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Acute in-patient psychiatry: how patients spend their time on acute psychiatric wards[†]

AIMS AND METHOD

We observed levels of social interaction and activity among in-patients on 16 acute psychiatric wards in 6 hospitals in a large mental health trust. Each ward was observed for 1 week and attendance at organised activities was audited over 3-week periods.

RESULTS

At any time during the day 84% of in-patients were socially disengaged and mainly inactive. On average only 4% of in-patients' time was spent in an organised group activity, with many in-patients opting out altogether. Provision and take-up of group activity programmes varied widely between wards.

CLINICAL IMPLICATIONS

Provision of organised activity needs to be a higher priority in acute services, and there should be national and local standards for what should be provided. Concerted organisational strategies and assertive approaches by staff are needed to engage in-patients in group activity programmes.

A number of reports (Sundram, 1987; Department of Health, 2002; Sainsbury Centre for Mental Health, 2002) emphasise that people with mental health problems who are admitted to hospital do not have enough to do, and patients routinely show dissatisfaction with the activities they can undertake (Sainsbury Centre for Mental Health, 1998). There is some evidence that wards with more social interaction are associated with better clinical outcome (Collins *et al*, 1985). However, owing to staff ratios of typically one nurse to four or five patients and the numerous other demands on nurses' time, one-to-one interactions with staff form a small part of each patient's day. Group programmes are a practical means of ensuring that patients have something purposeful to do, with many benefits including reducing stress and isolation, and learning new skills (Yalom, 1983). Such programmes have traditionally been the province of occupational therapy, but recent years have seen occupational therapists focusing more on individual work. This has left a gap in provision on many wards, filled, if at all, by an uncoordinated and sparse range of activities.

Advisory reports (for example Department of Health, 2002) suggest that social, recreational and occupational therapies and activities should be provided based on the assessment of need, but do not specify what or how much. In effect therapeutic activity programmes are a recommended but not required aspect of treatment. Treatment by default is often limited to being in hospital, receiving medication and reintegration back into the community.

There are many problems associated with engaging patients in treatment programmes, for example the

increased emphasis on patients' rights makes staff reluctant to insist on participation. Also, an increasing proportion of in-patients are compulsorily detained and they may be especially reluctant to engage (Sainsbury Centre for Mental Health, 1998). Further difficulties result from the highly diverse patient population and high turnover, and the lack of evidence as to what constitutes therapeutic activities. Finally, the changing nature of acute care has led to resources being targeted on the community.

The Department of Health (2002) recommends that in-patient services establish acute care forums, and these should establish benchmarks for the allocation of resources, use and practice in each ward. Furthermore, each commissioning body should carry out an annual review of its acute care services informed by such benchmarks.

In this study we observed the amount of time in-patients spent engaged in informal social interaction and organised activities.

Method

This study included all 16 adult acute locality wards in 6 hospitals in a large inner city mental health trust. Each ward was observed during a 5-day week, Monday to Friday, 9 am to 5 pm excluding lunchtimes, and 3 observations were made per day, each taking approximately 10 min; timings of each visit were randomly determined by drawing cards with 15-min time-slots from a hat for each day. The observer followed a set route and placed

[†]This is one of a series of papers on acute in-patient services.

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each patient's behaviour in one of 10 categories in an observational schedule (see Table 1). Reliability was found to be good during piloting, with intraclass coefficients of between 0.6 and 0.93 for two observers carrying out simultaneous observations. Bed occupancy rates were not known, and patients off the ward at the time of each observation were not included. Across 16 wards, 4103 individual in-patient observations were made, equating to an average of 17 in-patients per ward visit. The same in-patients were not necessarily seen on each ward observation during the week, given the high turnover of patients in the acute setting and some off the ward on leave at different times. The numbers of patients attending each organised activity on each ward was audited for a 3-week period using attendance registers. A more detailed audit of individual in-patients' attendance at activities over 3 weeks was carried out for 3 of the wards.

Results

Across 16 wards, at any one time 84% of in-patients were socially disengaged, either alone in their bedroom (46%), walking or sitting in a communal area, predominantly passive (34%), or engaged in self-care such as washing or making tea (4%). The remaining 16% were interacting informally or engaged in an organised activity (Table 1). This picture of social disengagement was remarkably consistent across the 6 hospitals ($\chi^2=1.42$, d.f.=5, $P=0.92$). A logistic regression analysis showed significant differences between wards within hospitals for 3 out of the 5 hospitals that had more than one ward ($\chi^2=5.46$, d.f.=1, $P=0.0195$; $\chi^2=6.13$, d.f.=1, $P=0.013$; $\chi^2=40.6$, d.f.=4, $P<0.0001$). The highest and lowest levels of social disengagement across the trust were for wards in the same hospital (91% and 75%).

Across the 16 wards, in-patients spent 4.1% (range 1.9–7.5%) of the 35-hour week attending organised activities; this equates to about 90 min per week. The number of activities provided varied between wards, with an average of 10.4 activities provided per week (range 4–14). A more detailed audit of 3 wards showed that 29% of in-patients attended no group activities during each week, 25% attended an average of one, 19% attended two, and 27% attended three or more groups per week.

In order to analyse range and type of group activity, these were grouped into six categories (see Box 1). The mean number of organised activities across all the wards were as follows: for talking, 1.8; non-verbal therapies, 0.9; creative/expressive, 2.9; skills/information, 1.5; physical/relaxation, 2.3; and recreational, 1.1. The range of provision varied, for example, some wards had no non-verbal therapy such as art therapy but had art activities run by nurses, whereas for others the reverse was true (Table 2). All 16 wards had weekly meetings open to all in-patients, but these were often poorly attended. Only 5 wards had any other type of smaller talking group. Although all the wards had access to gyms, these were typically used by two or three in-patients once or twice a week.

Table 1. Proportions of patients observed in different activities

	%
Patients socially engaged (n=656)	
Interaction with staff	4
Interaction with others	7
Negative interaction	1
Receiving care	1
Interaction in bedroom	1
Organised activity	2
Patients socially disengaged (n=3447)	
Standing/walking	12
Alone in bedroom	46
Self-care	4
Sitting socially disengaged	22

Box 1. Activity types

Talking groups	Ward community meeting, psychodynamic discussion group, depression management, anxiety management, coping with psychosis, hearing voices, substance misuse, pre-discharge groups
Non-verbal therapies	Music therapy, art therapy, drama therapy
Creative/expressive	Art and craft, woodwork, pottery, creative writing
Skills/information	Cooking, careers advice, local college education advice, outings to local resources for example mental health community resource centres
Physical/relaxation	Aerobics, gym, yoga, walking group, relaxation, meditation
Recreational	Videos, table tennis, pool competitions, table football, music appreciation, leisure outings

Discussion

The overall picture was that in-patients were socially disengaged most of the time and engaged in few organised group activities. Levels of social disengagement were strikingly similar between hospitals, although there were differences between wards in the same hospital. There was marked variation in organised activity provision between wards, including those in the same hospital, with some programmes having twice the in-patient engagement rates as others, as well as variation in the types of group activities provided. These findings are consistent with patient surveys which show that patients say they are bored and have little to do.

A range of factors determine levels of social interaction, including in-patient factors, ward atmosphere, ethos and culture, management style, organisation and staff mix. Wards that are run more efficiently are likely to have more and higher quality interactions taking place. However, organised activities are the most direct way of increasing interaction and purposeful activity. The findings suggest an absence of a consensus about what and how



Table 2. Number and types of organised activities

Ward ¹	Talking <i>n</i>	Non-verbal therapy <i>n</i>	Creative/ expressive <i>n</i>	Skills/ information <i>n</i>	Physical/ relaxation <i>n</i>	Recreation <i>n</i>	All <i>n</i>
1	2	1	0	0	2	0	5
2	1	1	1	0	1	0	4
3	2	1	3	1	2	0	9
4	1	3	0	0	2	0	6
5	5	3	0	0	3	0	11
6	3	2	1	3	4	2	15
7	5	0	4	0	2	1	12
8	1	0	4	2	3	2	12
9	1	0	2	2	0	2	7
10	2	0	7	2	2	1	14
11	1	0	1	3	2	4	11
12	1	1	5	3	3	0	13
13	1	1	5	1	2	0	10
14	0	1	5	3	1	0	10
15	1	0	4	2	4	3	14
16	2	0	4	2	4	2	14

1. Wards within same hospitals indicated by braces.

much activity should be provided, and often limited resourcing.

An important question is whether it matters if in-patients are largely inactive and socially disengaged. Measuring the association between activity levels and satisfaction or clinical outcome was beyond the scope of this study, which also focused on the amount of interaction and not its nature or quality. Arguably it is the quality of relationships that matters to patients, and a small number of highly significant interactions may be more important than the amount of time spent interacting. However, wards with more active patients seem to be associated with better therapeutic outcome (Collins *et al*, 1985) and numerous reports, including that from the Department of Health (2002), cite the advantages of organised activities and the deleterious impact of inactivity.

In terms of methodology, our observational sampling periods might have been unrepresentative, but the randomisation and large sample should have militated against this. One limitation was the focus on the Monday to Friday, 9 am to 5 pm working day. Some wards provide activities at evenings and weekends, however weekdays were considered the core period. Our method ensured that we measured those organised activities that actually happened rather than just those that were timetabled to take place. Because of the large number of different people providing group activities, great efforts were taken to ensure that all the activities that took place were included, but some may have been missed. Also we could not vouch with certainty that activity leaders were accurately completing attendance registers; short of sitting in on groups it would be difficult to achieve greater certainty in this regard.

When planning therapeutic activities programmes, clearly the needs of patients with different mental health problems and levels of functioning should be taken into

account, as well as a balance between normalising social activities and more specialised activities. Patients should have the opportunity to participate in an activity at least once a day and preferably morning and afternoon. A key problem is the difficulty in persuading them to attend; well-balanced high-quality group programmes do not automatically lead to high attendance. A minority of patients are too unwell to engage in formal activities at times during their stay, and others are often demoralised and resentful about being in hospital and wish to withdraw from contact. Staff cannot force patients to take part against their will, but the issue often results in a *laissez-faire* regime which is justified on the basis of human rights. Assertive strategies with support at all levels of the service are needed to create a culture of participation. Staff should reinforce the message that attendance is a key part of treatment and attendance should be monitored.

The aims of improving acute care need to extend beyond looking after patients, keeping them safe and giving them medication, to what they actually do when they are in hospital to aid recovery and promote their mental health. Further research and government guidance is needed on how much and what types of organised activities should be provided for in-patients, as well as ways of increasing participation rates.

Declaration of interest

None.

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Effects of a crisis resolution and home treatment team on in-patient admissions

AIMS AND METHOD

To evaluate the effects of a crisis resolution and home-based treatment team upon in-patient admission rates. We collected data for 2 years prior and 1 year post-implementation of such a service in Leeds. The chosen time frame allowed the new service to settle

in and controlled for seasonal variations.

RESULTS

There were 4353 admissions during the period of the study, with 3325 in the 2 years prior to the service and 1028 in the year after. Generalised linear analysis found a 37.5% reduction in monthly admissions

after the introduction of the team ($P < 0.0001$).

CLINICAL IMPLICATIONS

This study shows that in everyday clinical practice crisis resolution and home treatment teams lead to a sustained reduction in in-patient admission rates.

Crisis resolution and home-based treatment teams were pioneered in the 1970s. Such services aim to assess patients experiencing psychiatric crises in the community, where possible avoiding hospitalisation (Weisman, 1989). Although in recent decades such teams have been implemented across Australia, North America and now Europe, past research into their effectiveness has been limited. Within the UK the National Health Service (NHS) Plan and Policy Implementation Guidance set the agenda for establishing crisis resolution and home-based treatment teams (Department of Health, 2001). This was in the belief that such teams could reduce the need for in-patient admissions (Brimblecombe, 2001).

In terms of reducing in-patient admission rates, the best available evidence for the effectiveness of crisis resolution and home treatment teams is provided by a randomised controlled trial (Johnson *et al*, 2005a) which found that those randomised to a crisis resolution team were less likely to be admitted to hospital 8 weeks after the crisis. A quasi-experimental study (Johnson *et al*, 2005b) of 9 months' duration found a reduction from 71 to 49% (using an operational definition of crisis) in admission rates in the 6 weeks following a crisis. A Cochrane Review which selected randomised controlled trials evaluating crisis intervention and home treatment teams reported data from 5 studies (with 21 excluded; Joy *et al*, 2004). On considering the included studies they concluded that home care crisis treatment, coupled with an ongoing home care package, is a viable and acceptable way of treating people with serious mental illnesses.

To date there have been no long-term service evaluation reports to support the effects of crisis resolution and home treatment teams upon admission rates in everyday clinical practice. When Leeds Mental Health Trust introduced such a service in October 2004, we took the opportunity to measure its effects upon admission rates for 2 years prior to its introduction and for 1 year after. This time frame was chosen to allow time for the service to settle in, and also to control for any seasonal variation in in-patient admissions. The aim of the service was to provide community-based assessment and home treatment for people with serious mental health problems. There was an expectation that the team would lead to a reduction in in-patient admissions. Therefore two in-patient wards were closed in the month following the implementation of the service. This represented a total reduction from 155 to 101 general adult in-patient beds across Leeds. No other significant changes in service provision occurred over the study period.

Method

Leeds is a busy metropolitan city with a population of approximately 750 000 people. It is culturally diverse and densely populated with areas of both affluence and poverty located within close geographical proximity. Within Leeds a crisis resolution and home treatment service was implemented on 23 October 2004. This city-wide service provided 24 h community assessment and home-based treatment for adults aged 17–65 years. The