editorials

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Acute in-patient psychiatry: the right time for a new specialty?†

The closure of the large mental hospitals and the advent of care in the community in the 1990s were followed by a crisis in mental health services, including a seemingly intractable bed crisis, which led some to believe that care in the community had failed. Newer community services, such as home treatment and outreach support teams, have since played a major part in ensuring the survival of community care, but so has the belated realisation that no community service can succeed without the provision of effective acute hospital services. Now that most people in need of mental healthcare can receive it in the community, it has become clear that those who cannot be treated in the community have, almost by definition, specific needs that can only be met in the hospital setting.

For people whose life in the community has become untenable, care in the community may prove impossible, which is probably why now so many who are admitted to acute psychiatric units are compulsorily detained. Acute units face the complex task of managing patients with mental illness at the most critical stages of their lives, when they are most vulnerable and most in need of help. Symptom severity, risk to themselves or others, unclear diagnoses, and deterioration and neglect in the community are only some of the problems of those who require acute hospital care. Adherence to treatment remains an unfulfilled pursuit, particularly in the long term, but even when patients who require drug treatment actually take it as prescribed, up to a third may fail to respond to standard clinical approaches (National Institute for Clinical Excellence, 2002). These problems are invariably intertwined, often associated with substance misuse and medical comorbidity, and usually are further complicated by a range of social and legal factors. It is up to acute hospital care to manage these extreme situations, and to carry out crucial interventions in the short term that will enable long-term plans to be implemented and realised once patients are back in the community. As is the case with healthcare at large, this falls plainly within the remit of a specialist service.

Provision of medical care has evolved and has been structured to respond to patients' changing clinical needs, ranging from primary care and accident and emergency departments through to medical wards and intensive care units, each meant to offer optimal standards of care within its own sphere of competence. A flexible system has ensued that is constantly adapting to the healthcare needs of the population, at the same time incorporating developments and innovations in healthcare provision. Mental healthcare is no different. High standards of in-patient psychiatric care can only be met by hospital services that are properly staffed, trained and equipped for the task, and in an environment that is designed for the purpose. The National Patient Safety Agency has identified two major classes of factors that affect safety on adult acute psychiatric wards and that can only be addressed by a specialist service (Marshall *et al*, 2004). The first class, practice factors, involves risk assessment and prediction, de-escalation techniques, observation, physical interventions (restraint and seclusion) and rapid tranquillisation. The second class, services factors, includes physical environment, social and therapeutic environment and staffing. To perfect the set of skills and working practices aimed at optimal use of resources available, hospital work requires training in the right combination of communication and management skills, psychological and pharmacological interventions, clinical skills, cultural awareness and mental health legislation. Like any branch of medicine, psychiatric hospital care is an organised, multidisciplinary and interpersonal service where, to secure consistent care for patients, strategic priority should be given to staff stability and education in order to build teams with collective competence and a shared ethos of responsibility (Krogstad *et al*, 2002).

At Guy's Hospital, which caters for a deprived inner London area, acute hospital psychiatry has been functioning as a specialty for a decade (Dratcu *et al*, 2003). Turning acute hospital psychiatry into a specialty has proved to be an effective response to the local bed crisis and has since been successfully adopted elsewhere. The experience has shown that community and acute hospital care have different clinical priorities, working practices and time scales, and that both sides can only gain by working independently, particularly in the inner cities. Advantages to teams in both the hospital and the community settings include a clear focus on patients' current problems, coherent teamwork, and the opportunity to refine working policies and expertise and to

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further develop services within a well-defined framework. Continuity of care can be retained, if not improved, by ensuring effective interfaces across services.

At least at some stage of their lives, hospital treatment is and will continue to be necessary for many people with mental illness (Shorter, 1997). Acute hospital psychiatry has consolidated as a specialist service because the combination of severity, acuteness and risk that makes a person's admission to hospital necessary can only be managed competently by a matching combination of skills, resources and facilities. We now know that care in the community has not failed – what has failed is the misguided attempt to ignore the importance of hospital care. As if to make up for this oversight, acute hospital psychiatry as a specialty has emerged as a genuine bottom-up response of mental health services to patients' most pressing needs. As the full-fledged in-patient arm at the forefront of a modernised mental health service, acute hospital psychiatry should now be formally recognised as the specialty that it is, as the surest way of implementing accreditation systems, training programmes and ever-improving principles of in-patient care. Standards of care are bound to rise across all mental health services, and the major beneficiaries will be the patients themselves.

Declaration of interest

None.

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Acute in-patient psychiatry: dedicated consultants if we must but not a specialty[†]

Until very recently, acute and long-term in-patient mental health services have been low on the agendas of professionals, policy makers and research workers, despite the fact that they continue to absorb much of the adult mental health budget. Consultant time has been increasingly devoted to work in non-hospital settings, as first community mental health teams (e.g. assertive outreach, crisis intervention/home treatment and early-onset psychosis) and more recently the new 'functional' mental health teams have expanded. Staff working in in-patient settings have been perceived as of lower status than their colleagues working within community teams, at a time when the levels of disability and disturbance on acute wards are increasing dramatically and, in many areas, bed shortages are resulting in intolerable strain on the in-patient system. Admission is construed as representing a failure of the individual patient or the service, rather than a potentially valuable therapeutic option.

Acute Problems (Sainsbury Centre for Mental Health, 1998) dramatically underlined the poor quality of experience of many people admitted to acute wards. Policy changes, such as the drive towards single-sex wards, the rise of the 'functional' mental health teams and the increasing burden of work for Mental Health Act tribunals (which threatens to become worse with the new Mental Health Act), make the current orthodoxy of a single consultant spanning the community mental health team and its associated in-patient ward increasingly unsustainable. The introduction of home treatment/crisis resolution teams has further increased the level of need among in-patients and the consequent demands on in-patient staff (Ingram & Tachi, 2004).

[†]See pp. 401–402 and 404–405, this issue. This is one of a series of papers on acute in-patient services.

Solutions?

A move towards a solution to the crisis in in-patient care began with official recognition of the problem, which took the form of policy statements on acute in-patient services and intensive and low secure care (Department of Health, 2002*a*,*b*). Strategies have been elaborated to foster service improvement in in-patient settings, which make use of readily available modernisation tools (Rix & Shepherd, 2003); these strike one as unconvincing unless staff skills are improved in the process. More convincing local initiatives have included the provision of enhanced, dedicated senior medical resource to an acute ward (Dratcu, 2002) and the introduction of a 'triage' unit, again with enhanced senior medical resource, as a single point of entry into a local acute unit (Inglis & Baggaley, 2005).

Acute in-patient care as a specialty?

We are moving towards a new orthodoxy within adult mental health services, which requires consultant time to

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