Social climate in forensic mental health settings: A systematic review of qualitative studies

Patrick Doyle[a,b,*], Ethel Quayle[a], Emily Newman[a]

[a] Clinical & Health Psychology, School of Health in Social Science, University of Edinburgh, Teviot Place, Edinburgh EH8 9AG, United Kingdom
[b] NHS Fife, United Kingdom

ARTICLE INFO

ABSTRACT

Social climate is a commonly evaluated aspect of inpatient forensic mental health settings. However, there is little clarity in the literature on the components of social climate. To identify these components, qualitative studies of staff and patient experiences of social climate were systematically reviewed using best fit framework synthesis. An a priori framework was developed based on nine existing models of social climate. A systematic search identified twenty studies of sufficient quality to be included in the review. These studies included staff and patient perspectives across all levels of inpatient forensic settings. In all twenty-two themes were identified in the review papers. From these themes, a model of social climate was developed. Seven factors were identified as part of the social climate, including the therapeutic relationship, care and treatment orientation, the secure base and four aspects of the ward environment. The findings indicate that common measures of social climate may not fully represent the construct. Themes related to the patient group, the staff group, the physical environment and system level factors were identified as influencing social climate. The model described allows for consideration of interventions to positively influence social climate.

1. Introduction

Although social climate has been a concept in inpatient mental health research for over 50 years the essential elements of the construct remain unclear (Brunt & Rask, 2007). The variety of terms used to describe the 'quality' of the environment, such as therapeutic milieu, ward atmosphere and social environment (Brunt & Rask, 2007) is in part due to the interest in social climate across several disciplines including psychology (Moos, Shelton, & Petty, 1973), psychiatry (Clark, 1974) and nursing (Peplau, 1989). The current study will use the term social climate, referring to both the physical conditions of the ward, as well as the context and the social relationships between its members. Social climate can be seen as a dynamic characteristic of inpatient settings that influences or impacts upon the members of the ward, both staff and patients (Milsom, Freestone, Duller, Bouman, & Taylor, 2014).

Social climate is not synonymous with organisational culture (Duxbury, Bjorkdahl, & Johnson, 2006) which can be seen as "the way we do things around here" (Miller, 2015, p.74) and describes the organisation, management and informal structures that surround the functioning of the ward. While the culture of the ward is likely to impact on the social climate, the concept covers the social and emotional experience of the ward (Schalast, Redies, Collins, Stacey, & Howells,

2008). Similarly, the presence of a safe environment is important, though does not appear to be sufficient for a positive social climate. Social climate has been linked with levels of violence (Cutcliffe & Riahi, 2013; Nijman, 2002; Ros, Van der Helm, Wissink, Stams, & Schaftenaar, 2013). Furthermore, a recent systematic review of qualitative studies identified safety and security as a condition necessary for recovery in forensic mental health care (Shepherd, Doyle, Sanders, & Shaw, 2015). Social climate may be better understood as a multifactorial construct, which in forensic settings includes: safety from violence, supportiveness of therapeutic gain, and provision of opportunities for personal growth (Tonkin, 2015).

The breadth of the construct of social climate is also unclear. Moos' (1989) definition of social climate sees it as one of five factors within the dynamic system of inpatient psychiatric care, along with the physical environment, organisational structure and both staff and patient characteristics (Brunt, 2008). However, therapeutic milieu traditions include the physical and organisational structures as part of social climate or therapeutic milieu (Mahoney, Palyo, Napier, & Giordano, 2009). Theoretical perspectives and intervention strategies related to social climate include therapeutic community (Haigh, 2013) and milieu therapy approaches (Gunderson, 1978), that see the structure and environment as the means to engender change. Social climate is also

---

important in prison environments and has been cited as potentially a key factor in the success of rehabilitative interventions (Day, Casey, Vess, & Huisy, 2012). Therapeutic community approaches have been utilised in both prison and hospital settings (e.g. de Boer-van Schaik & Derks, 2010) and variations in the relative focus of different aspects of social climate are seen as indicative of different types of treatment environments. It has also been suggested that different populations benefit from different treatment atmospheres (Duxbury et al., 2006).

There is however, a potential difference between prison and hospital settings in terms of social climate. A therapeutic environment is a more clearly articulated goal of hospital settings, while prison settings have an additional deterrence function (Gunn, 2000). There is also, perhaps a longer history of the environment been seen as the treatment in hospital settings through milieu therapy, social psychiatry (Clark, 1974) and democratic therapeutic community approaches. Though prison based therapeutic communities are well established (Day & Doyle, 2010; Vandevelde, Broekaert, Yates, & Kooyman, 2004) it is perhaps reasonable to suggest that considerations of a therapeutic atmosphere are more to the forefront in hospital settings. The current review focuses on forensic mental health settings, that is forensic wards and hospitals where individuals are detained due to mental health difficulties.

1.1. Social climate in forensic settings

The focus on social climate, both in research and clinical practice has changed over time, with therapeutic milieu approaches being supplanted by a focus on individual treatments (Duxbury et al., 2006; Oeye, Bjelland, Skorpen, & Anderssen, 2009). Despite this, social climate may be particularly relevant to forensic mental health settings, which can be highly structured and are often characterized by long-stay, static populations (Willmot & McMurran, 2013). Within forensic settings, a balance between security and therapy is often evident (Jacob, 2012). This dual focus, which incorporates the need to maintain awareness of the potential for community harm, may lead to difficulties in maintaining a recovery focus, over and above difficulties experienced in different areas of the mental health system (Mann, Matias, & Allen, 2014; Shepherd et al., 2015). The physical security of forensic settings (such as a 17 ft high fence; C. Taylor, 2011) may also impact on the social climate. Most patients are involuntarily detained, and in a UK context their treatment may also be subject to governmental oversight, which can lead to a sense of powerlessness in patients (Livingston, Nijdam-Jones, & Brink, 2012).

While social climate has been researched over the last 50 years, there is a lack of conceptual clarity around the components and factors that influence social climate. In both research and clinical practice, the range of theoretical perspectives of social climate and lack of a shared definition has led to a somewhat unbounded concept. This can be evidenced by the range of descriptive studies (for review see: Tonkin, 2015) and the limited number of intervention studies based on social climate. Much of the evidence base on social climate has been quantitative in nature, and through this a range of factors have been identified that influence social climate. The quantitative evidence as it relates to measurement of social climate is reviewed by Tonkin (2015). However, a source of evidence that may add to the conceptualisation of social climate is qualitative literature. For the majority of the time where social climate has been a topic of research forensic service users' voices were largely absent from the research literature (Coffey, 2006). However, there has been a growth in research in forensic settings giving voice to service user perspectives (e.g. Clarke, Lumbard, Sambrook, & Kerr, 2015; Shepherd et al., 2015). Given this source of evidence, returning to the perspectives of those who experience the atmosphere to identify its constituent components would seem a first step towards solidifying social climate.

Reviewing the qualitative evidence is also important due to the differences in coverage of the measures used in quantitative studies of social climate. Tonkin (2015) found 12 separate measures of social climate in 85 articles. The two most commonly used measures in Tonkin's review are the Ward Atmosphere Scale (WAS) and the Essen Climate Evaluation Schema (EssenCES). Do these measures accurately capture the extent to which a climate is therapeutic? Do they provide a basis for intervention to alter social climate? Tonkin (2015) suggests that further research to examine the theoretical construct of social climate is warranted to understand what is measured by current questionnaires. The WAS (Moos, 1989) has ten subscales, though it was developed over 50 years ago and may no longer be relevant to current forensic mental health environments (Rossberg & Friis, 2003; Schalast et al., 2008). In contrast, the EssenCES (Schalast et al., 2008) is a brief measure, developed as a screening instrument for forensic settings, with three subscales covering therapeutic hold, experienced safety, and patient cohesion and mutual support. Tonkin (2015) in reviewing the evidence suggests that the EssenCES has the most empirical support for use in a wide variety of forensic settings. There is less empirical support for using the WAS though there is recognition that as a longer measure, it may give a deeper insight into social climate.

However, the lack of definitional clarity and the wide range of measures used make it difficult to compare findings. This is particularly evident when significant differences are found in studies comparing staff and patient experiences of a shared environment (Livingston et al., 2012; Long et al., 2011). Though this may relate to differing perspectives or measurement error, it may also be due to differences in the perceived therapeutic nature of the unit. This highlights a further difficulty in defining social climate, that is the extent to which the staff members' experience of their working environment differs from the patient experience of care and confinement on the ward. The extent of measurement of social climate suggests we have moved beyond the perspective of the World Health Organisation's's (1953) view of social climate as intangible. However, a model describing the elements of social climate remains elusive (Brunt & Rask, 2007).

1.2. Research aim

The review focused on qualitative studies of social climate in forensic mental health settings. Due to an identified lack of clarity in the definition of social climate the review sought to identify how the concept is described by patients and staff in forensic mental health settings. The review sought to develop a model that describes both the facets of social climate of forensic inpatient settings, as well as the wider factors that operate on the social climate. The aim was not to identify an optimal social climate, but to develop an understanding of the factors of the shared environment that contribute to staff and patient understandings of social climate. It was expected that both helpful and unhelpful aspects of social climate would be identified in the literature.

2. Systematic literature review

While there are many available methods to synthesise qualitative studies (Barnett-Page & Thomas, 2009; Dixon-Woods, Booth, & Sutton, 2007), as the current review seeks to examine the links between theory and lived experience framework synthesis was identified as the most suitable method. Framework synthesis allows for the development of a conceptual model of the phenomenon of interest (Carroll, Booth, & Cooper, 2011; Dixon-Woods, 2011) and has been identified as a means to inform health related decision making and practice, through identifying the likely sources of intervention (Barnett-Page & Thomas, 2009).

'Best fit' framework synthesis is a two stage review process, with the first stage being a priori selection of an initial framework of themes (Fig. 1; Carroll et al., 2011; Carroll, Booth, Leaviss, & Rick, 2013; Cooper, Squires, Carroll, Papaioannou, & Booth, 2010). A systematic approach to developing the initial framework reduces the risk of bias in a framework based on the authors' prior experience or own theoretical preference (Booth & Carroll, 2015; Carroll et al., 2013). In the second