Editorials

Is locating acute wards in the general hospital an essential element in psychiatric reform? The UK experience

JONATHAN TOTMAN, FARHANA MANN, SONIA JOHNSON

Abstract. Locating psychiatric wards in general hospitals has long been seen in many countries as a key element in the reform of services to promote community integration of the mentally ill. In the UK, however, this is no longer a policy priority, and the recent trend has been towards small freestanding inpatient units, located either within the communities they serve, or on general hospital sites, but separate from the main building. Whether locating the psychiatric wards in the general hospital is essential to psychiatric reform has been little discussed, and we can find no relevant evidence.

Perceived strengths of general hospital psychiatric wards are in normalisation of mental health problems, accessibility to local communities, better availability of physical health care resources, and integration of psychiatry with the rest of the medical profession, which may facilitate recruitment. However, difficulties seem to have been encountered in establishing well-designed psychiatric wards with access to open space in general hospitals. Also, physical proximity may not be enough to achieve the desired reduction in stigma, and complaints from the general hospital may sometimes result in undue restrictions on psychiatric ward patients. There are strong arguments both for and against locating psychiatric wards in general hospitals: an empirical evidence base would be helpful to inform important decisions about the best setting for wards.

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INTRODUCTION

This editorial originates in a discussion between Michele Tansella, editor of *Epidemiologia e Psichiatria Sociale* and a co-author, SJ, a London-based academic psychiatrist. In discussing alternatives to inpatient care, it was clear that, despite a shared commitment to the development of community psychiatry, their assumptions regarding inpatient care were markedly different. MT, like many European social psychiatrists, held locating psychiatric beds in the general hospital to be an essential component in psychiatric reform; SJ did not regard this as a crucial feature of a high quality service. A divergence seems to have developed between England and other European countries on this issue: a literature search indicates that this has been very little documented or discussed. In this editorial we therefore aim to address this

gap by describing the apparent move away from general hospital-based psychiatry in the UK, and by summarising its advantages and disadvantages.

UK PATTERNS OF INPATIENT BED PROVISION: THE MOVE AWAY FROM THE GENERAL HOSPITAL

Deinstitutionalisation in the UK was initiated in the 1950s. In 1961, Enoch Powell, then Minister of Health, made his 'Water Tower Speech', establishing a strong government commitment to this process. Powell welcomed the closure of the nineteenth century asylums and forecast a 50% reduction in hospital beds for the mentally ill within 15 years. As for the remaining beds, he said, "we know already" where they ought to be: within the general hospitals.

These sentiments were enshrined in policy 14 years on in the government White Paper *Better Services for the Mentally Ill* (Department of Health and Social Security, 1975). This set the agenda for a new future of community-based mental health care with an emphasis on "inte-

Address for correspondence: Professor S. Johnson, Dept of Mental Health Sciences, University College London, Charles Bell House, London W1W 7EY (United Kingdom).
E-mail: s.johnson@ucl.ac.uk

gration rather than isolation". Alongside closure of the Victorian asylums and development of community care by local authorities, it strongly advocated psychiatric units based in the local general hospitals that also cared for people with a full range of physical illnesses.

Thirty-five years on from this landmark White Paper, the UK has adhered to several of its tenets. Most asylums have closed, and community care remains a priority and is relatively well developed (Johnson *et al.*, 2001). However, none of the policy documents of the past fifteen years advocate locating psychiatric beds in the district general hospital (DGH), and the marked trend seems to have been towards establishing small stand-alone inpatient units. Thus in this respect the vision set out in *Better Services* has not been realized, although DGH psychiatric units still exist in a minority of centres.

Trends across Europe in location of inpatient services are not well-documented. However, it appears that at least in some countries, the commitment to the goal of managing mental illness in the DGH has been sustained, with shortfalls measured in terms of persistent use of the old asylum buildings (Haug & Rössler, 1999; Becker & Vázquez-Barquero, 2001; Fakhoury & Priebe, 2002). This divergence in policy, practice and values is one that seems to have gone largely unnoticed in the academic literature. No research appears to have evaluated it: given this gap, this article has been informed by consultation with a number of senior UK experts on mental health services, with whom we communicated regarding potential reasons for the divergence from the European model and its advantages and disadvantages. A wide range of views was expressed and is summarized below. The experts whom we consulted are listed in the acknowledgements section, but none are in any way responsible for the following précis of the arguments for and against psychiatric units in the DGH.

WHY THE DIFFERENCE?

One reason for the divergence from the model of psychiatric units in DGHs may be organisational. NHS services are managed by bodies called Trusts, responsible for service delivery in a local area. Separate Mental Health Trusts were strongly advocated in the late 1990s by people with leadership roles in mental health services, a policy endorsed by the *National Service Framework for Mental Health* (Department of Health, 1999). The thinking behind this separation was to ring-fence funding for mental health, thereby protecting services from other potentially 'greedy' specialities. UK general hospitals are

usually owned by Acute (medical trusts), so Mental Health Trusts may have to pay to use beds on their sites. This may be especially costly when general hospitals are on expensive and overcrowded inner city sites. It may be financially and organisationally simpler to manage an independent psychiatric unit owned by a single Trust.

A further potential reason is the cultural context of reform. In continental Europe, deinstitutionalization occurred slightly later than in the UK, and was often framed as part of a revolutionary rejection of repressive conventions and institutions (Basaglia, 1987). Perhaps in the UK the ideological commitments underpinning psychiatric reform tended to be less fervent at the outset, so that integrating the mentally ill into general population treatment settings was a vision for which there was never the same passion in the first place.

Changes in UK policy and practice may also reflect disappointing experiences of DGH psychiatry. The quality of acute psychiatric inpatient care in the UK has caused considerable concern in the past 15 years (Lelliott & Bleksley, 2010). Around the year 2000 when separate Mental Health Trusts were being established in many areas, the DGH acute units which had replaced acute asylums in many areas were often not seen as high quality environments. Studies of inpatients' experiences of acute care have rarely placed great emphasis on the location of wards, with areas such as safety and relationships with staff receiving much greater emphasis (Lelliott & Quirk, 2004; Quirk & Lelliott, 2001, Gilburt *et al.*, 2010).

FOR AND AGAINST DGH PSYCHIATRIC UNITS: THE KEY ISSUES

A number of themes recurred in our discussions with key UK experts regarding the pros and cons of DGH psychiatric units. These are accessibility and integration within local communities; architecture and surroundings; provision of physical health care; stigma, and the relationship between psychiatry and medicine.

ACCESSIBILITY AND INTEGRATION INTO LOCAL COMMUNITIES

One of the important principles of deinstitutionalisation was to bring mental illness into the public gaze. The hospitals were no longer to be far-off sites with fenced perimeters but familiar buildings in the heart of the community. Arguably, the mainstreaming of psychiatric inpatient care within the DGH allows for better community

integration than is achievable in a separate unit. General hospitals tend to be clearly visible, well sign-posted and easily accessible by public transport. Stand-alone psychiatric units on the other hand often conceal themselves from the public gaze, disguise themselves in their names and do not normally 'advertise' themselves externally (for example, on transport networks). This makes them harder to get to for patients and visitors and risks fostering the air of mystery which deinstitutionalisation sought to avoid.

However, the re-mergence of stand-alone psychiatric hospitals does not mark a return to the asylum. On the contrary, the design of contemporary inpatient units has been informed by lessons learned from the failures of the asylums (Royal College of Psychiatrists, 1998). On a purely physical level, they are a far cry from the "isolated, majestic, imperious" buildings described by Powell, typically being small units of no more than 4-5 wards, situated within the communities they serve. Thus they may offer good opportunities to maintain community links and to focus throughout patients' brief stays in hospital on helping them to return home and resume their normal lives (Curtis *et al*. 2009).

ARCHITECTURE AND SURROUNDINGS

One of the key advantages of stand alone psychiatric units is that they can be built fit for purpose. Research supports the intuitive assumption that the physical environment of a ward affects patients' experiences of admission and their interactions with staff (Graham *et al*., 2002; Karlin & Zeiss, 2006). In the UK, during the early days of deinstitutionalisation, new psychiatric wards in DGHs were often built on the model of general medical wards, with a view to adaptability. In other cases they were converted from existing wards. Several of the experts we consulted reported that this often resulted in wards that were poorly suited for mental health care. Unlike many other inpatients, psychiatric inpatients are usually not bed-bound, and it is only natural that they will want access to fresh air. This poses a problem if the psychiatric ward is, say, on the sixth floor of a hospital tower block. The tower block design of many city DGHs may also pose a suicide risk. Finally, and in counterpoint to the arguments of the previous section, a smaller unit, with its own outdoor space, may be more appealing to visitors – at least to those already familiar with the unit – who need not navigate through a large hospital complex.

A Royal College working party report of 1998 provided recommendations on the optimal size, configuration and design of inpatient mental health wards. Adequate space, including access to outdoor areas, was recognised as crucial. The report suggests that psychiatric wards are best located in independent structures but on the same site as the general hospital. This set-up has now become common and may represent a trade-off between the unique needs of the psychiatric ward and the advantages of being in the general hospital.

PHYSICAL HEALTH CARE

Being in the general hospital clearly has advantages for patients' physical health care, the quality of which has been a matter of great recent concern in the UK (Phelan *et al*., 2001). Routine physical investigations are probably easier to carry out, and the technology and expertise of the general hospital are more accessible. Physical healthcare resources cannot, however, be assumed to be freely available just because psychiatric wards are on the DGH site. Financial issues arising from the separation of physical health and mental health trusts often limit this even where mental health wards are on the DGH site: an example is where cardiac arrest teams may not attend psychiatric wards even a short distance away because they are not funded by the same Trust.

A SHARED SPACE

People who are acutely psychiatrically unwell may find it difficult to observe the rules and boundaries of the hospital, for example regarding which areas the public may enter. Where they are very distressed or disturbed, physically ill people may also find their presence alarming. This can create tension between medical and psychiatric staff and may result in excessive restrictions being enforced.

STIGMA

If sharing a space creates difficulty, there is also a danger that the presence of psychiatric patients in the DGH may not shape attitudes in the intended direction.

The motive in placing psychiatric patients within the DGH is to normalize mental illness. Doing so draws attention to the commonality of mental health problems and the fact that, like other physical health problems, they can be treated. Research supports the view that stigma towards people with mental illness can be reduced through contact (Couture & Penn, 2003).

But the evidence from social psychology also suggests that the amount and quality of contact moderate its effectiveness in reducing intergroup discrimination (Brown & Hewstone, 2005). Under the wrong conditions, exposure could even have the opposite effect. Deep-rooted prejudice may be reinforced by limited and negative encounters with psychiatric patients. Thus stigma could attach equally to a psychiatric ward in the DGH as to an independent unit, especially if the ward remains locked the majority of the time and those on neighboring wards gain only glimpses of what goes on inside.

THE RELATIONSHIP BETWEEN PSYCHIATRY AND MEDICINE

An aim of placing psychiatric beds within the DGH is to establish mental illness as an illness like any other: to be diagnosed, treated and cured. It may also have benefits in terms of encouraging psychiatrists to offer their medical expertise in psychopharmacology and in diagnostic assessment, skills that are especially important in the acute crisis. The general hospital setting is well suited to this, lending weight to the role of the psychiatrist and imbuing it with a sense of responsibility and leadership.

However, one reason for a loss of enthusiasm for DGH psychiatric units may be challenges to an illness model of mental health problems. Thus where, for example, the focus has shifted to a recovery model, establishing schizophrenia and other disorders as mental illnesses like others may be seen as a less relevant and desirable goal, especially by professionals other than doctors. Furthermore, maintaining the physical separation between the psychiatric unit and the DGH may have implications for the relationship between psychiatry and medicine that go beyond the walls of the hospital. A separate psychiatric unit advertises itself as something different from a 'hospital' as commonly thought of. It sends a message that what it does is and can be different, taking a perspective beyond a traditional expert-led illness model.

One danger of an excessive separation between psychiatrists and the rest of the medical profession is exemplified in the current recruitment crisis in psychiatry. Very few UK medical graduates are currently choosing the specialty, and it was estimated that only 6% of recent applicants for Membership of the Royal College of Psychiatrists were UK graduates (Oxtoby, 2008). A gulf between psychiatrists and the rest of the medical profession is often suggested as an explanation. At a recent Royal College academic event focusing on recruitment, senior academics described the geographical and functional split of services as 'shameful' and 'incredibly divisive'. Psychiatrists are notably absent at general hospital grand rounds, do not share the hospital mess, have separate canteens and so may be almost as invisible as their patients. This reduces the opportunities for reciprocal education and creates the danger of psychiatry becoming marginalised.

CONCLUSIONS

Psychiatric inpatient care in the UK is increasingly being provided outside the general hospital in small stand-alone units. The reasons for this reverse-trend are unclear, and there has been no research to date documenting or evaluating the practice. Several of the issues discussed in this editorial are tied up with broader debates about the nature of mental illness and psychiatry. In view of this and the lack of relevant evidence, it is perhaps not surprising that opinion amongst relevant experts appears very divided. Interestingly, hesitant scepticism about the viability of the move into the DGH was around even at the time of deinstitutionalization. Somewhat prophetically, *Better Services for the Mentally Ill* contains numerous references to the practical, social and ideological difficulties involved in the move into the general hospital:

…those concerned with mental illness services still face the very real dilemma of wanting the benefits of integration, yet wishing to retain the different approach to therapy that mental as distinct from physical illness so often requires…. (2.6)

Whether the UK trend has been driven more by the ideological motive of providing more therapeutic care or by practical and financial reasons, remains unclear. We also remain uncertain whether the path recently taken in the UK is an unusual one or whether similar trends are observed in other countries. Large resources are invested in acute mental health wards and where they should be located is a fundamental decision. Our editorial has made it clear that there are strong arguments both for and against locating psychiatric wards in the DGH: surely this important topic deserves both further debate and more empirical investigation, in which already available data sets may allow us to make a start in comparing settings.

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