Inpatient psychiatry: why do we need it?

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Abstract. The author makes the case for the necessity of inpatient psychiatric services in a comprehensive, community based, system of care. The editorial begins with an historical perspective on mental hospitals. It then discusses acute and intermediate psychiatric inpatient units. A section also covers forensic units, also indispensable for a region or population of any size. The editorial concludes with a call for recognizing the purpose and value of inpatient services and thus using them most effectively.
Declaration of Interest: None.

INTRODUCTION

Over 200 years ago inpatient psychiatry left its dark ages, which had been driven by religious explanations of the devil incarnate or faulty functioning of bodily juices. The former gave us burning at the stake or dunkings (an early version of today's torture of waterboarding) and the latter gave us emetics, purgatives and bloodletting.

The French and American revolutions of the late 1700s ushered in an age of enlightenment in mental health called *traitement moral* by Phillipe Pinel and *moral treatment* by his American, British and European successors (Sederer, 1977). The psychiatric hospital, a "well ordered asylum", came to represent a humanistic and hopeful approach to treating people with serious mental illness. Stressors produced mental illness, so the theory posited, and thus it was necessary to provide moral treatment in which "… the patient was made comfortable, his interests aroused, his friendship invited, and discussion of his troubles encouraged. His time was filled with purposeful activity" (Bockoven, 1956).

Inpatient treatment became the road to recovery, and its effectiveness was notable. Hospitals sprang up in the UK, continent and the USA (where founding Superintendents formed a group that met to share ideas and established what today is known as the American Psychiatric Association). Asylum treatment, the precursor of inpatient treatment as we know it today, was born. What followed in the next century is not good news – but it is a cautionary tale about inpatient care today, and for the foreseeable future.

THE BREAKDOWN OF MORAL THERAPY IN THE UNITED STATES

Overcrowding, inadequate facilities, economic bad times, mixing of the ill with the poor and immigrants, and the aging and deaths of the leaders of the moral therapy movement all conspired to erode humanistic care. Soon American asylums were more interested in control, achieved by intimidation and force, than in purposeful activity and recovery. By the end of the 1800s, moral therapy was replaced by custodial care and patients languished, their fate often a lifetime of neglect (at best) or cruelty (at worst) in state hospitals in the United States. And so it was (with some exceptions) until the advent of chlorpromazine, de-institutionalization, general hospital psychiatry and community mental health almost a century after the end of the moral era. Hope for people with serious mental illness sprang anew. A belief in science and community care inspired the landscape of mental health care we have today.

But the promise of this new era has yet to be fulfilled. Between 1955 and 2000 the population of American state hospital patients dropped by 90% (!) – from 560,000 to 56,000 – but this happened, at least in the USA, without the establishment of an accessible and adequate community care system (which has to include acute and intermediate length inpatient services, more below) in the context of rising housing costs and the breakdown of

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families, especially in poor, urban communities. These circumstances produced conditions where vulnerable people, especially those with serious mental illness and without the safety net of asylums and the support of families and communities, found their way to homelessness and incarceration in other institutions, like jails and prisons, and for some nursing and adult homes (low stimulation, custodial settings that offer shelter but generally no road to a real life in the community). In other words, the promise of asylums in the 1800s and community mental health in the 1900s was well founded but not well executed or sustained. Here is the cautionary lesson. Unless the institutions, comprehensively arrayed, that serve the most vulnerable are supported, over time, to meet their mission they will fall into disarray and fail those they are meant to serve. This is not easy, nor inexpensive, though it actually costs less than neglect (Gladwell, 2006; Sederer, 2009).

WHAT WILL IT TAKE?

If we look at the science of psychiatry today we are reminded that effective care for people with serious mental illness is *comprehensive*. No one etiology of disorder has the breadth and depth needed. No treatment alone is optimal. No one profession alone can do the job. *And no one setting alone is sufficient*. Our field requires a primary locus of community care – including primary medical care as well as mental health specialty care – by providers of varied disciplines including psychiatrists, social workers, nurses, psychologists, rehabilitation specialists and peers. But when a person's condition is life threatening or unresponsive to the best of community care we need acute hospitals, residences and for a very few extended hospital stays. This is what is meant by comprehensive. Without all the pieces, integrated and interactive, the mental health system will fail its recipients and its communities.

THE MENTAL HEALTH SYSTEM OF CARE AND THE ROLE OF INPATIENT PSYCHIATRY

Inpatient capacity within a system of care is not only needed, it is an *asset*. While no longer the centerpiece of a mental health system as it was for centuries, inpatient services remain the backstop, the emergency and safety valves, of a community centered, recovery oriented care system. As good as community services can get, and that is often more an ideal than a reality, emergencies happen, crises erupt, the unexpected happens and someone with a serious mental illness no longer is safe without hospital level of care. Think of mental disorders like many other chronic illnesses: for the most part, diabetes, heart disease and cancer are well treated in the community – until something life-threatening comes along and the patient needs professional, 24 hour care. So it is for the serious mental disorders whose prevalence is typically greater than these other illnesses and whose severity can call for intensive care. Routine and continuous community care depends on accessible and quality inpatient services. For purposes of discussion, I will separate out **acute inpatient care** from **intermediate inpatient care**.

ACUTE INPATIENT CARE

Acute care is defined as crisis intervention for safety or treatment requiring 24 hour medical and nursing care in a locked setting with an average length of stay of one to three weeks (7-21 days). Units are designated for children and adolescents (up to 18 years of age) and adults; a variety of specialty units (and hospitals) have developed and are noted below. Admissions to inpatient acute care usually are from hospital emergency rooms or community settings because of a deterioration in functioning that behaviorally presents as danger to self or others.

A fundamental goal of acute care is to develop an alliance with the patient, and in the case of children, with the family. The patient's admission often is involuntary and mental illness generally has compromised his or her judgment, challenging their capacity to believe that parent(s), caregivers, family, and friends mean to help – rather than harm. Alliance underpins engagement, the critical process of becoming a caregiver. To establish an alliance the primary clinician, psychiatrist and other members of the treatment team will need to understand what the patient and family want and need in order to achieve trust and value – and thus to stand a chance at engagement. (Sederer & Rothschild, 1997).

During an acute care stay, interventions are focused on the primary goal of rapid return to the home, family or another community setting. An acute psychiatric hospital stay aims to: enable the individual to leave the hospital safe and in the case of children, along with the family, to be as engaged and connected as possible to the services and supports that will take place in the community assess the completeness and accuracy of the diagnosis and treatment plan that existed prior to admission as well as understand what destabilized the individual so that admission was needed assess individual strengths and limitations in the realms of behavioral, social, psycholog-

ical and family functioning and tailor interventions that maximally empower clients' and families' efforts toward a successful process of recovery in the community collaboratively plan with the patient, community care givers, families and other supports needed to succeed on leaving the hospital provide medication and individual and group treatments focused on problem solving; to engage family/friends/supportive others in problem solving; and to develop and implement a plan for follow up or aftercare that has the promise of being realized.

An acute stay is thus an exercise in rapid assessment, alliance and engagement, focused problem solving, and brief treatments that can show results in days to weeks. A conceptual 'care path' guides the course of the acute stay so that clinicians and administrators are continually considering and collaborating with patient, family and community caregivers about what needs to be the focus of the stay and the work that needs to be done to ready someone for discharge.

Care is provided by a team of professionals who have contemporaneously the same and different roles and responsibilities. The registered nurse (RN) has continuous patient oversight, dispenses medications, monitors health and behavior and is responsible for unit management. The primary clinician, who may be a nurse, social worker, psychologist, or physician, is the single person accountable for the patient's care: he or she is the person who the patient identifies when asked who is your primary clinical person on the unit? The primary clinician's work is to engage the patient, collaborate with other caregivers and family, and problem solve to ready the person for discharge. The primary clinician may also be the principal person on the team who works with the parent(s) or caregivers around antecedent events that may have precipitated the hospitalization, provides family intervention during the hospitalization and plans with the family around post hospital follow up (aftercare). At times, another member of the treatment team, possibly a clinical social worker, engages the family in these ways. The psychiatrist (or psychiatric resident or fellow) has treatment planning responsibility for the patient, provides supervisory and consultative services to the treatment team, prescribes medications and other biological treatments, and helps to ensure the quality of care provided. The medical specialist, a general practice physician or at times a nurse practitioner or physician assistant, assures that the individual's medical problems are identified, treated effectively, and that treatments begun in the hospital can and will be provided after discharge. In working with adults, we are witnessing the use of a peer specialist, an individual with a serious mental illness who is in recovery, who understands the patient's perspective, can create trust with the patient (and family), and helps to ensure a recovery oriented and person-centered experience for the individual who is hospitalized. Peers can also assist in transition to the community and with learning symptom management. In working with children and adolescents, family advisers and patient advocates perform similar functions aimed at ensuring the child and family's perspectives and needs are addressed within a complicated inpatient and community mental health system. Other key clinical staff make up the treatment team, and *hospital care is a team job*.

Some inpatient **services have developed expertise in particular disorders or problems**. Among these are units specializing in eating disorders, perinatal psychiatry, geriatrics, obsessive compulsive disorders, aggression, personality disorders (especially borderline personality disorder), and treatment resistant psychotic disorders (including affective and schizophrenic illnesses). The costs of extended hospital stays and the problems associated with people remaining in institutional settings for long periods of time, including 'atrophy' of their capacities for independent thinking and functioning, have tended to minimize the provision of these services, though some continue as less costly and more autonomous residential treatment centers. Forensic units are discussed separately, below.

INTERMEDIATE HOSPITAL CARE

Paradoxically, intermediate length hospital care may be even more challenging than acute care, and in smaller supply. In the United States, each state operates (or contracts for) hospital services to serve those individuals whose conditions do not safely or sufficiently remit in weeks, who need months or longer to stabilize for return to the community (Hepburn & Sederer, 2009; Holloway & Sederer, in press).

Intermediate hospital care should be the mental health site that families recognize they can turn to for loved ones whose illness is the most challenging and not responsive to community based and shorter term inpatient care. Intermediate hospitals must serve as *centers of excellence* – tertiary, even quaternary, care facilities than provide expertise, experience and time for recovery to proceed. Traditionally, intermediate care (lasting months, and historically for some patients lasting a lifetime) was chronic care – a site to keep people safe and fictionally to keep the community safe while little was done to restore their capabilities to return to family, community and a produc-

tive life. That notion is now as outdated as the manual typewriter.

Intermediate care *for adults* can be provided both on inpatient as well as transitional placement units that are a part of the hospital services (TPPs). The TPPs are bridges to community living and to ambulatory aftercare services for those individuals who do not need locked confinement but lack the capacity to function even minimally autonomously in the community. Both intermediate care inpatient units and TPPs aim to restore a person's functioning to permit successful community living.

Intermediate care *for youth* is also provided on inpatient units, with stays of months and many times in excess of 180 days, or in residential facilities. Youth are admitted to intermediate care when acute hospitalization has not been effective in reducing the severity of the child's or adolescent's symptoms to the point that he or she is able to function more adaptively in the community and is no longer a threat to self or others. Intermediate care provides further intensive care to achieve these goals and prepare the youth for discharge to a home environment or a less restrictive residential setting, such as a residential treatment facility (RTF) or other group home.

When hospitalizations of even 6-12 months or more will not result in sufficient improvement to allow a youth to return to a home or family environment safely (often the result of severe family dysfunction, physical or sexual abuse, trauma, or parental neglect) placement in a residential program, such as a RTF, is necessary. The goals of RTFs are to continue to treat the youth and family so that a return to the family or to a less intensive community setting is possible. Lengths of stay in RTFs are variable, but 1-2 years is not uncommon.

Intermediate hospital care includes:

- a careful and extensive functional assessment and tertiary/quaternary psychiatric and medical care
- psychiatric rehabilitation (for adults), education (for youth) and skill building focused on improving a person's capacity to function within a community setting
- active engagement with family and the person's social support system
- continuous attention to movement to a less restrictive life in the community

Generally, access to intermediate level of care is by referral from acute care services when clients do not sufficiently respond to short term interventions. Transfer to an intermediate care hospital should occur within days after appropriateness for this level of care has been determined. For the great majority of adult patients intermediate hospital care will result in discharge to the community in less than six months and rarely will a stay exceed one year. When youth require longer term care that is greater than one year or so, other residential options, such as RTFs should be considered.

Intermediate hospital care remains an essential component of a comprehensive system of mental health care. It is the mental health equivalent of tertiary (or quaternary) care and must be provided in what recipients and their families regard as centers of excellence.

THE FORENSIC UNIT (OR HOSPITAL)

If they don't exist, most countries find they have to create them. Forensic hospital units (or actual forensic hospitals) aim to balance the public safety while enabling people with serious mental illness to return to the community on a recovery path. Forensic units generally provide some or all of the following services.

First, are services to individuals incarcerated in prisons. These services include acute care in a forensic unit or hospital to clinic care inside the prisons (similar to the community based care model, and in fact patients served are often termed 'outpatients').

Second, are individuals found incompetent to stand trial and require treatment to return to their legal proceedings. Many individuals are briefly treated (they receive services resembling acute care), with additional resources dedicated to addressing their legal needs. In complicated cases, intermediate stays are necessary.

Third, are insanity acquittees (so called Not Guilty By Reason of Insanity – NGRI). Their treatment needs are continuously weighed against public safety concerns, with courts having the final word. Treatment in forensic units focuses on addressing those factors contributing to their risk of offending in the community, coupled with psychiatric rehabilitation, engagement with family and other social support systems, and preparation for a less restrictive life in the community. The goal for insanity acquittees is eventual transition to community living.

Fourth, (in some states and countries) are those individuals deemed too dangerous to be treated in the adult psychiatric hospitals. These individuals require the additional structure, staff, and expertise of the forensic unit. They have had prior failed treatment attempts in community hospitals and adult civil hospitals.

Finally, in many states in the USA sex offender treatment is provided in forensic units, under specific legal statutes that vary from state to state. This is a highly specialized service intended to treat recidivistic sex offend-

ers with mental abnormalities who pose a danger to the community.

Although forensic units have a mandate to serve the public safety, they are hospitals whose treatment still involves engagement of the individual and their family or other support systems, comprehensive, evidence based care, a recovery orientation, and very rigorous aftercare planning. All this is done amidst the complexities of their ongoing legal issues and court involvement.

CONCLUSIONS

Inpatient units are not going away. At the very least they remain inescapable (sic) since they are the only sites to appropriately treat and manage involuntary patients whose safety, and that of the community, is at stake – unless you consider our jails and prisons proper sites for acute care.

What's more is that the quality of inpatient services is measurable (Burt *et al*., 2002) Quality can be defined, measured, and when needed improved upon – as is true of all medical services When inpatient psychiatry is seen as a part of a *comprehensive, quality driven, and accountable system of mental health care* (for some, if not many with serious mental illnesses), as a necessary component in the tough road of recovery, the more its value will be clearer and its use optimized. Not as the place to send someone when the clinic closes at 5 PM but as the tertiary care center that is needed, for short and sometimes lengthier stays, when community services have done what they can and more is needed.

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