editorial

Psychiatric Bulletin (2002), **26**, 81–82

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Acute hospital care: the beauty and the beast of psychiatry

In the UK few have anything good to say about acute hospital care in psychiatry these days. Overcrowded with patients, understaffed and inadequately resourced, in-patient care has been described as ineffective, inefficient and poorly organised (Muijen, 1999). The situation is particularly critical in deprived inner-city areas (Goldberg, 1997), where daily bed occupancies as high as 120% (Lelliot *et al*, 1994) have come to epitomise the crisis in mental health care (Powell *et al*, 1995; Marshall, 1997). This is clearly detrimental not only to staff, in terms of morale, training and standards, but, ultimately and foremost, to patients themselves (Sainsbury Centre for Mental Health, 1998).

The closure of Victorian asylums and large institutions was supposed to run concomitantly with the implementation of care in the community, which, in theory, was supposed to improve the patients' lot (Thornicroft & Bebbington, 1989). Much research has been done to ascertain the advantages of community care (Thornicroft *et al*, 1998) and to provide guidelines for how it should be carried out (Becker *et al*, 1998). For reasons ranging from the economic to the ideological, with concerns about patients' welfare somewhere in the middle, hospital care was demeaned as if it were the ugly and unwelcome relation of treatment options in psychiatry (Prior, 1991). With all emphasis placed on care in the community, hospital care was regarded as a minor and inevitable irritant that, at worst, should be avoided and at best be tolerated. From the 1980s the number of psychiatric beds in England and Wales was dramatically reduced, from 150 000 to less than 40 000. In inner-London this was accompanied by rates of bed occupancy that could reach 130% and a marked increase in compulsory admissions to hospital. A census carried out in January 1999 found that over half of the acute in-patient population was detained under the Mental Health Act 1983 and that over a third of acute patients were staying in hospital for longer than 3 months (MILMIS Project Group, 1999). A feeling of gloom seems to pervade everyone involved: the Government, who not long ago declared the failure of care in the community (Department of Health, 1998); mental health professionals, particularly psychiatrists, who are now difficult to recruit and to retain (Milton, 1998; Storer, 1998) and who retire early as soon as they can (Kendell & Pearce, 1997); and the patients, particularly those (so very many) who are still admitted to hospital (Sainsbury Centre for Mental Health, 1998).

Many would say that community care has not bloomed as expected because it has not been deployed as it should (Goldberg, 1997; Marshall, 1997). Lack of resources may be to blame. Yet all the hype about community care seems to have obscured a pressing issue: at least at some stage of their lives, hospital treatment is and will continue to be necessary for many of those who suffer from a mental illness (O'Driscoll, 1993).

Common sense dictates that care in the community can only work for patients who are well or stable enough to live and survive in the community. There is, however, a number of situations that may prove impossible or difficult to address in the community. It is necessary that certain patients are admitted, such as those at risk or whose diagnosis is unclear, those that require treatment for acute psychotic states or severe depressive disorders or those in need of review following relapse or deterioration of their mental states. Moreover, admissions are often required to offer patients and others, particularly their carers, protection and respite. Frequently, hospital care may also prove the only alternative available when the prospect of living in the community is shattered by homelessness (Commander *et al*, 1997) and social deprivation (Shepherd *et al*, 1997).

Acute psychiatric units have, therefore, the daunting and complex job of managing patients at the most critical stages of their lives, when they are most vulnerable and in need of help. Moreover, admission is likely to occur when there has been a failure in the patients' support network, formal or informal – an event that even the best resourced community services may not always be able to avert. Long-term care plans are formulated or revised in the course of patients' admission to hospital, with far reaching implications to both their progress and the care they will receive in the community long after they have been discharged. More often than not, it is in the hospital that major decisions about clinical management of patients in both the short- and long-term are made.

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These crucial tasks are at the very core of mental health care. It follows that community services alone are unlikely to ever make up for the need of acute hospital care when it arises (Tyrer *et al*, 1998), as so often is the case. Perhaps more to the point, no community service is likely to succeed if it does not count on the provision of an effective, well-structured and readily available acute in-patient service. Although this would probably be true even for community services that have reached standards of 'glittering perfection' (Trieman *et al*, 1999), it seems no more than a statement of fact when standards are less than perfect. Ironically, one of the main reasons why care in the community 'has failed' may be the neglect of acute hospital services (Burns, 1998).

It is probably time to review and reshape acute hospital services with the same determination with which community services were once promoted. Recognising that the role of acute hospital care has become blurred after years of drifting along could be a first step in the right direction. Although hospital and community services may share common goals for their patients, they fulfil different functions, have different priorities and operate on different time scales. It is up to acute hospital care to carry out essential interventions in the short term that will enable long-term plans to be implemented and achieved once patients are back in the community. To this end, acute psychiatric services have to operate with a set of skills, facilities and resources that may not be the same as those required in the community. A clearer distinction between hospital and community care, where the different priorities of each are translated into a well-defined, practical and coordinated division of roles, is likely to raise standards at both ends. Not only could provisions that are necessary for each to work effectively be thus identified, and resources hopefully allocated accordingly, but training programmes and working practices be developed that clearly reflect the specific functions and needs of each setting.

At Guy's Hospital, which covers a deprived London inner-city area with a large itinerant population and high psychiatric morbidity, the separation between hospital and community care has proved to be a sensible alternative to address unremitting pressures on services, such as heavy clinical workloads and high rates of admission throughput. A dedicated hospital-based, consultant-led multi-disciplinary team was able to devise and implement solutions for the local bed crisis that otherwise would be unlikely to emerge. At the same time, an effective interface between the hospital and community mental health teams was developed that ensured both continuity and high standards of care for patients across the services.

Acute psychiatry is a critical area of mental health care that should be regarded as a sub-speciality in its own right. The experience so far strongly suggests that it should be duly accredited as a key component of mental health care. Imminent changes in mental health legislation are likely to set standards for in-patient care that can only be met by hospital services that are properly staffed, trained and equipped for the task. Bringing acute hospital care to its rightful place at the forefront of psychiatric care may prove the catalyst that is missing to make mental health services stand firmly on their feet and walk steadily along a more even path, perhaps with fewer chances to stumble over 'failures' down the way.

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