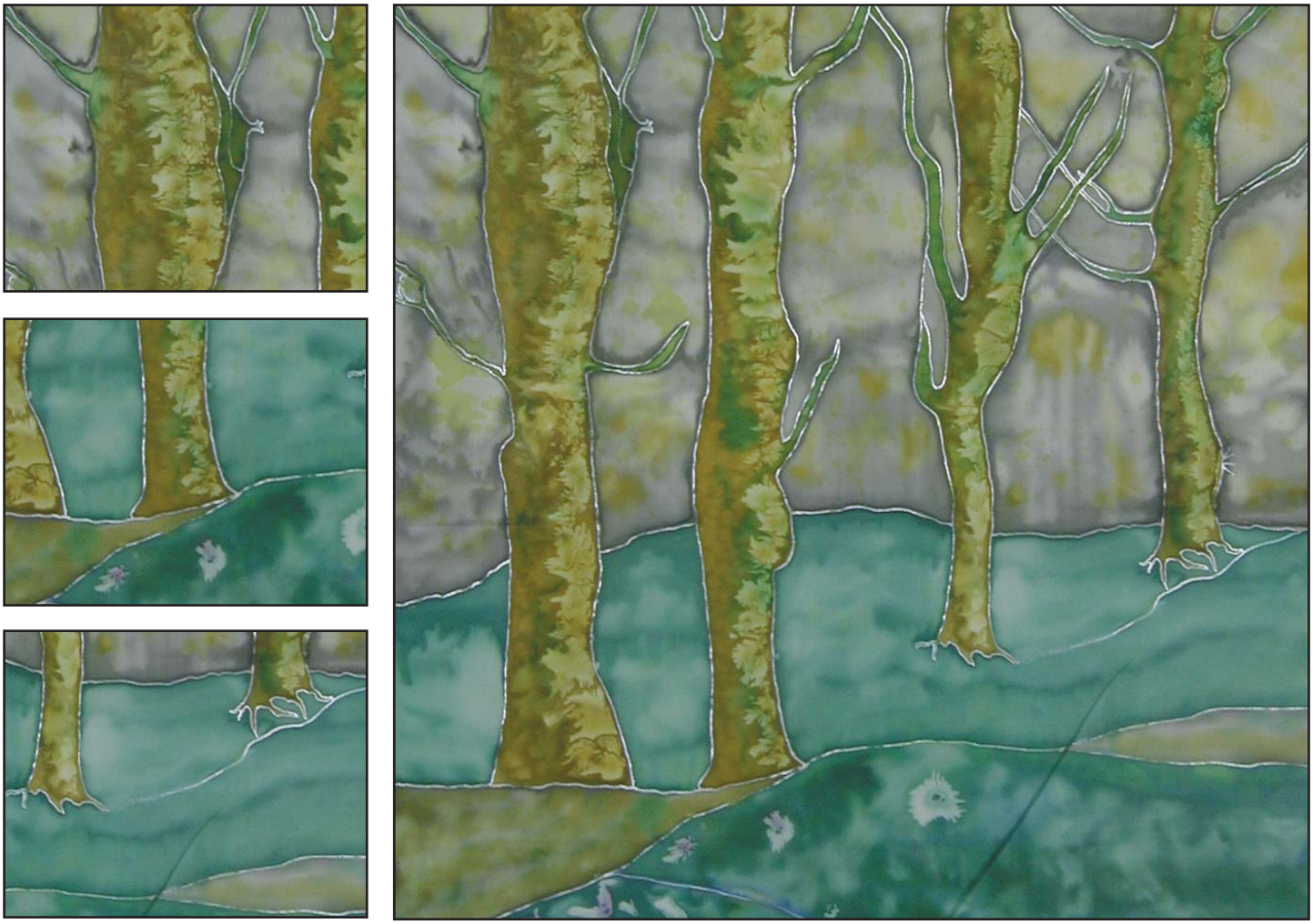
NHS

National Institute for Mental Health in England

Cases for Change

Hospital Services



mental health questions? **ask NIMHE**

Cases for Change

Mental health services in England are experiencing a period of unprecedented change. The pace of this change is potentially matched only by the pace at which information about both effective and less effective practice in mental health care is emerging. Over the past five years an incredible wealth of published literature has continued to remind all those engaged in developing mental health services of the reasons why fundamental change is necessary and of how services might be improved to better meet the needs of service users.

In addition to the evidence emerging from the research literature, it is important to recognise the role that publications appearing beyond the peer-reviewed journals have also had in informing the many cases for change that exist in adult mental health care today. These include publications reporting non-research based service reviews and the expert opinion of groups and organisations representing the interests of mental health service users, carers and professionals.

For those engaged daily in supporting change in local mental health services it can be difficult to feel well informed of the context of evidence and opinion within which current mental health policy has been established. With this in mind, in late 2001 the National Institute for Mental Health in England (NIMHE) commissioned a review of recent literature on adult mental health services with a view to producing an accessible summary of the emerging cases for change.

Cases for Change comprises ten booklets.

- **Introduction:** describes the background and methodology of the review and also summarises the findings and suggests areas for future research/policy development.
- **Policy Context:** describes the context of the review with an overview of recent mental health policy.

The following seven booklets each consider a different aspect of mental health service provision:

- **Primary Care**
- **Community Services**
- **Hospital Services**
- **Forensic Mental Health Services**
- **Partnership Working Across Health & Social Care**
- **User Involvement**
- **Anti-discriminatory Practice**
- **Emerging Areas of Service Provision:** reviews the literature that does not fit neatly into any of the previous topics.

The review collates evidence from over 650 documents published between January 1997 and February 2002 concerning adult mental health service delivery and/or policy in England. With the information collected synthesised into a number of key themes or issues, the review aims to describe how we got to where we are today and sets out the cases for change from the evidence base.

The articles highlighted at the beginning of each booklet as The Nature of the Evidence are those that are particularly relevant to the cases for change cited in the booklet concerned. Each document within the review has been classified using the "hierarchy of evidence" adopted in the *National Service Framework for Mental Health (NSF)* (Department of Health, 1999a):

- Type 1 evidence represents at least one good systematic review, including at least one randomised controlled trial.
- Type 2 evidence represents at least one good randomised controlled trial.
- Type 3 evidence represents at least one well-designed intervention study without randomisation.
- Type 4 evidence represents at least one well-designed observational study.
- Type 5 evidence represents expert opinion, including the opinion of services users and carers.

At the end of each of the main booklets, there are critical commentaries by service users and practitioners/managers/policy analysts from across England. These commentaries are intended to emphasise that different groups of people have different priorities and identify different cases for change. All contributors have been encouraged to be as challenging as possible and, where they disagree with interpretations, to say so.

Each booklet can be read independently or alongside one another to bring together a full picture of the development of mental health services. We hope this will be helpful in enhancing our understanding of the history as well as emphasising the need to develop future individual services within the context of an integrated system of care and support.

Cases for Change should be seen as a starting point and as a means to an end rather than an end in itself. By summarising the key issues that have emerged from the literature and by emphasising the diversity of opinion that exists within mental health services, Cases for Change may help to encourage debate about the best way forward and the way in which different view points can be balanced to achieve mutually beneficial outcomes.

Cases for Change has been written by a multi-disciplinary research team based at the University of Birmingham with the active support and encouragement of Susannah Rix at NIMHE Eastern, the guidance of the Expert Panel, and service users and practitioners who have provided written commentaries for the main sections of the review. Our thanks also to colleagues in the mental health group at the Department of Health for their editorial input to help finalise the publication.

The research team comprised:

- Jon Glasby, a qualified social worker and a lecturer at the Health Services Management Centre.
- Helen Lester, a GP, national primary care career scientist and Co-Director of the University of Birmingham's Interdisciplinary Centre for Mental Health.
- James Briscoe, a consultant psychiatrist and senior lecturer in the University of Birmingham's Department of Primary Care.
- Marion Clark, a former teacher who worked on this study as a user consultant.
- Steve Rose, Library and Information Services Manager at the Health Services Management Centre at the time of this review and now Health Care Libraries Manager, University of Oxford.
- Liz England, a clinical research fellow in the University of Birmingham's Department of Primary Care.

Four Seasons

These original artworks were designed and painted by a team at The Hollies in Ipswich, Suffolk. Working together the group generates ideas, energy and input. The community spirit engendered provides a platform that allows creativity to shine through. The group experience builds confidence and develops a sense of esteem. *"This kind of work may not cure our problems, but this is the first year I have not been admitted to hospital".*

The Hollies is a Social Enterprise developing meaningful work opportunities for people who have used mental health services. Social Enterprise can and does create real jobs. The pictures illustrate a theme of constant change and renewal in nature. They reflect the changes that can evolve through Social Enterprise and working together.

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The Nature of the Evidence

	Number of Articles
Type I	0
Type II	3
Type III	0
Type IV	16
Type V	18

Background

Going into hospital can often be traumatic at the best of times. Almost inevitably, people will be feeling unwell and may be worried about what will happen to them. Some may be concerned about the welfare of their family, friends and homes while they are away. Others may see hospital admission as a slippery slope into 'the system' and will be nervous about what contact with health and social care professionals may mean for them.

While in hospital, some people will dislike the environment they are in. They may feel disorientated by a new and unfamiliar setting or demoralised by their enforced inactivity. They may be frustrated that they cannot go home sooner, irritated by ward routines or anxious about what the future may hold. Some may also find it difficult to relax or to sleep as a result of the communal nature of many hospital wards and an environment which is often hot and noisy. They may also be concerned about their personal safety, privacy and dignity, and frightened by the behaviour of others.

On discharge, some people will be glad to be going home and relieved that they are well enough to leave hospital. For others, however, hospital discharge can be a step into the unknown and they may need time and support in order to regain their confidence. Some may feel that pressure on beds has forced them to leave hospital before they are ready and given them insufficient time for rehabilitation or to prepare for recovery. For people with ongoing needs, moreover, follow-up arrangements may not always materialise as hoped, leaving people to rely on family and friends.

For all these reasons, therefore, being admitted to hospital, staying in hospital and being discharged from hospital can be a difficult and uncomfortable experience for any one of us. In mental health, however, the process can be even more traumatic. As the Sainsbury Centre for Mental Health (1998a, p.9) observes:

"If and when people with severe mental health problems can no longer manage to live in the community… they, their relatives, and society expect care to be available in a therapeutic and humane place. In practice, this means admission to an acute psychiatric ward and inevitably losing some degree of freedom and privacy. Most people suffering from a severe mental illness will have been in hospital at some stage in their lives. A considerable proportion will have been admitted against their will under the Mental Health Act because they were judged to be a danger to themselves or others. At the point of admission people become patients, and will be in a severe state of crisis, both personally and mentally. Imagine being transported to a frightening unknown place, possibly in an ambulance or police car, while suffering from deep despair or confusion. It is unlikely that at any point in their life anyone could feel more vulnerable, and would be more in need of high quality and sensitive care."

Traditionally, services for people with mental health problems have been dominated by institutions, with many people being placed in long-stay hospitals or asylums. As discussed in the Policy booklet, however, this emphasis on institutional care was replaced in the second half of the twentieth century with a recognition of the need to care for more people in the community, either in their own homes or in community-based settings which are as homely as possible. As a result of this, the number of hospital beds for people with mental health problems has fallen considerably. Despite this, there are a number of key issues (see also figure 1):

- Hospital services still account for the vast majority of mental health expenditure.
- Falling bed numbers has been accompanied in an increase in admissions, resulting in shorter lengths of hospital stay.
- The threshold for admission to hospital is changing so that patients currently in hospital have greater needs than may once have been the case.

Cases for Change

In general, the documents reviewed in this booklet tend to focus on acute inpatient care in general and on three main areas of service provision in particular:

- Hospital admission.
- The hospital stay.
- Hospital discharge.

Figure 1 The Importance of Hospital Services

"Over the past 50 years the number of psychiatric inpatient beds in England has decreased greatly. The number has fallen from a peak of over 150,000 in England in 1955 to 42,000 in 1994-5. Despite the increase in community services, these beds still account for two thirds of expenditure on mental health services, and they remain an essential and large component of the range of services for severe mental health illness. Despite the fall in the overall bed numbers, the number of admissions a year has increased from 207,000 in 1984 to 237,000 in 1994-5, representing an increase in throughput per bed each year, from 2.6 to 5.7."

(Ford et al., 1998, p.1279)

"Many recent studies have highlighted the enormous pressures currently facing acute psychiatric wards. There has been a dramatic decline in hospital beds for mental health care since their peak at 155,000 in the mid-1950s. The number of available beds in NHS hospitals has more than halved in the last decade or so to around 37,000… At the same time demand has been rising. Throughput in mental health beds has more than doubled… Referrals of patients appear to be rising while at the same time the severity of problems of people treated in hospital has also increased… [Thus], studies have reported increasing numbers of patients on wards with drug or alcohol abuse problems, people referred by court diversion schemes (aimed at keeping mentally ill people out of the prison system) and people needing accommodation in low or medium secure units."

(Sainsbury Centre for Mental Health, 1998a, p.10)

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Hospital admission:

Hardly surprisingly, one of the main results of the decline in the number of psychiatric beds and rising demand has been a significant increase in pressure on hospital services. Indeed, a consistent theme throughout many of the sources reviewed in this study is the alarmingly high occupancy rate of mental health beds, which frequently exceeds 100 per cent (see figure 2). To cope with such demand, hospitals are forced to maintain waiting lists, to send some patients home on leave in order to free up beds for others and to transfer patients to hospitals outside the local area (a practice traditionally known as extra-contractual referrals or ECR, sometimes referred to as Out of Area Transfers or Individual Patient Placements). Thus in inner London in January 1999, there were 241 patients on leave (123 of these with an urgent need for a hospital bed) and 80 people in ECR beds, with a further 88 people in other types of bed, at home/in the community or in prison/police cells (Audini et al., 1999). Clearly, the implications of such pressure on beds can be extremely serious. For example:

- Quality of care can be compromised by admitting patients to hospitals at a long distance from their homes, discharging or sending people on leave early and not admitting other patients.
- The use of ECRs is not only unpopular with service users, but is also very costly, diverts money away from community services and disrupts continuity of care.
- Sending people out on leave can also can create significant administrative difficulties for hospital wards as patients can sometimes return at any time, making it difficult to use temporarily vacant beds for other people requiring admission.

Against this background, a worrying finding emerges from Green's (1999) study of 336 emergency referrals to an Essex mental health trust, which suggests that patients assessed as presenting a risk to the public are no more likely to be admitted to hospital than those presenting no risk. In seeking to explain this situation, focus groups with local clinicians suggested that ward staff were sometimes reluctant to admit aggressive patients (for fear of their own safety) and people with personality disorders or those who misuse substances (as staff felt that they could not offer effective treatment to these people). Above all, however, the research noted that if all patients deemed to be a risk to the public were admitted to hospital, there would not be enough beds.

Despite immense pressure on existing beds, the answer may not necessarily lie in expanding hospital services. This is the result of a number of factors:

- Occupancy rates are not uniform throughout the country, and the evidence suggests that pressures are particularly strong in the south of England (especially London) and in inner-city areas (see, for example, Audini et al., 1999; Greengross et al., 2000; Shepherd et al., 1997). As a result, it may be that local agencies may need to reassess the level of their provision with a view to increasing bed availability in some areas, but not in others.
- There is evidence to suggest that some admissions to hospital may be inappropriate. In North Cheshire, for example, 35 out of 520 people were admitted to hospital as a result of social problems (Cawley et al., 1997), while national research undertaken by the Sainsbury Centre for Mental Health (1998a) found that one in ten people were admitted for social reasons or for respite care. Elsewhere, a systematic review of the appropriateness of acute bed use cites two studies – both published prior to 1997 – which

Figure 2 Bed Occupancy

In Dewsbury, two adult mental health wards often have bed occupancy rates exceeding 120 per cent (Auckland et al., 2000).

Regular surveys of 13 inner London psychiatric trusts undertaken by the Royal College of Psychiatrists have found that average occupancy rates have always been above 100 per cent during each of the seven censuses conducted between 1994 and 1999 (Audini et al., 1999). Crucially, the study distinguishes between three different ways of calculating occupancy rates:

- 'True' occupancy – all people registered as inpatients plus those awaiting admission. In January 1999, this rate was 128 per cent.
- 'Ward' occupancy – the total number registered as inpatients. In January 1999, this rate was 112 per cent.
- 'Minimum' occupancy – people registered as inpatients minus those on leave who were thought not to need a bed kept available, plus those for whom a bed is required but who are placed elsewhere because no acute bed is available locally. In January 1999, this rate was 112 per cent.

As a result, the researchers conclude that "between 1994 and 1999 there were consistently more patients requiring acute inpatient care than there were beds available. This leads to poor quality care and is not cost effective" (p.593). To reduce bed occupancy rates to a more manageable level of 85 per cent, the authors calculate that a further 14 beds or community alternatives will be required per 100,000 population.

A 'national visit' carried out by the Mental Health Act Commission to 199 adult psychiatric inpatient units in England and Wales found that occupancy rates were 86 per cent if patients on overnight leave were excluded, but rose to 99% when such patients were included (Ford et al., 1998).

A national survey of 173 mental health trusts found that around 70 per cent are often or sometimes over-occupied and that just under 40 per cent often or sometimes have to use ECRs (Greengross et al., 2000).

Bed occupancy in a study of 11 different sites across England ranged from 73 to 136 per cent (Higgins et al., 1999). Nine sites reported occupancies above 85 per cent, with five having occupancies of 100 per cent or more.

A Social Services Inspecorate report found high levels of occupancy of inpatient beds, particularly in London, and high levels of demand from people who have a mental health problem and misuse substances (Watson, 2001).

suggested that just under one-third of admissions may be inappropriate (quoted in McDonagh et al., 2000). Key factors contributing to inappropriate admissions may include inadequate assessments undertaken by junior and non-specialist staff in A&E and general wards, inadequate community services and a lack of alternatives to hospital out of normal office hours (Auckland et al., 2000; Minghella and Ford, 1997). Other patients may experience what is often described as 'revolving door' admissions to hospital (repeated admissions due to breakdowns in community services or as a result of services treating outward symptoms of mental illness rather than tackling the underlying causes) (see also figure 3). Taken altogether, findings such as these suggest that it may be possible to reduce the number of hospital admissions by making more accurate initial assessments of people's needs and by developing community-based alternatives to inpatient care.

Figure 3 Revolving Door Admissions and Breakdowns in Community Services

In one London health authority, researchers studied the process of care for a sample of 100 consecutive discharges from acute wards in two mental health trusts (Minghella and Ford, 1997). Overall, three-quarters of the sample had been in hospital before and many were readmitted after the research was completed. Despite this, around half did not have a recorded care package or had a package which broke down prior to admission. Elsewhere, a national study of acute care found that (Sainsbury Centre for Mental Health, 1998a, p.16):

"89 per cent of admission [in the study] were classified as emergencies. However, 40 per cent of the patients had previously been admitted to the same service in the last 12 months, 20 per cent within the last 90 days and 13 per cent within the last six weeks, confirming the so-called 'revolving door' of mental health care. This high rate of people returning to acute care in a crisis indicates the difficulties community services experience in preventing admission or finding alternative forms of care for people with mental health problems."

Hospital stays:

Once in hospital, some people will receive high quality services that meet their needs. Despite this, the documents contained in this review suggest that some service users may have extremely negative experiences of hospital services. In 2000, for example, a national survey of 343 people with experience of hospital services carried out by Mind revealed a series of extremely worrying findings (Baker, 2000, p.6):

- More than half (56%) of patients said that the ward was an un-therapeutic environment, more than double those who said it was therapeutic (25%).
- Just under half (45%) said that ward conditions had a negative effect on their mental health. Only just over a quarter (27%) said it had a positive effect.
- Just under half (45%) said they found the atmosphere on wards 'depressing' and bleak.
- Almost a third (30%) of patients said that they found the atmosphere on wards unsafe and frightening.
- Just under a third (30%) said illegal drugs were being used on the wards. Two thirds of these patients (66%) said that drugs were easily available to patients.
- Almost two thirds (64%) of patients who needed an interpreter did not get one.
- More than half (57%) said they didn't have enough contact with staff. Only 35% said they did.
- The vast majority (82%) of patients who said they didn't have enough contact with staff said that they spent 15 minutes or less with staff each day.
- Almost 1 in 6 (16%) of patients said they had experienced sexual harassment on the ward, and 72% of those patients who complained said that no action was taken to prevent it happening again.
- Almost two thirds (60%) of patients had problems getting a restful nights sleep.
- Just under half (45%) of patients said they didn't have enough access to food, and 31% said they didn't have enough access to drinks.
- A quarter (26%) of patients said the toilets weren't clean.

Overall, the research concluded that "the survey paints a grim picture of life on many psychiatric wards – a depressing environment, unsafe, dirty, with illegal drugs easily available, minimal contact with staff, not enough to do and not enough access to food, drink, bathing facilities, interpreters if needed, telephones and fresh air" (Baker, 2000, p.31). Unfortunately, many of these findings are mirrored in other studies, suggesting that they may not be unique to the Mind survey. Thus, the Social Services Inspectorate suggests that users often experience inpatient wards as stressful rather than therapeutic environments (Watson, 2001), while social work trainees in Merseyside observing psychiatric wards are very critical of the quality of care provided (see figure 4). Similarly, Goodwin et al's (1999) analysis of the views of 110 inpatient mental health service users identifies a number of key criticisms, including inadequate buildings, poor food, insufficient access to telephones, a lack of control, a lack of respect showed by staff to patients and a lack of information:

"X ward was very dull and in need of redecoration – when I first entered the ward it gave me the feeling I wanted to turn back and go home. Not a homely feeling but a cold feeling, I couldn't relax. I felt more depressed going into hospital."

"I don't think I have much influence. I will tell them how I feel but I don't expect they will pay me much attention."

"The ward staff are very helpful if they've got the time but, like all hospitals, they haven't always got the time to sit and talk and listen and when you're mentally ill that's what you want."

"The gentleman I'm under goes in for telling you rather than asking you. I can't ask him questions. He doesn't put you at ease."

"The staff don't help you. They just sit around talking and eating and drinking and smoking. I wish the staff would talk to me more. They hear me crying and don't help me." (Goodwin et al., 1999, pp.45, 47, 48, 50)

Other recurring issues from the literature include:

- High levels of staff vacancies and the use of workers employed on a casual basis (Ford et al., 1998).
- Staff dissatisfaction with rapidly increasing administrative duties and reduced contact with patients (Higgins et al., 1999).
- Widespread boredom amongst patients (Warner et al., 2000).

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- Disempowering regimes that promote a culture of infantilisation (Barnes et al., 2000; see also the User Involvement booklet).
- The difficulty of maintaining a therapeutic environment as a result of pressure on beds and an increase in the severity of patients' needs (Higgins et al., 1999).
- Insufficient contact with staff other than doctors and nurses and a lack of involvement from community services (Sainsbury Centre for Mental Health, 1998a).
- A lack of meaningful interaction between staff and patients (Mac Gabhann, 2000).
- A lack of information for users and carers (Watson, 2001).
- The difficulty of reconciling the needs of smokers and non-smokers (Goodwin et al., 1999).

Hospital discharge:

From the wider literature, we know that arranging timely and effective hospital discharges can be a particularly problematic area of practice (see, for example, Glasby, forthcoming; Tierney et al., 1994). In particular, key problems can include:

- Poor communication between hospital and community.
- Lack of assessment and planning for discharge.
- Inadequate notice of discharge.
- Inadequate consultation with patients and their carers.
- Over-reliance on informal support.
- Lack of (or slow) statutory service provision.
- Premature discharges in some cases and delayed hospital discharges in others.

Although hospital discharge is often only discussed in relation to user groups such as older people, there is some evidence to suggest that similar issues may also arise in mental health services. In 1999, for example, a Department of Health funded study of acute psychiatric nursing care found that the pressure on beds meant that patients were discharged from hospital before they had sufficiently recovered and were often quickly readmitted after their community services broke down (Higgins et al., 1999). At the same time, research by the Sainsbury Centre for Mental Health (1998a) indicates that discharge arrangements were often dealt with in an ad hoc way during ward rounds, with only one-third of patients receiving a formal or separate meeting to plan for leaving hospital. Most patients had very little notice of their discharge and had little involvement in discussions about their futures. Involvement from carers and community staff was also limited:

"Discharge is often unplanned with inadequate involvement of community staff, patients and carers. Use of the Care Programme Approach (CPA) is variable and is often resented by staff. Only 34 per cent of patients had a discharge planning meeting and most patients had no idea that they were to be discharged until a few days before they left, and had little involvement in discussions about their future."
(Sainsbury Centre for Mental Health, 1998a, p. 6)

Although some patients may be discharged from hospital prematurely, others may remain in hospital much longer than they need to because of a lack of community services. In 1999, a review of alternatives to acute psychiatric beds found that between 20 and 60 per cent of patients could be better placed (although the latter figure was produced by a study outside the UK) (Bartlett et al., 1999). The following year, a systematic review of the appropriateness of acute bed usage found that between 24 and 58 per cent of days of care were not considered appropriate (McDonagh et al., 2000). In both studies, key factors contributing to delayed discharges were found to include a lack of housing, a lack of community services (such as group homes), a lack of rehabilitation services and, in a small number of cases, the need for higher levels of care. Similar findings have also been produced by a range of other commentators, suggesting that a substantial number of people would be able to leave hospital if community alternatives were more readily available (see figure 5).

Overall, what is most surprising about the literature on hospital services is the relatively low number of documents which address this topic. In comparison to other areas of this review, the hospital chapter contains only a fraction of the material devoted to topics such as primary care or community services. This is highlighted by a number of the commentators cited above, who emphasise two key factors:

- The relative neglect of hospital services is a product of the current emphasis on community care.
- More research needs to be undertaken in order to improve our understanding of the issues at stake in this important area of policy and practice:

"In recent years, political and managerial attention has focused predominantly on the consequences of the failure of National Health Service community services to provide effective care to people with severe mental illness in the United Kingdom (leading sometimes to homicides committed by persons suffering severe mental illness such as Christopher Clunis and Andrew Robinson). However, what happens inside hospitals has received less scrutiny. Not since the reports and inquiries of the 1960s and early 1970s into the poor standards of nursing care provided in some long-stay psychiatric hospitals has hospital care been under the spotlight."
(Higgins et al., 1999, p.52)

"The combination of increasingly pressured acute wards and high levels of casual staffing cannot be good for the care of patients. These problems are most severe in London, where patients have more severe problems… The policy, managerial, and training focus has been on developing community services. This has resulted in a relative neglect of inpatient settings. [This study] has shown that attention must be given to inpatient wards, which are an essential and major element of mental health care."
(Ford et al., 1998, p.1823)

"There is scant evidence about the effectiveness and quality of care of acute wards in dealing with people with psychiatric problems. Relatively little is known about exactly who are the people who stay on acute psychiatric wards and what happens to them while they are there. There is a sense that hospital care is a black box, with people entering and leaving, and we have high but vague expectations about what happens in between. The issue about quality and effectiveness of care is crucial, however, not least because acute inpatient treatment is the most intensive and expensive form of mental healthcare – but also because patients on acute wards have to sacrifice both privacy and freedom during their stay. Moreover, they are unpopular with many of these patients. It is crucial, therefore, that hospital stays are used to best advantage, treating the patients who need and benefit most from this regime and for the shortest necessary time."
(Sainsbury Centre for Mental Health, 1998a, p.11)

Figure 4 Users' Experiences of Hospital

Users in a SSI inspection had a negative experience of hospital services due to (Watson, 2001, p.14):

- Delays in admission caused by limited bed availability.
- Shortage of beds leading to patients sleeping on other wards and having no personal space.
- Women service users having insufficient privacy on mixed sex-wards.
- Users from minority ethnic backgrounds who spoke to no-one with knowledge of their language, religion or culture during their in-patient stay.
- The disruptive behaviour of other patients which sometimes led to the police being called, for example, to search for illicit drugs.
- Lack of daytime occupation, boredom and no access to quiet area.

In Merseyside, social work students observing local psychiatric wards highlighted the following issues (Walton, 2000):

- Institutional aimlessness: patients are often bored, do little other than watch TV and are regularly moved round by cleaning staff. Ward routines have become ends in themselves and the physical atmosphere is debilitating. The limited activities on offer are seen as being very patronising, but users take part to try to demonstrate that their mental health has improved and secure an early discharge.
- Poor staff-patient relationships: Most staff time is spent on administrative tasks, talking to each other in the office and watching patients rather than engaging with them.
- Narrow approaches to mental health: Staff see patients as being 'ill' and pay little attention to users' social backgrounds. As a result, the presenting problem is often seen as the issue to be addressed with no consideration of the factors that may have caused this problem in the first place. There is an almost total reliance on psychiatric drugs as the solution to mental health problems.
- Indifference to civil and human rights: Staff tend to treat all patients the same way irrespective of whether or not they have been admitted as compulsory patients. Some people have little knowledge of the law and have had no training at all in this area. Ward routines are very rigid and some are unnecessarily stressful (such as denying people drinks outside set times even though dry mouths are a common side-effect of medication or the oppressive nature of ward rounds, with patients unable to contribute due to the large number of professionals that come to see them).

Negative experiences have also been identified by the Sainsbury Centre for Mental Health (1998a, p.35):

"A total of 112 patients were interviewed at or around the time of discharge about aspects of the care and environment on their ward… More than half (55 per cent) had no separate bedroom. Nearly three-quarters (71 per cent) did not have a secure locker for their belongings. Nearly half (47 per cent) had no quiet area where they could take visitors. 20 per cent felt washing facilities were not private. There were also concerns about hygiene – 22 per cent were unhappy at the cleanliness of the ward – and food – 28 per cent did not like the food while 37 per cent did not judge mealtimes to be pleasant and enjoyable. Most worryingly, nearly a third (32 per cent) did not feel safe on the wards."

Despite these findings, service users can be very clear about what they want from hospital services. As an example, Mac Gabhann's (2000) study of patients' views suggests that service users value:

- Support and understanding.
- Being able to talk and be listened to.
- Being away from home pressures.
- A sense of safety/sanctuary.
- Freedom and choice.
- Feeling part of a friendly community.

To achieve these goals, patients wanted nurses to be more flexible to individual needs, to respect and invest in relationships and to spend more time with patients.

Figure 5 Delayed Hospital Discharges

Study	Delayed discharges	Causes/Possible Alternatives
Fulop et al (1992)	37%	Lack of accommodation and long-stay hospital care.
Lelliot et al (1994)	61%	Lack of continuing care provision, rehab, supported group homes or low-staffed hostels.
Fulop et al (1996)	23%	Professional support in the patient's home, housing/more appropriate housing, group homes, rehabilitation.
Koffman et al (1996)	24%	Residential/nursing home care, total dependency psychiatric care, community services (e.g. day/home care), housing.
Connolly and Ritchie (1997)	54% in '94 46% in '95	Not reported - NB Delayed discharge figures relate to patients whose admission lasted 3 months or more.
Minghella and Ford (1997)	26%	Problems finding suitable accommodation (including forensic care).
Shepherd et al (1997)	27%	Lack of supported housing, lack of rehab services, need for secure accommodation and need for specialist services.
Sainsbury Centre for Mental Health (1998a)	19% (after 1 week)	Lack of accommodation, lack of home-based support lack of rehab services, patient required higher levels of supervision.

In seeking to respond to the many issues raised above, the literature implies that there are few 'easy answers' and that the way forward may lie in taking a whole systems approach that considers the full range of mental health services (see, for example, Lee and Bradley, 2000; Minghella and Ford, 1997; Shepherd et al., 1997). Many of the problems of over-occupancy, poor quality acute care and delayed discharges cannot be resolved in isolation, but require concerted action across the full range of available services (see figure 6). Ultimately, as Higgins et al (1999, p.61) observe:

"Without close examination of what is happening in hospitals… and without suitable remedial action, it is conceivable that hospital care might once again be subject to the scrutiny and criticism that cast a shadow over psychiatric services in the 1960s and 1970s. Nurses and other mental health professionals need to work together to prevent such circumstances arising and to develop the full spectrum of services required in each locality."

Further Information

For people wishing to explore some of these issues in more depth, the following sources provide a useful starting point:

- The Sainsbury Centre for Mental Health outlines a template for evaluating inpatient services and provides an example of the findings which such an approach can produce (Warner et al., 2000).
- Watson's (2001) inspection of compulsory mental health admissions for the Social Services Inspectorate sets out a series of standards around responsive services, assessment and admissions, care planning and care management, inter-agency collaboration, anti-discriminatory practice, staff development and training, and organisation and management. The final report is also accompanied by a short leaflet outlining key themes from the inspection and providing good practice guidance.
- A Royal College of Psychiatrists (1998) Working Party has produced a series of recommendations about the size, staffing, structure, siting and security of new acute adult psychiatric inpatient units.
- The Sainsbury Centre for Mental Health's Acute Solutions Project was launched in November 2001 in partnership with the Department of Health, the Royal College of Psychiatrists, the Royal College of Nursing and the NHS Confederation. The aim is to develop a generalisable model of care that users experience as both safe and therapeutic, and where staff strengthen their skills and experience and have improved morale. Further information is available via the Sainsbury Centre for Mental Health website (www.scmh.org.uk).
- Recent Department of Health policy guidance on adult acute inpatient care provision (Department of Health, 2002e) can be downloaded from www.doh.gov.uk/mentalhealth. This guidance augments existing National Plan and NSF guidance and is a supplement to the *Mental Health Policy Implementation Guide*. It aims to encourage and assist a reorganisation of inpatient services for people who are acutely ill, including the provision of a safe, structured and therapeutic inpatient experience, the development of effective service user centred decision-making processes and ward arrangements and to ensure adequate clinical and support inputs to maximise the time spent by staff therapeutically engaged with service users. Local Acute Care Forums in each Trust will identify the strengths and weaknesses of current

local arrangements, stimulate appropriate action and sustain a momentum of change.

Above all, however, user-centred accounts of hospital services give a clear indication of users' priorities for change and provide very powerful and graphic descriptions of people's experiences as inpatients. Examples include the Sainsbury Centre for Mental Health's (1998a) Acute Problems report, Mind's national survey of patient's views (Baker, 2000) and Goodwin et al's (1999) qualitative analysis of the experiences of inpatient mental health service users. Also very revealing is Walton's (2000) study of the experiences of trainee social workers, many of whom appear to have been shocked by the "bleak" nature of local psychiatric wards (p.77).

Critical Commentary

In my attempt to write a critical comment about this chapter, I find that nothing I have read shocks or surprises me. Set against the backdrop of current national and local policy initiatives, and the increased drive to involve people who use services in planning, design and delivery, we really have to question why the services individuals experience at the current time is still as appalling as they are. Inherently, we also have to recognise that the people who provide the mental health services - who are under considerable pressure to meet policy criteria - are as undervalued by the system as their clients. As I have not only used mental health mental health services, including admissions to hospital, but have also worked in them for the past 10 years as an academic and professional, I can only express with hindsight the numbing, hostile and cold environment I found myself in during those times. The initial assessments made about me, in isolation to the people who love and care about me, excluded a valuable and sustainable resource that should have enhanced and worked in partnership with service providers towards my recovery.

In my capacity as project manager with Mind I introduced the concept of self-assessment into the mental health arena - you can probably imagine that 8 years ago this was received with much cynicism. However, grounded in that project work and in light of the current standards within the NSF for mental health, the language of person centredness and recovery are becoming more and more frequently used. In order to address the problematic provision of acute services we need to adopt a recovery based, whole systems approach that is built on respect, responsibility and the rights of all the stakeholders. Until we make this fundamental paradigm shift towards a culture that nurtures and values not only the people who use the mental health services but the people that provide them, we will not redress the balance or come anywhere near to meaningful opportunities for all people.

Alison Cox, Director, Keepwell Ltd

Critical Commentary

The concerns in relation to inpatient care are now numerous and well documented. The chapter draws upon a number of significant studies in relation to the aforementioned using the service users' "pathway" as an overall structure. In order to make the case for change the chapter concentrates on a number of studies which are critical of service provision within mental health services, and although they are relatively contemporary they do pre-date important developments in relation to improving the experience of service users and professionals, albeit such change is being driven and informed by several of the studies quoted within the chapter. As an example, the development of crisis intervention and assertive outreach teams are already making a significant positive impact upon occupancy levels and discharge arrangements. This process has been augmented by the recent implementation of care co-ordination which rightly places a greater emphasis on the involvement of the service user and their carers throughout the whole of the service users contact with both inpatient and community services.

The mental health collaborative project (commissioned by Trent and Northern & Yorkshire NHS executive offices and the Northern Centre for Mental Health) has been running for some fifteen months in number of pilot sites within these regions. The initial feedback and audit from the project has been encouraging and has demonstrated that improved inpatient services can be achieved and has not necessarily involved significant increases in available resources.

The chapter does outline a significant need to improve services and make inpatient stays feel safe and beneficial to the service user. Although there are "green shoots" to be observed, the inpatient experience needs to be significantly improved consistently and across the board if it is to eliminate the deficiencies outlined within the chapter.

Ron Weddle RMN, Nurse manager, Newcastle upon Tyne

Figure 6 The Need for a Whole-systems Approach

"In the short-term, better bed management at every stage – at admission, throughout the patient's stay and at discharge – can relieve some of the pressures [on hospital services]. To solve the problems of over-occupancy and costly delayed discharges in the longer term, a range of care options, with several… alternatives for different levels of need and different kinds of problems, must be considered. Acute inpatient care should be viewed as one component of such a spectrum, operating a specific, well-defined function – that is to provide intensive 24-hour care for those patients whose needs for intensive assessment, immediate treatment and stabilisation of symptoms."

(Moore and Wolf, 1999, p.22)

"More important than beds is the total range and quality of services. Inpatient services and community services must be provided together to meet people's needs. The quality of clinical decision-making helps people access appropriate services. We may need more beds, especially in the hardest-pressed inner city areas. But we also need more community mental health services, and to invest in a comprehensive range of inpatient and community services that work together in flexible and integrated ways."

(Lee and Bradley, 2000, p.31)

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