

3 Acute Care in Crisis

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Introduction

In 1985, someone looking for help with a mental health problem could expect to be treated in a psychiatric hospital. They could also expect their local hospital to be a former asylum, about a hundred years old, located outside their town or city, consisting of large buildings in extensive grounds and identifiable by a prominent water tower which was visible for miles around. Community-based approaches such as day hospitals and community psychiatric nurses had been in existence since the 1950s, but service provision was patchy and in most areas did not represent a realistic alternative to inpatient care. By 1986, official figures showed that although over 80% of people with mental health problems were living in the community, more than 80% of the available resources were being spent on hospital care (NIMHE, 2003).

In 2005, someone with that same mental health problem could expect a very different approach to be offered by a range of crisis resolution/home treatment teams, crisis houses, partial hospitalisation, early intervention services, assertive outreach teams and multidisciplinary community mental health teams, provided by a combination of health, social care and voluntary sector organisations. This chapter tells the story of the transition from NHS-run institutional care, to the mosaic of residential and community-based services from a range of providers that we have today.

Numbers of beds/hospitals

In 1987/88, the total number of psychiatric beds had fallen from a peak of 154,000 in 1954 to around 67,000 (DH, 2004a). The number of beds has continued to fall, so that by 2003/04, the most recent year for which the information is available, there were 32,400 altogether, of which 13,261 were acute care beds for adults, a further 2,500 were beds in secure units, and the remainder were 'long stay' beds (i.e. non-acute care and beds for people in other age groups) (DH, 2004b).

A number of factors contributed to this reduction in beds. Enoch Powell, as minister of health, started the move towards community care in 1961 by announcing his vision for mental health services over the next 15 years, including a closure and re-provision programme for the 'water tower hospitals' (Powell, 1961). Not underestimating the resistance

his plan would encounter, Powell had urged “ruthlessness” in the pursuit of “drastic and fundamental change” in order to improve mental health care. But the closure programme did not really get going until the mid 1970s, following the publication of the White Paper *Better Services for the Mentally Ill* (DHSS, 1975), and the first full hospital closure did not take place until 1986 (Stewart, 2003). The re-provision programme resettled large numbers of former long-stay patients into smaller residential units in the community. It also led to acute psychiatric inpatient units being built on District General Hospital sites, a move that helped to dispel some of the stigma associated with using mental health services. The concept of ‘care in the community’, shaped by numerous policy and consultation documents, was to become the mantra for mental health services for the next two decades and beyond.

Of the 130 psychiatric hospitals in England and Wales in 1975, 116 have now closed and the others are much reduced in size (Mahoney, 2004). Although this programme is largely complete nationally, some NHS trusts are still finalising plans for new units to replace these large institutions. At the same time, a second wave of re-provision is under way as commissioners and providers of acute inpatient services re-evaluate the suitability of their premises to meet the needs of the 21st century, with a move towards creating smaller, more domestic-style units. Recent central requirements on the provision of single sex accommodation are also affecting the design of new acute inpatient units (NHSE, 2000).

However, recent research suggests that six European countries, including England, have been undergoing a process of reinstitutionalisation during the past decade, based on an increase in the number of forensic beds and places in supported housing (Priebe *et al.*, 2005). It further suggests that a similar increase in the prison population during this period is also contributing to an institutional response to the containment of perceived risk.

The impact of changing policy on acute inpatient services

The theme of mental health policy during the last 20 years has been the growth and development of community-based services alongside a reduction in the reliance on inpatient care. An understanding of some of the key government policies and guidance relating to, or affecting, inpatient care is helpful in seeing how far acute services have come.

Box 1: Policies and guidance affecting acute inpatient care 1975-2002**1975: *Better Services for the Mentally Ill*** (DHSS, 1975)

This White Paper set the scene for developments throughout the 1980s and beyond, describing the way in which NHS, local authority and voluntary sector agencies should provide an integrated mental health service, with the focus on community-based services.

1988: *Community Care – agenda for action* (Griffiths, 1988)

The Audit Commission (1986) had reported that although hospitals were reducing in size, community services were not sufficiently resourced to provide alternative types of care. This led to Roy Griffiths' 1988 report, which proposed the transfer of all community care to local authorities.

1989: *Caring for People* (DHSS, 1989)

This White Paper, a response to the Griffiths' report, set out the framework for changes to community care, including a split between the purchasing and providing functions of health and social care agencies, and an encouragement of the use of a broad spectrum of services, including independent as well as statutory sector providers.

1990: *National Health Service and Community Care Act* (House of Commons, 1990)

This gave local authorities responsibility for community care assessments and provision and introduced the Care Programme Approach (CPA), effective from 1991, as the framework for the care for people with mental health problems.

1993: *Health of the Nation, Key Area Handbook, Mental Health* (DH, 1993)

This expanded on the three mental illness targets set out in the 1992 *Health of the Nation*. The targets included significantly improving the health and social functioning of mentally ill people, and reducing suicide rates.

1996: *The Spectrum of Care: Local services for people with mental health problems* (DH, 1996)

This handbook summarised the core components that should make up a comprehensive local service for people with mental health problems. It included information on the types of treatment and the range of settings for treatment and social care, including 24-hour care for people in acute mental health crisis.

1997: *The New NHS: Modern, Dependable* (DH, 1997)

This White Paper included the replacement of the NHS internal market with new funding arrangements, reforming the 'purchaser/provider split' that had begun in 1991.

1998: *A First Class Service: Quality in the New NHS* (DH, 1998a)

This strategy paper announced the intention to set national standards through evidence-based National Service Frameworks, along with the formation of the National Institute for Clinical Excellence (NICE) which would produce guidance on

Box 1: Policies and guidance affecting acute inpatient care 1975-2002 (continued)

clinically- and cost-effective treatments. It also set out a number of initiatives to monitor the quality of services provided: clinical governance within health care providers, the formation of the Commission for Health Improvement (CHI), and the establishment of a performance framework.

1998: *Modernising Mental Health Services: Safe, Sound and Supportive* (DH, 1998b)

This presented the Government's strategy for reforming mental health services for the adult population and announced a massive injection of funding over three years. In a Foreword, Frank Dobson, the Secretary of State, made the startling statement that "care in the community has failed". The document went on to make a commitment to ensuring there were "enough beds of the right kind in the right place", stating that in some areas, particularly London, there would need to be more beds for acute care.

1999: *National Service Framework (NSF) for Mental Health* (DH, 1999)

This set national standards for mental health services, mostly focused on elements of community services. Standard five says that people who need "a period of care away from their home" should have timely access to a hospital bed, or an alternative place, in the least restrictive environment and as close to home as possible.

2000: *The NHS Plan* (DH, 2000)

Most of the focus of this 10-year plan was on community-based services such as the development of a range of specialist teams. While part of the rationale of the new services was to reduce pressure on beds, the *NHS Plan* gave no specific mention to acute mental health hospitals at all.

2001: *The Mental Health Policy Implementation Guide* (DH, 2001)

This supported the delivery of adult mental health policy at the local level, following on from the *NHS Plan* and the *NSF*. Although emphasising the need to see mental health services as "whole systems", it too did not address acute inpatient services, merely acknowledging their importance and promising guidance at a later date.

2002: *Mental Health Policy Implementation Guide: Adult Acute Inpatient Provision* (DH, 2002)

This describes acute inpatient care as "a core and integral component of the *NSF* to which all the *NSF* standards are relevant", making the point that despite the reduction in bed numbers, more is spent annually on hospitals than on community services. It provided guidance on how to improve services, acknowledging the importance of the physical, psychological and therapeutic environments of care. It said inpatient care was one possible response – rather than the only option – to someone needing care at a time of mental health crisis.

The therapeutic inpatient environment

Those who commission services increasingly expect to be able to draw on published research evidence to help shape their view of what they should fund. In this evidence-based climate, it is instructive to be reminded of Muijen's warning (2002) that there remains no research evidence demonstrating "the therapeutic effectiveness of hospital care as compared with other services". He adds that the key to therapeutic care is investing in inpatient staff – their recruitment, training and retention – and in designing services "around the wishes of the patient", without which wards will "neither be therapeutic nor safe". Yet in the late 1990s and early 2000s, a number of research studies looked at what was happening in acute inpatient units, and found many causes for concern.

In 1998, the Sainsbury Centre for Mental Health examined inpatient care in 38 sites across the country, focusing in more depth on a representative sample of nine inpatient wards and interviewing 112 inpatients (SCMH, 1998). This study found that one in ten people had been admitted for the 'wrong' reasons – social reasons or respite care. Nearly three-quarters of all patients who were on the wards two months later probably did not need to be there. Serious deficiencies in the standard of care offered by acute inpatient services were identified. In particular, the care provided did not meet individuals' social and therapeutic needs, the ward environment was generally poor and lacking in amenities, and the needs of specific groups of patients were not separately addressed.

One of the most striking findings, common to a number of studies (including those by Barker, 2000, and McGeorge & Lindow, 2000), is that inpatients often feel unsafe in hospital, with some experiencing harassment and verbal or physical abuse. Mind's current 'Ward Watch' campaign (2004) is backed by a survey that found many respondents still felt unsafe in hospital, that mixed sex wards were still common, that patients felt they were not helped by being in hospital and that patients were not treated with respect by staff.

One service user's chronicle of life on a psychiatric ward, (Antoniou, 2000) highlighted another common problem – the boredom and frustration of the inpatient routine. This was echoed by a number of service users who reported that boredom was the most consistent feature of their inpatient stays (Rose, 2001).

The role of service users in monitoring standards in acute services has increased over the past decade through initiatives such as User-Focused Monitoring (UFM). Many hospitals have undergone this process, in which groups of users design, co-ordinate and implement reviews of services and make recommendations for improvement. This approach is currently being used in at least 10 NHS trusts across the country.

An attempt at making things better in acute care is currently being undertaken by four English trusts that are trying to develop new ways of providing acute inpatient care, keeping service users at the heart of the process, through participating in SCMH's *The*

Search for Acute Solutions project. This three year project aims to improve life on the wards through local programmes of staff development and training and through service development.

Monitoring acute inpatient care

The Commission for Health Improvement (CHI) was established to monitor the quality of care provided by NHS Trusts. Through regular clinical governance visits to inpatient units, CHI built up a picture of life in mental health acute inpatient units, publishing a digest of their findings in *What CHI has found in mental health trusts* (2003). The report revealed high bed occupancy rates, of over 150% in some places. The Healthcare Commission has now taken over the role of monitoring health care provision from CHI, and is expected to continue with a similar monitoring programme, at least in the short term.

The Mental Health Act Commission (MHAC) is a special health authority with a statutory remit to monitor the operation of the Mental Health Act 1983 in respect of detained patients. It carries out a regular visiting programme to review the operation of the Act in mental health hospitals, which includes inspecting records and interviewing detained patients. ‘Count Me In’, the first national census of all inpatients in England and Wales, on 31 March 2005, is being led by the MHAC in collaboration with the National Institute for Mental Health in England (NIMHE) and the Healthcare Commission (MHAC, 2004).

The physical environment

The Royal College of Psychiatrists has contributed to the thinking on the constituents of an ideal acute inpatient unit through their working party report on “the size, staffing, siting and structure of new acute adult psychiatric inpatient units” (RCP, 1998). They recommended setting up project teams involving clinicians, service users, carers, and the voluntary sector to plan new units and their operational policies. They felt that the ideal unit’s size would be between 10 and 15 beds per ward, consisting of between 3 and 5 wards, no more than two storeys high, and sited on a District General Hospital campus in a convenient location for the population served. They also stressed the importance of high quality design and finish, having a safe area for exercise, ensuring that all sleeping accommodation is in single rooms with en suite facilities, and that women-only communal rooms are provided. Overall, security issues should be an integral part of the design, supported by effective policies and adequate staffing levels, to ensure that wards are – and feel – safe places both for service users and for staff.

Other research studies and reports have identified the role played by the physical environment in the mental health and safety of staff and inpatients alike. An inquiry report by Blom-Cooper *et al.* (1995) found that an inpatient building's unsuitability for its purpose had contributed to a tragic homicide. Other researchers, including Lawson and Phiri (1999, 2000) have highlighted the beneficial effects of a new psychiatric unit compared to the hospital it replaced; in particular, reduced lengths of stay were attributed to the building's improved design.

More recently, the *Health Service Journal* (2004) has been campaigning to improve the physical fabric of mental health units, having identified many wards in sore need of improvement.

Detained patients

Legal provision exists to compel some individuals, who do not accept the need for mental health intervention, to have their mental state assessed and to be treated against their will. The Mental Health Act of 1983 was effectively a re-drafting of the previous Act of 1959, formulated on the basis that hospitals were the keystone of mental health services and that patients subject to the Act would be compulsorily admitted to hospital as a first step towards assessment and treatment. The new Mental Health Bill, currently progressing through the legislative process, changes this assumption by including compulsory orders which can be applied to people living in their own homes.

Department of Health records show that the number of formal admissions to hospital under the Mental Health Act 1983 almost doubled since the end of the 1980s. There were 16,000 formal admissions in 1988-89, rising to a peak of 26,900 in 1998-99, with the most recent figures showing there were 26,700 formal admissions in 2002-03, representing a small increase on the previous year (DH, 2004c).

It has been argued that this increase is related to the proliferation and success of crisis resolution and home treatment teams at keeping out of hospital some people who would in the past have been admitted. While these teams have reduced the overall number of admissions in some areas, the individuals who *are* admitted tend to be those experiencing the most severe mental health problems, who are unable or unwilling to engage with community services, and so are more likely to be compulsorily detained.

The overall decrease in the number of beds may also be a factor, as if only the most acutely ill people can get admitted this may provide a perverse incentive to the staff involved in the process of 'sectioning' to opt for a compulsory admission. In addition, Laurance (2002) argues that the published recommendations of inquiry panels following homicides committed by individuals known to mental health services have contributed to

the development in some areas of risk-averse practice, with some clinicians responding to the public's and politicians' fears by an increased use of the Act.

As conditions for inpatients got worse, the situation of those detained against their will also gave cause for concern. In 1996, the Mental Health Act Commission in collaboration with the Sainsbury Centre for Mental Health undertook a 'National Visit' – a one day census in around 47% of all acute mental health inpatient units in England and Wales, looking at issues of bed occupancy, staffing levels, and services for women patients (SCMH, 1997). High bed occupancy rates and low levels of staffing were found, little interaction took place between nurses and patients, and there was a lack of safe facilities for women patients.

A second 'National Visit' in 1999 focused on the care of detained patients from Black and minority ethnic groups (Warner *et al.*, 2000). It examined the recording and monitoring of patients' ethnicity, how racial harassment of patients by other patients and by staff was dealt with, staff access to training in race equality and anti-discriminatory practice, and the provision of, access to, and use of interpreters. It was found that many people from Black and minority ethnic groups were not receiving care that met their cultural, religious and communication needs. Although policies to guide practice in the key areas of recording and monitoring ethnicity, dealing with racial harassment, staff training, and the use of interpreters were not universally in place, some excellent examples of good work were identified.

Workforce issues

Since 1985, staff in acute inpatient units have become the poor relations in a Cinderella service. The new crisis resolution and other new community teams have encouraged experienced clinical staff, mainly nurses, to move out of hospitals into services where they enjoy working in new ways, with more autonomy, and often with higher salaries. This has left many acute inpatient wards denuded of their most experienced staff. Trusts, forced to focus on introducing the new teams, may have had no money to spare for developing their inpatient staff through ongoing training, which has resulted, in some areas, in relatively unskilled, inexperienced and demoralised staff being left on the wards.

There is evidence, however, that acute inpatient staff are once more becoming seen as crucial to providing effective care in all parts of the service. This started with the publication of *The Capable Practitioner* (SCMH, 2001), outlining a unifying framework which encompasses the skills, knowledge and attitudes required within the workforce to effectively implement the National Service Framework for Mental Health, focusing on the key professional disciplines of psychiatry, nursing, occupational therapy, social work, clinical psychology and non-professionally aligned support work. These capabilities were

formalised by the Department of Health, through SCMH, in setting out *The Ten Essential Shared Capabilities* that all qualified and non-qualified mental health staff working in the NHS, social care, voluntary and independent sectors, should acquire as part of their core training (NIMHE, 2004).

The training of acute inpatient staff has now been informed by new training guidance (Clarke, 2004) which aims to make current training and development opportunities more relevant and available to inpatient practitioners from all professional groups.

New ways of organising services and configuring teams have presented a challenge to traditional ways of working, and psychiatrists in particular have had to rethink their role as head of the multidisciplinary team. Kennedy and Griffiths (2001), and Colgan (2002) report that some psychiatrists have already changed the way they work, becoming more focused on community-based work or making acute inpatient care a speciality in its own right. Psychiatrists' roles are also coming under national scrutiny, with a multi-agency steering group providing guidance to Trusts, consultant psychiatrists and other professionals on issues such as medical responsibility and new models in order to promote flexibility for local practice to address shortages in psychiatrists and the need to work differently (NIMHE/CWP/RCP/DH, 2004).

Alternatives to inpatient care

Increasingly during the past two decades, acute inpatient hospitals were being seen as just one possible response to people experiencing a mental health crisis, rather than the only option. The growth of crisis resolution/home treatment teams in England during the 1990s and 2000s developed from a model already being used elsewhere. They provided a community-based approach through which many service users were able to remain in their own homes during a period of mental health crisis. Authors who have documented these developments include Stein and Test (1980), Houlst *et al.* (1983) and Johnson and Thornicroft (1991). An evaluation of a pioneering home treatment team in Birmingham concluded that it had reduced inpatient bed usage, increased people's contact with community mental health services, and overall had cost less than a more conventional model of care (Minghella *et al.*, 1998).

Orme and Hogan (2000) report that the role of the voluntary sector in providing care and respite to people in mental health crisis, some provided by service user-led or user-run organisations, was slowly growing in the 1990s. A number of projects were funded in 1996 by the Mental Health Foundation, including residential services, safe houses and telephone support services. An evaluation of some of these services (MHF/SCMH, 2002) concluded that they had an important part to play in the overall range of care for people in a crisis.

Conclusion

To reflect on the position of acute inpatient care at the start of the 21st century, the key to understanding life on acute wards is the expectation that they will fulfil a number of clearly defined roles and functions. Despite Department of Health guidance, many acute units are still struggling to define what they do, and how they can work effectively within the ‘whole systems approach’ to providing mental health care.

The inpatient policy implementation guide stresses the need for the philosophy of care to be “explicitly user focused” (DH, 2002). It also quotes from an earlier Mind report in stating that the purpose of an adult acute inpatient service is “to provide a high standard of humane care in a safe and therapeutic setting for service users in the most acute and vulnerable stage of their illness. It should be for the benefit of those service users whose circumstances or acute care needs are such that they cannot at that time be treated and supported appropriately at home or in an alternative, less restrictive residential setting” (Mind, 1999).

Staff and service users from the NHS trusts participating in the *Search for Acute Solutions* project, held a series of workshops with SCMH staff to explore the role and function of acute inpatient care. The results were synthesised into the following description, taken from the unpublished SCMH report (Braithwaite, T., in Warner *et al.*, 2003) on the base-line evaluation of the project.

Box 2: The role and function of acute inpatient care

Crisis resolution: to provide rapid help and support through crisis to people with mental health problems who are severely distressed and cannot be beneficially treated/supported at home.

Safety, security and space: in a calm, dignified and homely environment
– respite, asylum or sanctuary.

Assessment (including risk assessment): to provide rapid multi-disciplinary and collaborative inter-team (community and inpatient) assessment to identify service users’ immediate and longer term goals, keeping the service user at the centre as the expert and focusing on their strengths as well as their needs.

Planned admissions as part of crisis prevention: for treatment and therapeutic interventions that are more beneficially provided on an inpatient basis.

Therapeutic treatment and care focused on recovery: during the inpatient stay, to start problem solving and initiate or continue a range of therapies (including therapies that are often stopped when someone is admitted), treatment and care that will set them on the road to recovery and will be continued by relevant community services. To help service users to develop affirmative attitudes to their experience.

Box 2: The role and function of acute inpatient care (continued)

Assertive discharge that supports community inclusion: to develop, from the time of admission, a care pathway that links the person to appropriate community resources and agencies, and supports to enable them to return home as soon as possible, ideally within two weeks. To support the maintenance of existing positive networks and links (family, friends, education, care co-ordinator, employment) to actively prevent social exclusion during the inpatient period. The range of options offered to be negotiated with and tailored to the individual person. There should be flexible levels and types of support and a focus on developing personalised relapse prevention and coping strategies and community inclusive plans that enable people to maintain and expand their skills.

Part of an integrated whole system of mental health services: For acute inpatient care to be able to become more focused, it was considered crucial that there should be a well-linked whole system of mental health care. This should provide earlier intervention to help prevent people becoming acutely distressed and would need to include well-functioning alternatives to admission in the community including crisis resolution services and home treatment for people for whom acute inpatient care is not the best option. Where admission to hospital is the most appropriate option, it should be time limited or for the shortest period required to resolve the crisis. Community and inpatient services should work together throughout admission and when planning discharge. Early discharge should be provided with sound linkages to necessary community supports (including non-mental health specific resources) to limit the likelihood of relapse and readmission and promote recovery.

This description may, perhaps, serve as a starting point for those responsible in the next 20 years for making acute care an effective and valued aspect of mental health services – an aspiration that has never been of greater importance than it is today.

Acute Care in Crisis is a sample chapter from Beyond the Water Towers

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The last 20 years have seen dramatic changes in UK mental health services. From a system dominated by large Victorian hospitals to a service based on a growing range of community services, mental health care has been transformed in the last two decades. This book charts that progress and examines the key issues facing mental health services. With contributions from many of the country's leading experts in mental health care, it is essential reading for anyone wanting to learn about recent developments in policy and practice.

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