Acute hospital care: ineffective, inefficient and poorly organised

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Despite all the emphasis on community developments during the last decades, especially since the introduction of *Caring for People* (Department of Health, 1989) and somewhat ambiguously reinforced by the present government in *Modernising Mental Health Services* (Department of Health 1998*a*), figures show that the hub of mental health care is still the hospital. Take cost: in 1997/98 national expenditure by health authorities on in-patient care was 65% of the overall mental health budget (Health Select Committee, 1998). A comparable picture is shown for staff. The large majority of nurses are still working on the wards, probably as many as 75% (Department of Health, 1998*b*), although these figures are not wholly reliable due to classification problems.

These figures might be seen as surprising if contrasted with the decline in bed numbers. Overall numbers of NHS beds for people with mental illness were down to 38 780 in 1996/97 from 50 280 in 1991/93 (Department of Health, 1998*c*). Most of this reduction is due to transfer of long-stay beds from the NHS to private nursing homes and residential places. Intriguingly, the highest proportional increase is for beds in secure units, whereas adult acute beds have shown an 11% reduction to 14 500 places. Hardly numbers that one would have thought capable of consuming such a large proportion of resources.

This apparent contradiction is explained by clinical activity. Rates of admission per 1000 population has increased slightly from 4.2 to 4.4 between 1991/92 and 1995/96, but from 3.7 to 4.6 (more than 20%), for the key group aged 20–24 years old. In England and Wales, 89% of admissions are unplanned emergencies and about 30% of people are admitted under a Section of the Mental Health Act 1983 (Ford *et al*, 1998), but this figure rises to 57% of patients in inner London (Ward *et al*, 1998). Unsurprisingly, duration of stay has dropped and occupancy rates have gone through the roof. Reports of occupancy rates of over 100% are frequent, with rates especially high in inner cities (Shepherd *et al*, 1997; Ford *et al*, 1998).

This intense pressure on beds has changed the profile of patients on psychiatric wards. In-patient units are filled with highly disturbed people, 75% with a diagnosis of schizophrenia (Shepherd *et al*, 1997), and growing proportions have complex problems, whether social, psychological or physical. The main concern now must be whether patients with the most severe mental illnesses have the opportunity to recover sufficiently to cope with the demands of community living again on discharge, and whether our hospital wards offer acceptable conditions to do so.

Considering the attention given to the quantitative aspects of hospital care, it is surprising how little is known about what is actually happening on our wards. Very little research has taken place during the last decade studying conditions on in-patient wards or the styles of in-patient care most therapeutic for a changing population.

A few publications allow us a glimpse and impressions are not reassuring. A nationwide spot visit of acute adult wards by the Mental Health Act Commission (Ford *et al*, 1998) reported that on a quarter of wards no nursing staff were interacting with patients at the time of the visit. The high staff vacancy rate, the 30% of staff working on a casual basis, and especially the large number of staff pre-occupied with safety procedures such as 'specialling' or 'door-duty' may explain much. In inner London just over 50% of night-staff are agency or bank staff or are working overtime (Ward *et al*, 1998). A recent study of acute wards by the Sainsbury Centre (Sainsbury Centre for Mental Health, 1998) adds some detail. Most striking is the lack of rehabilitative activity: 40% of patients did not take part in any social or recreational activity during their stay, 30% not even in therapeutic activities. Five per cent received psychological therapies. Interestingly, doctors were seen relatively frequently – 11 contacts during an average 38-day stay. Another study found that patients spend 4% of time with staff and 28% doing nothing or watching television (Nuffield Institute for Health, 1996). All this suggests an atherapeutic environment, a care vacuum, rather than a place offering the most intensive therapeutic interventions to the most vulnerable and unwell

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people. Unsurprisingly wards are unpopular with patients, particularly women, who feel bored and unsafe (Sainsbury Centre for Mental Health, 1998).

Hospital care became the preferred form of treatment for severe mental illness in the early nineteenth century, and has been accepted as the 'gold standard' against which other forms of care have to be judged ever since. No sensible clinician would suggest that services can be run without any form of intensely staffed 24-hour provision, if only as a place of safety. However, we have little hard evidence as to the effectiveness of hospital care in general, nor to effective components of admission. Studies of hospital care have found few ward variables that consistently predict effectiveness, including length of stay. The most powerful predictor of good outcome in any hospital programme is staff motivation (Erickson, 1975). None of the many trials comparing home care, assertive outreach or day hospital care with standard hospital care has found an advantage for hospital care. However, none of these studies could avoid the use of hospital care for their most severely ill patients altogether.

Whether hospital care addresses patients' needs is easier to answer. It offers a form of asylum and medical and nursing care, but it fails to address other needs in social and psychological areas. For example, only 2% of in-patients receive benefit advice, and the exceptional nature of sessions with psychologists or occupational therapists is telling (Sainsbury Centre for Mental Health, 1998).

The lack of integration and absence of alternatives to hospital care in most services remains a major problem, both for those hurriedly discharged and those staying unnecessarily. It is deeply worrying that most patients have no idea they are about to be discharged until a few days before they depart, and have little involvement in decisions about their aftercare. Nevertheless, most people receive follow-up arrangements, about a third to the local community mental health team and another third to out-patients (Sainsbury Centre for Mental Health, 1998). For those staying, many do so reluctantly because of a lack of suitable alternatives, mostly accommodation or community support (Shepherd *et al*, 1997).

A picture is emerging of an inefficient, atherapeutic and poorly coordinated service, profoundly demoralising to both patients and staff and unable to cope with the growing pressures. What can be done?

First, we need to question the function of the ward as a depository for all those people community services cannot manage. Hospital wards are a bizarre and illogical mixture, probably uniquely so, of old and young, male and female, psychotic and depressed, retarded and agitated and voluntary and detained. Most attention has been given to the disadvantages to women on mixed gender wards, but other groups also have rightful claims for special consideration. Stratification is often based on consultant team and geography, arguably of more benefit to the provider than the consumer. Not all problems can be addressed simultaneously, nor will a single solution be suitable nationally, but a number of small units, as proposed by the Royal College of Psychiatrists (1998) can be used flexibly in a variety of ways.

Second, 24-hour care should offer safety in a therapeutic and humane environment. It could be argued that optimal therapeutic care ought to be a fundamental and legally enforceable right, especially for those admitted on a Section of the Mental Health Act. This suggests units planned on therapeutic principles, serving homogeneous groups of patients who are likely to benefit from the same 'milieu' and range of interventions, cared for by specialised staff in sufficient numbers.

Third, hospital wards need to become one element of a comprehensive service, used only for short periods during an episode when less restrictive forms of care such as home or day hospitals are unsafe. Since wards are the most specialised, expensive and least desired part of the system, they should be a last resort. Alternatives should be available wherever possible such as crisis services, day hospitals or intensive case management teams, allowing a smooth transfer through the system. This means that attention should shift away from the obsession with individual service components, whether in the community or in NHS facilities, to the interactions of systems as a whole. Few services are planned anticipating the impact of parts of the system on each other. Linked-up care is an appropriate phrase in this context, not only incorporating other parts of the NHS, but also social care.

The oft-posed question whether more beds are needed seems largely irrelevant within the context of the present state of service on offer. The priority must be to make 24-hour care therapeutic and acceptable to its customers, conscious of its place within the system as a whole. Of course, this will not be cheap. Serious investment in capital and revenue is required. Ward design will have to be adjusted, but more importantly, staff will have to be trained and supported.

The role of psychiatrists could become that of system champion. Psychiatrists have a unique overview of the system and could facilitate the right intervention at the right time, based on the needs of service users. Since they are often the stable rock in a fast changing sea, as

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illustrated by very rapid turnover of other staff (Peck, 1997), they are also crucial for holding the change process together.

Most importantly, leadership has to be grasped. Major new funding has been promised to mental health, and specific monies have been dedicated to training, community and hospital services. If ever there was a time for professionals, and particularly psychiatrists, to take the initiative in practice development and research, and be hailed in doing so, it is now.

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