Shorter hospitalizations at the expense of quality? Experiences of inpatient psychiatry in the post-institutional era

From the early 1950s, effective drug and psychological therapies coupled with pressures from antipsychiatry have driven a very persuasive vision of deinstitutionalized psychiatry in which the vast bulk of psychiatric care was to be delivered in the community. It was thought that small psychiatric units in general hospitals might be sufficient, although some asylum patients would need longer-term care in sheltered accommodation, mainly because they had lost skills and family contact.

In 1955, there were some 150,000 hospital beds for the mentally ill in England. By 2012 there were just 22,300, and by the end of last year 2,000 more had gone. This dramatic reduction has been helped along by developments in community care, such as assertive community treatment and crisis home treatment. Of these, crisis home treatment has had the largest impact, shown in controlled trials to be a clinical and cost-effective means of reducing hospitalization[1].

Of course, even the best functioning crisis home treatment cannot safely manage all crises in the community, and so in parallel there has been an ongoing effort to shorten the length of hospital stay for all who cannot be dealt with elsewhere. The latest manifestation of this has been the introduction of "triage" wards. These highly staffed wards cap length of stay at around 7 days, with patients either discharged home (with crisis home treatment support as needed) or transferred to a longer-stay ward in the hospital. But therein lies a problem. Patients who are transferred to the other wards in the triage system tend to be those who have the more challenging disorders, with severe breakdown of community tenure and of relationships within the community team. In one of the few studies to examine the impact of introducing a triage system on the overall length of hospital stay, we showed that the accumulation of these more complex patients with lengthy hospital stay soon filled the other wards, effectively negating any economic benefits of the triage ward[2].

The reduction in acute hospital beds might be viewed as a tremendous success for deinstitutionalization in the UK, were it not that the demand for inpatient care now grossly outstrips supply, accompanied by a rising tide of demoralization and dissatisfaction with care among hospital staff and patients. A recent survey showed that the number of patients having to be hospitalized outside their home area because of a shortage of local beds doubled, from 1,301 in 2011/12 to 3,024 in 2013/14, with typical bed occupancy in excess of 100%[3]. Only the most acutely ill are admitted, and the proportion who are compulsorily detained has risen while voluntary admissions have fallen[4]. There are reports that many patients asking for admission are being told that they are "not ill enough" to warrant it[5]. On the other hand, around one-sixth inpatients in the above survey were sufficiently recovered to be discharged, but were languishing in hospital because they needed a longer period of residential rehabilitation or were waiting for housing and other community services.

For at least a century it has been known that dramatic failures and hospital scandals occur when staff are too preoccupied by bureaucracy, and too burnt out or detached from their patients and other members of the care team to be able to feel and show appropriate compassion and care. While mercifully such dramatic failures are rare, there is realistic concern that the staff working in overcrowded "pressure-cooker" environments can become demoralized and feel swamped fire-fighting behavioural problems and attending to paperwork, leaving little time for therapeutic activities with their patients. While international standards recommend a variety of group and individual therapeutic activities that together come to an average of at least 2.5 hours daily over and above the time spent in one-to-one contact[6], these standards are seldom met. In a recent survey of acute inpatient wards, we found that structured activity and one-to-one contacts amounted to only 4.5 hours per week. There was a wide variation between wards, with some patients reporting no participation in any formal activity[7].

There are several publications of standards and guidelines backed up by inspection and voluntary quality improvement initiatives[6], that if followed would certainly result in improved standards of care. There are also specific skills-based interventions aimed at better management of violence and risk supported by controlled trial evidence[8], and much written on simple procedures linked with effective leadership that are known to improve the patient experience of general hospital care that apply equally to the psychiatric setting[9].

While the UK continues reducing beds, the picture is different in other European countries, with Germany, Croatia, Lithuania and Latvia actually increasing provision, and Belgium and the Netherlands having far higher number of beds per capita. Nevertheless, in the opinion of many UK psychiatrists, we probably have sufficient beds if only something could be done to solve the problems of delayed discharge[3]. Some even argue that, rather than trying to increase hospital care, we should be looking to replace it with residential alternatives in the community. This has been a successful pathway in some European settings[10], but in England these are rather more localized efforts, such as crisis houses linked to home treatment teams. Most provide fewer beds than a typical acute inpatient ward, and the majority only accept voluntary admissions. Many do have fewer problems with staff morale and are preferred by patients but, because of their relatively isolated community base, they are not viewed as sufficiently safe places to take the more acutely unwell, especially where there are risks of violence. Paradoxically, when run alongside rather than replacing hospitals, they may have even contributed to the worsening inpatient situation, as they divert admissions of the more compliant, less chaotic

patients, leaving the most disturbed and disabled to enter acute care.

It seems obvious that longer-term residential care is needed for the complex more disabled patients that are clogging acute care, but in the decades following the closure of the asylums, the UK also quietly disinvested in longer-term care, so that there are now fewer rehabilitation beds per capita than elsewhere in Europe[11]. At one point it was even a matter of policy that the new assertive community services would enable all psychiatric rehabilitation beds to close, and around half of the community rehabilitation teams were wound up, the staff being re-tasked to provide for the home treatment and other new community teams. Similar processes were seen elsewhere in Europe and North America, with the provision of longer-term residential care bearing little relation to local mental health needs[12]. In the U.S., Sisti et al[13] pointed out that the numbers of patients now cared for in long-term state facilities are around 10% of what they were in 1955, and noted (as have many North American commentators) the growing numbers of mentally ill in jails and prisons, that they argued have now become the nation's largest mental health care facilities.

In conclusion, we are where we are because we have ignored much of our own advice to the world on ensuring we provide what we need in the community before rushing to shut down hospital care[14]. I believe the one thing we can do to improve the quality of inpatient care is to take steps to reduce the current "pressure-cooker" environments of acute care and so allow inpatient teams the space to deliver quality care to their patients. To achieve this, while I am certain that a return to the large asylums is not the solution (see also Cohen et al[15] in this issue of the journal), it is clear that we need to ensure adequate provision of inpatient rehabilitation and closer implementation of the guidelines for rehabilitation pathways that already exist. In these settings, as indeed all inpatient care, the ultimate determinants of quality rest on good leadership by example and the presence of compassionate staff, trained and supervised appropriately.

Tom K.J. Craig
Psychology & Neuroscience, King's College London, Institute of Psychiatry, London, UK

1. Paton F, Wright K, Ayre N et al. Health Technol Assess 2016;20:1-162.
2. Williams P, Csipke E, Rose D et al. Br J Psychiatry 2014;204:480-5.
3. Commission to Review the Provision of Acute Inpatient Psychiatric Care for Adults. Interim report 2015. www.caapc.info.
4. Health and Social Care Information Centre. Adult critical care data in England. www.hscic.gov.uk.
5. MIND. Listening to experience: an independent enquiry into acute and crisis mental healthcare. www.mind.org.uk.
6. Cresswell J, Beavon M, Robinson H. Standards for acute inpatient services for working-age adults, 5th ed. London: Royal College of Psychiatrists, 2014.
7. Emese C, Flach C, McCrone P et al. Soc Psychiatry Psychiatr Epidemiol 2014;49:665-71.
8. Bowers L, James K, Quirk A et al. Int J Nurs Stud 2015;52:1412-22.
9. Aboumatar HJ, Chang BH, Danaf AJ et al. Med Care 2015;53:758-67.
10. Mezzina R, Vidoni D. Int J Soc Psychiatry 1995;41:1-20.
11. Samele C, Urquia N. Epidemiol Psychiatr Sci 2015;24:371-5.
12. de Girolamo G, Picardi A, Micciolo R et al. Br J Psychiatry 2002;181:220-5.
13. Sisti DA, Segal AG, Emanuel EJ. JAMA 2015;313:243-4.
14. Thornicroft G, Alem A, Dos Santos RA et al. World Psychiatry 2010;9:67-77.
15. Cohen A, Chatterjee S, Minas H. World Psychiatry 2016;15:116-7.

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