroom) and patients are escorted by staff if they attend off-ward activities. In order to enter the hospital all staff and visitors must pass through airport-style security and searching, which includes metal detectors and baggage x-ray equipment. Access to potential weapons and illicit substances is also prevented by regular searching of both patients and their rooms. Patients are subject to frequent urine testing for illicit drugs and their mail and telephone calls are also monitored.

In common with other secure hospitals, balancing security with the need to maintain a therapeutic environment can be difficult. However, it should also be borne in mind that, due to the patient group at the hospital, these security measures are necessary in order to create a safe environment in which treatment can take place. The Fallon Inquiry into Lawrence Ward at Ashworth Hospital (Fallon, Bluglass, Edwards et al., 1999) demonstrated how a lack of effective security and control can adversely impact upon treatment. Unfortunately, the resulting security review of all the English high secure hospitals (Tilt et al., 2000) has perhaps resulted in a primary emphasis upon physical and procedural security at the expense of relational security and therapeutic needs (Davies, 2004).

Development of deaf services at Rampton

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Historically Rampton has had some expertise in working with deaf patients; admitting a small number of deaf patients since the 1970s and employing its first Deaf Communication Support Worker (DCSW) in 1983. Until five years ago the deaf patients at Rampton were managed on different wards depending upon their primary clinical diagnosis (i.e. mental illness, personality disorder or learning disability). In 2002, a specialist Deaf Service was established, as it became clear that the experiences of social isolation and communication frustration shared by many deaf people underlined the need for such provision in the treatment and care of forensic patients who are deaf.

Until 2004, the small number of deaf patients requiring high-secure care was dispersed between all three high secure hospitals. However, following the report of a high-profile homicide by a mentally ill Deaf man (Mishcon, 2000), a government publication (Department of Health, 2002) suggested that specialist

centres of expertise and care pathways be developed for deaf people with psychiatric problems presenting a risk to others. The decision was then taken that the Deaf Service which had been established at Rampton would become a specialist national service for all deaf patients requiring high secure care.

Connaught Ward

The physical environment

Connaught Ward is situated within the main hospital building. Although sharing the basic design of other wards it was renovated prior to being opened as the National High Secure Deaf Service for Men, and attention has been paid to making the environment as 'deaf-friendly' as possible (for example ensuring that the lighting is good in all areas to facilitate viewing of BSL/lip-reading). The ward environment offers adequate room space for both large group meetings and individual therapy sessions. This is provided within the security of the ward area and has been designed to minimise any visual noise that might create barriers to signed communication (e.g. highly patterned decoration or furnishings which cast large shadows).

Other adaptations include extra windows being inserted into the walls of seclusion rooms so that communication can still take place between the patient and staff members. Assistive technologies have also been provided such as a ward minicom and flashing lights in each bedroom (as alternatives to knocking on doors). All patients have their own single room. Adjacent to the ward are the offices of the Deaf Communication Support Workers (DCSWs) and Sign Language Interpreters (SLIs) to help facilitate close working between them and ward-based staff.

The patients

Connaught Ward currently has ten patients all of whom became deaf in childhood before the full development of spoken language (pre-lingually deaf). Most of the patients have developmental histories that include childhood abuse, substance misuse, minor brain injury (often as a result of the pathology which originally caused their deafness, such as measles infection), difficulty forming and sustaining appropriate relationships, personality difficulties, and mental illness. As is common with many deaf people, all have experienced social exclusion and communication deprivation to varying degrees. It is interesting to note that only one of the current patients has a family member who is able to communicate using sign language, demonstrating how, for many deaf people, social exclusion and communication deprivation is often experienced within their own families.

All the patients are male and their ages range from 27 to 53 with a mean age of 44 years. The length of time they have been in Rampton hospital ranges from 20 years to six months with a mean duration of current stay of nine years

(which is considerably longer than the current hospital average length of stay for hearing patients of six and a half years). In terms of offending behaviour all have committed serious violent and/or sexual offences which include homicide, rape, grievous bodily harm and arson.

Most of the patients on Connaught Ward primarily define themselves as being culturally Deaf. That is to say that communication on the ward is largely conducted through the use of BSL or Sign Supported English (SSE), a system of sign that utilises the sign lexicon with English grammar. Deaf patients not only share a language to communicate with but may also share a similar set of life experiences. All of these factors work well in building rapport, friendships and an informal peer support system. For this reason, grouping deaf patients on a ward that exclusively provides care for deaf people is justified and advantageous for service provision and patient rehabilitation. However, selecting patients by such criteria is quite different from how patients are usually grouped throughout the rest of the hospital, whereby patients are grouped together on wards by their primary psychiatric diagnosis. Thus there are separate wards for those with mental illness, personality disorder, and learning disability. Grouping the deaf patients together means that Connaught Ward is unique within the hospital in that patients who are mentally ill share a ward with patients with personality disorder and learning disability. This can impact upon the degree to which patients can relate to one another on the basis of their mental health, although they may be more likely to have shared cultural identities and experiences.

Deaf patients have no choice about the ward to which they are admitted or the staff team with whom they have contact, as Connaught Ward is the only service which can meet their specialist needs. Whilst most patients within Rampton are able to request a change of clinical team or a change of ward this is not the case for the Deaf patients on Connaught Ward, who literally have nowhere else to go. Even in other similar secure, highly-modified therapeutic communities (such as Woodstock Ward at Broadmoor and Cedars Villa at Rampton) patients who have no choice about being placed in the hospital can decide whether or not they want to participate in the TC or remain placed within the main non-TC wards. This lack of choice means that it is not possible to apply the rule of voluntariness to this unit.

The ward is a male-only ward, yet this does raise questions with the recent admission to the hospital of a deaf female patient. Given the current policy in the high secure hospitals that male and female patients should remain completely separate, she has been placed within the Women's Service and is not eligible for admission to Connaught Ward. The risk of her becoming isolated and vulnerable through a lack of a common language or culture has to be managed within the hospital policy of separating the sexes and providing gender sensitive services.

The staff

Uniquely within the hospital the Deaf Service consists of both deaf and hearing staff members and has made a commitment to employ deaf staff as part of the multidisciplinary team. These staff members are fluent in BSL and share a membership with the Deaf community and its associated culture. Reaching fluency in BSL is a lengthy, resource-intensive task. It is especially important that non-BSL fluent staff are aware of how to best work with both SLIs and DCSWs in order to facilitate communication between themselves and the patients. Training for this is rare and highly specialised and so is provided in-house.

Working with both deaf and hearing people has meant that working practices have had to be adapted to facilitate the use of SLIs. For example, in meetings not more than one person should speak at a time, chairs should be arranged so that all have a good view of both the speaker and the interpreter and it is sensible for people wanting to respond to a point to wait until the interpreter has finished and to put their hand up if they wish to respond. Such adaptations take time to get used to, but are essential if hearing and deaf staff are to work together effectively.

Having hearing individuals who are not fluent in BSL within the team can reduce communication and impact upon the amount and type of rapport that can be established. Communication breakdowns occur, as they sometimes do between hearing people, but are more frequent when hearing and Deaf people work together (Young, Ackerman & Kyle, 1998). It is often helpful to appreciate that communication breakdowns are inevitable, but can be repaired by all parties addressing each breakdown in a respectful and reflective way (Glickman, 2003). This can be frustrating at times as it lengthens many of the processes of working together (as a rule of thumb, a mixed hearing deaf meeting will take twice as long as a hearing only or deaf only meeting). Such situations can add to the feelings amongst hearing staff that it would be better and easier to work only with hearing individuals, hence encouraging negative projections onto the deaf people in the community/ward, be they patients or staff.

An effective treatment environment depends upon the inclusion of staff with relevant training, expertise and experience. On Connaught Ward, it is important that staff are not only proficient in BSL but that they are also highly Deaf aware. That is to say that they have an appreciation of the needs of Deaf people and what it is to be part of a Deaf culture.

Treatment programme structure

In view of the need to translate from English to BSL, the amount of information shared with patients surrounding the philosophy of the service, care provision and treatment plans is variable. Care provision and treatment plans are well covered in ward rounds where the information can be made accessible to the patients through appropriate communication support staff. However, the aims of work practices and information on policies are more limited. Translating

information into BSL and recording it onto a digital versatile disc (DVD) is required in order to make it accessible. This task has been started by various specialist mental health services for deaf people across the country, but is both time and resource intensive.

All patients have access to a daily programme of group activities; this can include alcohol and substance misuse group, anger treatment group, social skills group and regular community meetings (see Box A below for an example). All the groups are specifically designed and delivered to accommodate the specialist needs of the deaf patients. The provision for deaf patients is somewhat limited in comparison with that available to hearing patients due to the specialist training needed for staff and the lack of established treatment programmes and specialist resources. The rest of the hospital benefits from sharing skilled staff and materials for group work, but this is carried out in spoken English and is not appropriate for deaf people and a visual mode of communication.

Box A – Modified social skills group

A distinctive feature of the group is that it has been designed, and is run, purely in BSL with no use of interpreters. Facilitators are mostly native BSL users or bilingual. The group's main aim is to encourage patient participation, and through this to help them improve their social skills and motivation for engaging in other interventions offered by the professional staff.

This group draws on principles known to enhance communication, social problem solving, self-confidence, and assertiveness in deaf people. The facilitators use a lot of role play and games in order to encourage participants to become involved in structured activities aimed at increasing social interaction. Through this, participants learn to widen their understanding of their own and other people's communication skills, personal characteristics and social problem-solving skills.

The linguistic and cultural nature of the group also means that training and supervision of staff need to be provided in a linguistically- and culturally-sensitive manner.

Communication

Communication is a central issue when people from different linguistic cultures meet. The issues have an impact not only on how any Deaf Service is run but also determine the nature of how the principles of a TC approach are applied.

Whilst BSL provides a common language for deaf patients, communication ability is highly variable. This is largely due to the fact that many of the patients come from an educationally deprived background. This is not to say that they did not attend school. Instead it is a reflection of the history of Deaf education, whereby for many years an oral education was considered to be the priority and that sign language should be banned (Moore & Levitan, 1993). As a consequence, sign language may have never been formally taught to many Deaf

people, and learning may have been largely dependent upon learning from other school friends in private or from exposure to other Deaf people in the community. Many patients will have therefore been subjected to a learning delay not only in their own language but also in their understanding of real world knowledge. Their lack of language will have reduced their exposure and ability to digest any information actively or passively offered to them. Part of the staff team's work is therefore to formally teach sign language and communication tactics to deaf patients to improve communication ability.

Cognitive ability is another factor that can affect communication skills. However, it is unique to Connaught Ward that, as a result of deafness being the common factor between patients, deaf patients with learning disabilities are welcomed onto the ward with deaf patients who do not have learning disabilities. The fact that communication is valued as an important aspect of a deaf person's life within a dominant hearing culture means that this can be a positive feature of the environment on the ward. The hearing staff team also contributes to this dynamic through learning BSL and becoming aware of Deaf cultural issues, along with promoting working with deaf staff on the ward. This helps to redistribute the power relationship between individuals on the ward, and may be used to encourage reflection on their role and situation.

Culture

Historically, many Deaf people develop an inherent mistrust of hearing people. This stems from a long history of oppression by the hearing world, experienced both in school and in wider society. As with many minority groups this common experience works well to strengthen bonds between groups of Deaf people. Connaught Ward is one such example of this. This bonding can become magnified when hearing, non-signing staff are excluded from some activities as a direct result of their sociocultural distance. This exaggerates the divide between those who are deaf and those who are hearing. Of course, this is not something a TC aspires to deliver. If staff do not share the same language they can be prevented from engaging in conversations. However, even if they are able to sign fluently, it is unlikely that they will have experienced the same history as a deaf person and this lack of common ground can have an impact upon the amount of rapport that can be established between the deaf patients and the hearing staff. It can also have an effect on the amount of trust that the deaf patients have in the hearing staff, as their past experiences have taught them to be wary of hearing culture.

In the same way that the nature of communication differences has shaped how TC principles can be applied in the Deaf Service, cultural differences are also recognised to have a similar effect. Hearing culture exists but is only usually recognised when reflecting on Deaf culture. This is a characteristic that is shared by majority cultures that hold positions of power (as in masculine cultures, white Western cultures). Developing a mental health service for deaf people means that we have to recognise the assumptions made by our dominant hearing culture and check that these assumptions do not interfere with our

support and care for the patients. We have recognised that cultural differences influence staff team dynamics and relationships, boundaries and containment, and both physical and staff resources. Deaf staff have been involved in the development of the service since its inception and have helped to counter some of the unhelpful assumptions that may be made by hearing staff about deaf patients.

It is common for deaf services to offer Deaf awareness training to their staff in order to develop more cohesive working environments and this is also the case on Connaught. Awareness and knowledge about how deaf people experience the world (whether they are patients or staff), helps in creating more effective working relationships both within the staff group and also with the patients in their care. Deaf staff are also offered clinical supervision by a clinical psychologist in their first language of BSL. Regular staff meetings are intended to open up communication between all individuals and full communication support is provided by the use of SLIs.

It is however inevitable that a degree of sociocultural distance is ever-present and can compound any tension felt between the hearing staff and deaf individuals on the ward. As much as Deaf awareness is taught, certain cultural behaviours played out by either group can remain open to misinterpretation. We attempt to take an adaptive approach to resolving conflict between members of either culture and encourage staff to accept that misunderstandings and disagreements are inevitable between people of different cultural backgrounds. However, this is often not simple to do and relies on all parties to accept cultural differences as an explanation for conflict. Often this is easily recognised by members of a minority group as they are more than likely to have personally experienced oppressive responses to their culture. For members of the more powerful majority culture recognising their own oppressive practices and the validity of minority cultures' difference does not come easily (Glickman, 1996).

Applying therapeutic community principles

It was hoped that creating a community on Connaught Ward would provide an experience for the patients that is in contrast to their experiences of social isolation both prior to arriving in Rampton and also for those deaf patients who had been resident in the hospital on other wards for some time. Despite the variation in communication abilities across both patients and staff, it has been possible to use some of the general principles of a TC to help staff and patients address attitudes and behaviours as and when they arise. Staff attitudes to the mental health patients in their care have been shown to be a strong determinant of clinical outcome (Tattan & Tarrier, 2000). Likewise, staff attitudes towards deafness and Deaf culture are also important to help recognise how a deaf person's behaviour can be determined by the social and political context they find themselves in. More often than not, a deaf person's social and political context is determined by hearing people.

Whilst the application of TC principles has provided a number of benefits to the service, it has also proved (and continues to prove) challenging for both

staff and patients. We will now go on to discuss how the principles of a TC, as enumerated by Haigh (1999), have been applied to the service.

Attachment

Attachment theory has been influential on the development of TC principles (Campling, 2001), and has some specific implications for most deaf people. Campling has suggested that TC patients are helpfully understood as suffering from 'attachment failure' and often have early experiences of chaotic, abusive attachments lacking in 'basic trust' and, as such, individuals may find it difficult to express their distress or ask for help in a constructive manner. This is certainly true of the majority of patients on Connaught Ward, although their common experiences of social and familial isolation are also significant factors.

Campling (2001) described the task of a TC as providing a safe frame within which patients 'can explore intrapsychic and interpersonal problems and find more constructive ways of dealing with distress' (p.368) by offering patients the opportunities to build strong attachments. It is important to consider the attachment experiences of deaf people in the context of more powerful hearing cultures and the fact that 90% of deaf children are born to hearing parents (National Deaf Children's Society, 2007). All of our patients were born into hearing families, with only one of them being exposed to BSL and Deaf culture within their family. It is more common for deaf people to discover and develop their cultural identity outside of their family and educational experiences (Lane, 2000), which are dominated by hearing cultures that have often suppressed the use of sign language and Deaf cultural expression in favour of oral/aural expression and communication (Ladd, 2003; Lane, 2000). Recognising this fact means that providing opportunities for building positive 'strong therapeutic attachments' within a TC environment requires staff to develop a keen awareness of their own assumptions as a powerful group within the context of a hearing culture (Lane, 1996; Hoffmeister & Harvey, 1996). Cultural self-awareness and cultural competency are often difficult skills for powerful groups to adapt and incorporate into their daily practice (Sue, Arredondo & McDavis, 1992; Sanchez-Hucles & Jones, 2005).

Containment

Deaf patients on the ward are encouraged to express themselves freely in community meetings, individual and group psychology sessions, in ward rounds and in day-to-day life on the ward. More recently the implementation of the culturally specific social skills group (see Box A above) means that patients are receiving support in learning how best to express themselves and their opinions and the need for listening to and accepting others' opinions. The staff are experienced in the containment of often highly challenging emotions but this is not specific to Connaught Ward. What is more specific is the specialist work of the DCSWs who play a key role in the containment of our deaf patients. At times deaf patients can experience a large amount of communication frustration as

they encounter difficulties trying to communicate what they are feeling. This can be quite common, especially for individuals with limited signing ability and for those that have experienced communication deprivation in the past, meaning that their sign lexicon is quite limited as a result. Patients with Minimal Language Skills (MLS) can work with the DCSWs to find alternative ways of communicating what they are trying to convey. This may require some elaboration in sign language or take the form of visual aids such as picture boards or role play. Offering an alternative form of communication does well in containing communication frustration and the inability to express what is desired that might have otherwise been expressed in self-harming behaviour or violent behaviour towards others. Such an example of containment can be seen in Box B (below).

Rules are indeed ever present on Connaught Ward and certain behaviours do have consequences. Enhanced levels of observation or, exceptionally, seclusion may have to be used at times in order to maintain the rest of the community's personal safety. Relationship boundaries between staff and patients and patients with other patients are also upheld in order to maintain personal safety and reduce any potential future risk to the individual. This strict imposition of rules and boundaries can work to contain the individual and manage future behaviour. However, it may also act as a deterrent to the patient, who may feel that it is important not to communicate how they really feel or what they are really experiencing as they are concerned about the consequences of this upon their future care and treatment pathway.

Along with the expectation that misunderstandings and communication breakdowns are almost inevitable (Glickman, 1996), expert reflective supervision for all staff is considered essential to deal with the dynamics of the mix of hearing and deaf staff working with deaf patients. This is offered by the ward psychologist, and once a week the staff team meet as a way of offering peer support and discussing any issues that have arisen. Furthermore, members of the staff team regularly meet and engage with other specialist deaf service providers in order to discuss service provision and development. This in turn can act to normalise many experiences of the staff team.

As with many therapeutic communities, the projection of negative emotion, identification and splitting can be difficult to deal with (Campling, 2004), but the cultural differences between hearing staff, deaf staff and deaf patients overlay this with their own particular problems. For example, hearing staff are encouraged to reflect on their attitudes to deafness as a disability and how they may (unconsciously) behave towards their deaf colleagues and deaf patients. Likewise, deaf staff may be asked to reflect on their negative experiences with hearing institutions and individuals in authority over them and how this may colour their relationships with their hearing managers.

When working cross-culturally it is also important to be aware of the boundaries one imposes on oneself as a possible product of one's own culture. Many culturally Deaf people are direct in their communication and this can alarm a hearing member of staff who is not used to being brought to the point abruptly. However, cultural awareness and understanding are paramount and Deaf aware-

ness training can help to contain any anxieties surrounding these interpersonal issues that might present. Also, the wider Deaf community is quite small (there are approximately 70,000 sign language users in the UK; Royal National Institute for the Deaf, 2007), so issues of confidentiality arise frequently. There may be some tension around the fact that an SLI (around 300 in the UK; Royal National Institute for the Deaf, 2007), or a DCSW has previously been involved in a discussion with a patient in another context. The boundaries of professional relationships can often become stressed when a member of staff becomes aware that the interpreter may know more about the patient than they do.

Communication

The availability of appropriate communication is a powerful determinant of behaviour as can be shown in the case vignette of Mr A.

Box B – Case vignette

Mr A is a Deaf man in his twenties who was referred to Rampton Hospital from prison where he was serving a three-year sentence for assault. Whilst in prison, Mr A had no access to a sign language interpreter, deaf visitor or staff who were able to communicate in BSL, and subsequently had to rely on pointing, miming or passing notes in order to communicate. Mr A spent lengthy periods of time in segregation and was isolated from all other prisoners due to his extremely violent and assaultative behaviour towards others.

Since his transfer to Rampton Hospital, there has been a remarkable improvement in Mr A's behaviour and, apart from minor physical attacks on staff soon after his transfer, he has integrated well into the ward's deaf community with no violent behaviour for over three years. He communicates in BSL and has now learnt to control his anger by engaging in group work and individual therapy sessions with signing staff.

On reflection, Mr A feels that his behaviour in prison was a direct result of not being able to communicate effectively with staff leaving him with no other way of venting his frustrations or making his wishes known.

Maintaining a culture of enquiry within the community presents a challenge and is compounded by both issues of security and communication. Issues surrounding security have already been discussed above and so will not be elaborated on here beyond the fact that certain topics are discouraged as points of discussion for the patients. Topics are discouraged if they are considered to raise the probability of jeopardising risk and security by revealing too much information through discussion. Such topics may include discussion of previous offences or managerial issues. This also reduces the possibility of a hierarchy being established between patients on the basis of their previous offences and the possibility of sexual offenders sharing and promoting sexually deviant fantasies.

Communication differences on Connaught Ward also present a barrier to maintaining a culture of enquiry. When community meetings are held on the ward, the differing levels of communication ability between patients and staff challenge the ability to enquire and discuss certain topics to any depth. DCSWs are employed as part of the team in order to try and reduce problems presented by communication. The deaf staff however can also be presented with barriers if language skills in a patient are so deprived, or if psychiatric symptomology results in communication that is too difficult to understand.

One environment that allows for personal enquiry into managerial issues is the ward round. Here, the patient meets with the multidisciplinary staff team (MDT) and issues raised by both the patient and the team are discussed by all. SLIs and DCSWs are present and communication barriers are minimised as a consequence. Unfortunately, this lengthens the time of the ward round and the formality of the situation may not encourage open levels of communicating. Furthermore, it is the MDT that holds the overarching power over the patient and whether he remains on the ward or can start to progress through the system. It is therefore inevitable that some patients may feel that they do not wish to question the team on certain topics as this may highlight areas of risk and indeed jeopardise their chances of moving through the system.

Involvement

There are several ways in which all patients within Rampton can be involved in their treatment. These include: involvement in regular ward reviews, Care Programme Approach (CPA) meetings, access to independent advocacy services, Patients' Council Meetings, and management meetings with patients, carers and families. Patients from the High Secure Deaf Service are represented in all of these meetings and a deaf patient has chaired the Patients' Council.

In addition, the service has the advantage of employing deaf professional staff who promote positive role models. Patients have been involved in the design of more accessible food menus and patient information leaflets for new admissions to the ward.

Another example of how we try to involve patients and adapt their care to meet their specific needs is in the development of nursing care plans. Making the care plan easily accessible and understandable by both deaf patients and deaf staff and hearing staff is a key issue. In order to achieve this both the patient and deaf staff and hearing staff collaborate from an early stage. Nursing staff and the patients require support not only from the clinical team but also from SLIs and DCSWs in order to work together successfully. To make care plans accessible, alternative forms of communication such as pictures, diagrams and plain English are utilised. Whilst it could be argued that a similar approach should be used by all mental health services (i.e. collaborative, individualised care planning), the particular demands of working with this patient group make this essential.

Agency

Part of the TC model promotes patient responsibility for decision making and ensuring a safe therapeutic environment for all. The issues pertaining to offering our patients increased opportunities for responsibility is problematic within the environment of a high-secure hospital (see Davies, 2004). High secure hospitals admit and treat those patients who are thought to pose a 'grave and immediate danger' who have committed serious offences, including assaults, arson, rape or homicide. Given this, patients can only be allowed a limited amount of responsibility, when clinically appropriate, over only a small part of their day-to-day life.

For the majority of the patients Ministry of Justice (formerly Home Office) Restrictions (i.e. sections 41 or 49 of the MHA 1983 or CPIA 1991) apply. This means that even the patient's consultant psychiatrist (Responsible Medical Officer, RMO) cannot discharge the patient or give him permission to leave the hospital or agree to transfer to conditions of lesser security. Instead the RMO (as part of the MDT) can only make a recommendation to the Mental Health Unit at the Ministry of Justice who have the final say about such decisions, although the patient can apply to a Mental Health Review Tribunal (MHRT) for discharge.

Whilst the patients are often isolated from the world outside the hospital, the hospital itself does not operate in a social/political vacuum. The present political climate seems to favour security and incarceration of mentally disordered offenders over treatment and care (Davies, 2004); perhaps in response to the media interest in presenting mental illness as dangerous and unpredictable. Despite talking therapies having been accepted as an effective way of ameliorating distress (Layard, 2006), this has yet to become popularly accepted as a way of treating the mental health of people who have also broken the law. Progress is slow as health trusts have learnt to become wary of tabloid newspaper headlines such as 'the lunatics are running the asylum' (Taylor, 2002) in relation to attempts to empower patients and involve them in the practical running of hospitals such as Rampton.

As well as the difficulties above, which may be shared with other secure modified TCs (such as Grendon Underwood Prison, Cedars Villa and Woodstock Ward), there are also cultural difficulties in promoting a sense of agency within our patient group. In the past, many deaf people often had no choice in being dictated to by others. Their linguistic isolation from social information that the hearing population take for granted, together with their experience of services that often patronise them, means that many deaf people come to expect lenient treatment and less responsibility from hearing people who find them difficult to deal with.

Harmer (1999) presents this as a problem in general healthcare provision for deaf people stating that many experience healthcare as something that is done to them and not something that they have an active choice about. Of course, giving patients the responsibility to make decisions about their care would motivate engagement and increase self worth, but this is a big step for some of our deaf patients to take. Staff are made fully aware of the dynamics surround-

ing this process and support is provided by the MDT. Managing hostile dependency and containing the anxiety that accompanies a patient's increase in taking responsibility for their own behaviour is a frequent task of the care staff.

Conclusions

The therapeutic environment offered on Connaught Ward explicitly attempts to bridge the cultural differences between the mainstream hearing culture of forensic mental health care and the subjective experiences of deaf patients detained under the Mental Health Act (1983). The explicit acceptance of cultural differences means that certain principles of cross-cultural therapeutic work have been incorporated into our work practices. These principles share much with approaches taken in therapeutic communities (Thampy & Bhugra, 2004; Kelly, Hill, Boardman & Overton, 2004). Although, the ward does not provide a therapeutic community per se as a treatment for deaf patients' mental health needs, the principles are seen as necessary in order to provide a safe and culturally appropriate environment in which to begin to offer therapeutic interventions.

As a consequence of acknowledging the need to adapt work practices within a high secure environment along with the adaptations described here concerning caring for mentally-ill deaf people, we recognise that our work is highly specialist. A corollary of this is that continual training and supervision of staff is seen as essential. Both the necessity of a secure environment and the needs of deaf patients impose an extra skill base onto all of the professionals who work on the ward. Working practices need to be adapted while continually preserving respect for the patients as individuals.

Ethical issues

This paper has attempted to describe the work of a highly-specialised multidisciplinary national service. As part of its ongoing development the service aims to disseminate and inform others about its work whilst also actively seeking the views and participation of other stakeholders. However, we are mindful of the often sensitive nature of the work and the duty of confidentiality that we have to our patients. Both patients and the multidisciplinary team on Connaught Ward are aware that this paper has been written and are supportive of the authors doing so. Patient A is a composite description based on several different patients so that no individual patient is identifiable.

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